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House of Representatives

The House was not in session today. Its next meeting will be held on Tuesday, November 25, 2003, at 12 noon.

Senate

SUNDAY, NOVEMBER 23, 2003

The Senate met at 1 p.m. and was called to order by the President pro tempore [Mr. STEVENS].

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

O God, too near to be found and too good to make a mistake, help us to

trust the fact that You know us better than we know ourselves and desire for us abundant living.

Give us strength sufficient for this day and blessing that will enable us to transform hurting lives. As we rely upon Your wisdom, guide our steps and bring us safely to our desired destination. Keep us from trouble and let Your

faithfulness inspire us. Lead us beside peaceful streams and renew our strength.

Guide our Senators. And Lord, give them a faith that works by love and keep them strong and steadfast in their efforts to do Your will. We pray this in Your wonderful Name. Amen.

NOTICE

If the 108th Congress, 1st Session, adjourns sine die on or before November 24, 2003, a final issue of the Congressional Record for the 108th Congress, 1st Session, will be published on Monday, December 15, 2003, in order to permit Members to revise and extend their remarks.

All material for insertion must be signed by the Member and delivered to the respective offices of the Official Reporters of Debates (Room HT-60 or S-410A of the Capitol), Monday through Friday, between the hours of 10:00 a.m. and 3:00 p.m. through Friday, December 12, 2003. The final issue will be dated Monday, December 15, 2003, and will be delivered on Tuesday, December 16, 2003.

None of the material printed in the final issue of the Congressional Record may contain subject matter, or relate to any event that occurred after the sine die date.

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By order of the Joint Committee on Printing.

ROBERT W. NEY, *Chairman*.

• This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.



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S15591

PLEDGE OF ALLEGIANCE

The Honorable TOM DASCHLE 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 MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Today, the Senate will resume debate on the Medicare prescription drug conference report. We had an extended and vigorous debate on this historic legislation yesterday. Again, it is unusual to have a Saturday session and even more unusual to have a Sunday session, but the historic level which this debate has reached demonstrates the importance of doing just that.

There are a number of Senators who will be on the Senate floor to discuss this matter during today's session, and in an effort to accommodate the number of Senators who are seeking floor time today, we would encourage Members to limit their statements to no more than 30 minutes. We hope to work out a schedule so that Members will have a better understanding of at what point in the day or the evening they will be able to speak. If we can lock in 30 minutes per Member, or possibly work out alternating hours, which we will do, hopefully, in a few minutes, we will then have an orderly way to move forward so that everybody will have an opportunity to address this important issue.

Yesterday, it became apparent that we would not be able to lock in a time certain for an up-or-down vote on this important legislation, and at least one Democratic Member said that a filibuster would be the road to pursue. Thus, I filed a cloture motion on the conference report. That vote on the motion to invoke cloture is expected to occur sometime around 12:30 on Monday. All Senators will be notified when that vote is set.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The minority leader is recognized.

Mr. DASCHLE. Mr. President, I share the view expressed by the majority leader about the need for us to accommodate as many Senators as possible. It is my understanding that there is no objection to actually locking in a 30-minute time limit. Senators are free, of course, to ask unanimous consent to extend if they wish. So at this time I propound that request.

I ask unanimous consent that Senators be limited to no more than 30 minutes during the debate today.

The PRESIDENT pro tempore. Is there objection?

The Senator from Oregon.

Mr. WYDEN. Mr. President, reserving the right to object, and I do not intend to object, I just want to clarify one matter. My understanding is, and it is printed in the calendar, that there is already an order of speakers that has been established. I want to make clear that that will be recognized as we go forward today. I certainly will not object to the request of the distinguished minority leader. I just want to be clear that that will be the order of the speakers.

The PRESIDENT pro tempore. Is there objection to the original request?

The Senator from Massachusetts.

Mr. KENNEDY. Reserving the right to object on the order, I was referred to by my good friend, the majority leader, last evening at about 6:15 in reference to this legislation. The time-honored tradition of this body is to notify an individual when there is going to be reference made to them. I was not notified, and I heard later last evening that I was referred to. I indicated that to the leader. I would like to be able to do this in a timely way. I was listed yesterday to be either third or fourth in order, but I am not prepared right now—if there is some other previous order that has been arranged, I want to be able to reserve my rights that have been respected in this institution for 220 years, and that is when a Senator is referred to in terms of legislation, a fair opportunity is given for them to respond.

The PRESIDENT pro tempore. Is there objection to the original request?

The Senator from Nevada.

Mr. REID. Mr. President, I hope that Senators would not ask to extend beyond half an hour because it is so difficult to object. We have a lot of people. We have 17 on this side. Multiply that by half an hour and one gets the figures. I hope everyone will stick by the half hour that will be entered into, hopefully, momentarily.

I say to my friend from Massachusetts, the way the order is now set on our side, the majority leader would speak first. I would speak second. I would be happy to change places with the Senator from Massachusetts so he can go second, and I will go sixth or seventh.

Mr. KENNEDY. The Senator from Nevada, as always, is more than kind and generous. I appreciate that very much. I have no objection.

The PRESIDENT pro tempore. Is there objection to changing the order as the Senator from Nevada requested? Without objection, it is so ordered. The Senator from Massachusetts will take the place of the Senator from Nevada, and the Senator from Nevada will have the place in the order of the Senator from Massachusetts.

Is there objection to the minority leader's time limit of 30 minutes per speaker?

The Senator from Kentucky.

Mr. BUNNING. Mr. President, the list that is published in the calendar only has Democratic Senators in it. Obviously, there is an alternative list that would allow for Republican Senators to have a 30-minute block in between the Democratic Senators who speak.

The PRESIDENT pro tempore. The Parliamentarian informs me the Senator is correct, that a Republican Senator will go after each Democratic speaker if someone is here to be recognized.

Mr. FRIST. Let me also clarify that on the Republican side we are not locked into any order. The opponents to the bill are locked into an order of speakers. Ours has been just an agreement, so we are not locked into any order, but there will be a 30-minute limit, and we will be alternating back and forth.

Mr. BUNNING. I thank the Chair.

The PRESIDENT pro tempore. Is there objection to the minority leader's request? Without objection, it is so ordered.

Who seeks time?

RESERVATION OF LEADER TIME

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

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003—CONFERENCE REPORT

The PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of the conference report to accompany H.R. 1, which the clerk will report.

The legislative clerk read as follows:

Conference report to accompany H.R. 1, an act to amend Title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare Program and to strengthen and improve the Medicare Program, and for other purposes.

The PRESIDING OFFICER. The minority leader is first on the list.

Mr. DASCHLE. Mr. President, I will certainly not exceed 30 minutes. I hope I can speak using less time because we are getting a little bit of a late start.

Let me begin by saying what an important debate this is. This is a debate the consequences of which will last for generations. This debate in many respects will be every bit as important as the debate on Medicare in 1965. One really has to go back to that year, 1965, to fully appreciate what we are debating now.

There was a debate, of course, in that period of our history, in the mid-1960s, about whether it was possible for us to address what was a national embarrassment at the time. About half of all senior citizens in the early 1960s had no health insurance—none. They were left out. There were horror stories about what they had to do in order to accommodate the health problems they were facing. It was a painful chapter. In

some cases, because seniors had no health insurance, they were not living as long, the quality of their lives could not have been worse, and they were the poorest of the poor. They often had no income other than Social Security, and Social Security took them nowhere in regard to paying for the costs of health care.

Thanks to President Kennedy and then-President Johnson, the recommendation was made that we provide a national health insurance plan for seniors. Republicans, at that time, argued that it was not the role of Government, that it ought to be the private sector that provides health insurance. Democrats argued, in response, that given the group of people we were talking about, providing health insurance for senior citizens in the private sector had about as much profit in it as providing insurance for a haircut. You are dealing with the sickest, most elderly in our population. So there is not much of a profit incentive for insurers; there is not an incentive in terms of the demographics and all of the actuarial circumstances. The private sector has virtually been loath to insure seniors because of that. It is like insuring a haircut. There is an inevitability, if you are a senior, to that moment in one's life when illness becomes a serious threat. And obviously, that is when the circumstances involving the end of life become all the more real.

Medicare stepped in. Now, over the last 40 years, it has been one of the most successful programs in all of American history. Forty years of success, 40 years of providing health care with a consistency and a confidence we have never had in all of our time in this country.

My mother has benefits from Medicare. My mother benefits from Social Security. I can only imagine what it would be like today if she did not have Medicare and Social Security upon which to depend.

So Republicans, over the last 40 years, have tried to find ways to go back to that debate of 1965 and say: We still believe in the private sector. We ought to be able to find a way to provide insurance for a haircut and incentivize the private sector.

I will never forget the extraordinary statement made by the Speaker of the House, I believe it was in 1994. He addressed that very issue all over again when he said: It is still our hope and still our design to see Medicare wither on the vine.

For 40 years they have attempted to bring about an end, if not to Medicare itself, certainly to the concept of universal coverage through Medicare for all senior citizens.

That is really the backdrop that today we must recognize as we begin the debate on this bill. How is it that those very colleagues who 40 years ago argued that we really should not have a Government program for universal coverage for health care, who just 10 years ago said we ought to see Medi-

care wither on the vine, now in the name of Medicare are arguing we need to reform it, we need to improve it? We are not improving it with this bill. We are not reforming it with this bill.

Does Medicare need to be changed? Of course. And providing a meaningful prescription drug benefit is probably the single best reform we could enact, because medicine itself has changed. But to those who say we want Medicare to look more like the private sector, I say you don't speak for me with that assertion.

Medicare has had about a 4 percent administrative cost over 40 years; 96 percent of the money that goes into Medicare goes to benefits. Do you know how that compares with the private sector? I am told the average administrative cost in the private sector for insurance plans is not 4 percent. It is not even 10 percent. I am told the administrative cost for a private sector plan today on the average is about 15 percent—almost four times the administrative costs of Medicare.

So if you want to see the Medicare plan become more like a private plan, then count on spending almost four times more for administrative costs. At most, 85 percent of premiums go to benefits in private sector plans.

How ironic that we find our colleagues saying: We want to make Medicare more like the private sector; we want more competition.

We don't mind competition. But the kind of competition they want doesn't make a lot of sense to me. Why would we provide, instead of 96 percent of the benefits to the beneficiary, only 85 percent, and call that progress?

To make Medicare more "competitive," our colleagues want to give more than \$14 billion of incentives to the private sector to get them to insure a haircut. Their notion is that somehow we can find a way to make the private sector more interested in providing meaningful health care to seniors, when Medicare is doing it so well already.

There are a lot of very grave concerns we have about this legislation. I brought some charts to the floor to talk about some of these concerns. I want to address them, if I can, in the time I have allotted to me.

I think one of the biggest concerns I have is that seniors today are very concerned about prices. They are concerned that their drug prices go up each and every year.

I will never forget talking to a woman in Sioux Falls whose name is Florence. She told me that, at 73 years old, she must work and she must use the supplemental pay she gets from her job—at 73—simply to pay for the drugs she needs. Her drug bill is about \$400 a month. It goes up 10 to 15 percent every year.

She drives to Canada once every 3 months in order to save \$100 a month. She figures every 3 months she saves enough to actually buy the drugs for a month with that trip to Canada. So,

without question, I think most seniors are very concerned about what is going to happen to the costs of their drugs.

The answer, with all of the specific analysis done to date about the impact of this bill, the best analysis we can provide so far, is that up to 25 percent of all beneficiaries are actually going to pay more, not less, for the drugs they buy with the passage of this bill—25 percent. It could be more than that.

Many Medicaid beneficiaries are going to pay more than what they are paying right now.

And there are many in the private sector who are going to pay more. You are going to see several million Medicare beneficiaries who now have private coverage actually lose that coverage as a result of the passage of this bill. The estimate is now about 2.7 million senior citizens will lose their retiree coverage when this legislation is enacted into law.

There are a number of other concerns we have with regard to this particular bill, including the coercion of seniors into HMOs and increasing their Medicare premiums with the so-called premium support concept. Within 7 years, many seniors are going to be forced into a pilot project in at least six locations. In those locations at least, and maybe others, we are going to see not only increases in Medicare premiums, but also seniors coerced into HMOs. These are cases where seniors have never even thought about an HMO until now.

In addition, millions of seniors are going to go without drug coverage during part of the year. I will talk more about that later.

We also are going to keep drug prices high as a result of this legislation. There is very little this legislation does to reduce the cost of drugs at all, as I said just a moment ago.

And finally, we squander \$6 billion needed for retiree coverage on tax shelters for the wealthy and the healthy.

For all of these reasons—the cost to beneficiaries, the coercion of seniors into HMOs, millions of seniors who are going to go part of the year without any coverage at all, the fact that drug prices don't come down but they go up, and that we squander \$6 billion on tax shelters for the wealthy in the name of Medicare—it makes a mockery of the whole word "reform."

I said earlier that up to 25 percent of all beneficiaries will see more costs for drugs. There are two categories in particular. Studies have shown that 2.7 million retirees, including about 5,000 South Dakotans, will actually lose the coverage they have with the private sector when this legislation is enacted. And that 2.7 million number, I think, is actually going to be higher. For those millions of Americans and those thousands of South Dakotans, that would be the biggest blow of all. They have confidence now that they can go to the pharmacy, and they can buy their drugs. They do not have to worry about whether or not they are covered. They

had better start worrying because the problems kick in just as soon as this legislation is enacted, if it is.

Up to 6.4 million low-income beneficiaries are going to pay more or lose access to drugs they are now provided. I think the 25 percent number may be a conservative figure.

When you take the number of retirees adversely affected, when you take the number of low-income beneficiaries who may be worse off under this plan, you begin to appreciate the magnitude of the problem this bill is going to create for millions of senior citizens today who are totally unaware of its negative implications.

The legislation creates a dilemma. The choice seniors will face is higher premiums on one side or an HMO on the other. How is that reform? How does that possibly relate to this widely stated goal we all have that we simply want to provide a meaningful drug benefit to senior citizens? This bill isn't a drug reform plan, this is a Trojan horse for the collapse of Medicare.

We are going to see the loss of Medicare as we know it today if this legislation passes. I think this chart describes it pretty well.

If you want to see increased premiums, support this bill. If you want to see seniors forced into an HMO, support this legislation. It leaves a question mark for a senior citizen right now: What do I do? How do I respond? How can I prepare myself for what is about to come?

What is about to come regarding drug coverage is described on this calendar. This calendar says more than any speech probably can. This calendar describes in essence the drug benefit structure. Of all the concerns I have, the benefit structure is one of the most troubling to me. I want to describe it, but then I want to use this calendar to talk about its implementation.

A senior will start paying \$35 a month. We will come back to that figure in just a minute. A senior pays that \$35 a month 12 months out of the year—January through December. Then the senior must pay 100 percent of all the benefits up to the deductible. That is depicted in red. Then the first dollar of protection under this plan for drug coverage would kick in, following the \$250 deductible. Beneficiaries pay all of the \$250. The drug coverage kicks in from \$250 in spending up to \$2,250. The Government pays 75 percent of the benefit. After the benefit has been paid—75 percent Government, 25 percent senior, up to \$2,250—the Government says: Wait a minute. We paid all we can pay. You are on your own from \$2,250 up to \$5,100. You are going to pay all the costs during that period.

After the beneficiary pays \$35 a month, 100 percent up to \$250, and 25 percent up to \$2,250, they have to pay the entire cost up to \$5,100, even though they are still paying a premium, and then they have a 95 percent benefit that kicks in after that.

Basically, what this calendar depicts is the drug schedule for 2006 for bene-

ficiaries with \$400 per month in drug spending.

By the way, the benefit doesn't kick in until 2006. So there are premiums that kick in, and the benefit lasts for a period of time, during the months of February, March, April, and May. They benefit in June somewhat. But for the entire rest of the year they are on their own.

This convoluted benefit structure is scary, as I think of my own mother, and I think of all of those who are going to try to figure it out: How in the world do I know how much I owe? How much can I count on? How much of these benefits are really going to apply to me?

This period of no benefits is called a coverage gap. Some people call it a donut hole. Whatever you want to call it, it is a mistake.

Think of the myriad of administrative costs involved for every single senior citizen who is going to have to try to decide: Are they in the 25 percent category, the 100 percent category, or are they in the 95 percent category?

By the way, if you are a senior citizen with a lower income, you are entitled to a different schedule. First, they have to know what their income is. They are going to have to turn over their tax records to determine what kind of income they have and whether they are eligible or not. Once those tax records are determined, they then are presented with these different tables that they are going to have to try to figure out. Imagine a 90-year-old woman trying to figure out when she goes to the pharmacy what the coverage gap is: Do I pay the premium? Do I have to pay 100 percent? If I do, how do I pay for it? Am I breaking a law if I expect the pharmacy manager to give me the full benefit? How do I figure this out?

This convoluted, confusing, extraordinarily complex schedule is a disaster.

I will make a prediction. I will predict that within 12 months, we are going to be back fixing this so-called coverage gap. It is chasm, it is not a gap. It is a confusion chasm. It is a disaster. That, if nothing else, ought to warrant reconsideration of this legislation.

But as I say, the coverage gap widens over time. It is not just now. The premium, as I said, starts at \$35. In 2013, the premium goes up to \$58. The deductibles start at \$250. But guess what? In 2013, the actual deductible is going to be almost \$500. The coverage gap then goes from \$2,850 in 2006 all the way up to \$5,066 by 2013.

In other words, senior citizens are going to have to pay \$5,000 even though they are paying \$35, or in this case \$58, a month for the benefit. Can you imagine a senior citizen coughing up these kinds of dollars in just a few short years?

It is absolutely the most reprehensible expectation for senior citizens. They can no more afford \$5,000 in 2013 than they can afford it today. It is

wrong. This, if nothing else, ought to be a reason we should send this legislation back to the conference to figure out a better way of doing it.

The bottom line is, when it comes to the coverage gap, seniors are going to have to pay \$4,000 to be eligible for \$5,000 worth of benefits. Can you imagine that in the name of reform?

First of all, we are coercing seniors into an HMO. We are telling retirees they may lose their own health benefits. Two to three million people are going to lose benefits, and the benefit they are going have instead is a \$5,000 coverage gap and paying \$58 a month in 2013. That, perhaps more than anything else, is disconcerting. As I talk to seniors, the concern they have the most is, of course, the high cost of drugs.

First of all, our conferees wasted no time in eliminating the reimportation of United States-made drugs from Canada. They will point to language in the bill, but the bottom line is we will not see any change in the current law with regard to reimportation of drugs from Canada. There is virtually a prohibition on drugs from Canada. South Dakotans, North Dakotans, Montanans, Minnesotans, Michigan residents have counted on Canadian relief. That has been a big part of what has been their strategy in coping with the high cost of drugs today. That is going to be gone. They will not be able to reimport unless they go to Canada themselves.

They also have a prohibition—and this is amazing to me as one of the things Medicare has been able to show is it can leverage better prices; because of the power of pooling, we can leverage, whether it is hospital prices, doctor prices, prescription drug prices—and there is actually a prohibition for Medicare in the negotiation of lower drug prices on behalf of senior citizens. Drug companies can do it, pharmacy benefit managers can do it, but there is a prohibition on the Federal Government involving itself in negotiating on behalf of senior citizens for lower drug prices today. I have never heard of such a thing. If we cannot bring about a better price, if we cannot leverage drug prices more effectively through Medicare, who in the world can do it more effectively than the Government itself and Medicare specifically?

The reason prices are going to remain high is, No. 1, there is going to be very little competition from those sources where competition is already shown to be very effective; No. 2, Medicare itself, the Government through Medicare, is actually prohibited from negotiating better prices on behalf of seniors. That is an amazing provision of law that is inexplicable.

It goes on. I said earlier one of the concerns I have is this provision that allows \$6 billion to be squandered for those who are healthy, and in many cases wealthy today, money that could actually go for retiree coverage. It creates a new health savings account which is nothing more, of course, than a tax shelter for those who are wealthy

and will draw off people who are healthy. Ordinary Americans cannot afford it and it undermines the employer-based coverage we already have. Six billion dollars is a tremendous pool of resources that could have gone to making this program far more cost effective and far more accessible for a lot of seniors.

Instead, even though we did not have it in the Senate bill, even though we had bipartisan support for this \$6 billion going to those who need it the most, in keeping with the trend, in keeping with the philosophy of many on the other side, creating this tax shelter for the wealthy was a "must pass" piece of legislation.

The bottom line is we lost \$6 billion over the next 10 years that could have gone a long way to reducing the cost of drugs to everyone else.

How is it that with all these warts, with all these problems, with all these deficiencies, with all these concerns, this legislation could be before the Senate today? This chart shows it pretty well.

The Pharmaceutical Manufacturers Association had their agenda as well. I must say, they got virtually every single thing they wanted.

They wanted an administered drug benefit in the private sector that diluted the purchasing power of Medicare. They got it.

They wanted financial incentives for HMOs, another step away from Medicare. They got it.

They wanted a prohibition on Medicare negotiating prices, as I just described a minute ago. Guess what. It is there.

They wanted a meaningless reimportation provision because they did not want the competition. Guess what. That is in the bill as well.

They wanted a watered-down generic access provision. Check that off the list.

They wanted no public scrutiny and secret kickback arrangement potential within the contracts they have with the benefit managers and the insurers. That is in there, too.

They wanted a huge windfall profit. They are going to make more money in the next 10 years than virtually any other sector within our economy. No wonder stock prices are soaring today—because they also see the writing on the wall.

PhRMA had a checklist. PhRMA got their list checked, every single item on the list.

The bottom line is, of course, Medicare beneficiaries lose, PhRMA wins, and the bill comes before the Senate with this realization. PhRMA got what it wanted. But organizations that represent seniors, organizations that represent working families, organizations that represent State governments and city governments, organizations of all kinds—liberal, conservative, name it—organizations of all kinds have come forward to say: Please do not pass this bill. Send it back to the drawing board.

Recognize the damage you are going to do—not just to Medicare; recognize the damage you will do to the confidence and the security of senior citizens.

Now more than 200 organizations have said they oppose this legislation and they want the Senate to oppose it as well.

This legislation would have been killed in the House had they abided by the rules. One of the most flagrant demonstrations of abuse of the institution and rules I have seen: They took almost over 3 hours the other day to bring about the desired vote on the House floor in spite of the opposition of all these organizations.

You have all these organizations on one side. This picture depicts pretty well what is happening on the other. A meeting was called on November 13 to talk about the benefits of this plan, to convince seniors that somehow they are going to be better off. And all these empty chairs pretty well depict exactly what happened. Seniors know what is going on. They were not going to be part of a sham discussion. No one showed up.

No one ought to vote for this either. This legislation does not deserve our support. We can do better. This started out as a debate about providing meaningful help to seniors. It has turned into a debate to save Medicare.

We are going to do all we can to live up to the specific talks, to live up to the needs, the hopes and dreams of senior citizens today. We will do all we can to defeat this bill when those votes are taken.

I yield the floor.

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. FEINSTEIN. Mr. President, I listened to the distinguished Democratic leader and find that I agree with much of what he said. This may not be a perfect bill, but clearly there are positive and negative features to the bill.

I worked a year ago, and through an individual's help, was able to run the numbers with respect to a prescription drug plan and tried to make them come in within \$400 billion and found it to be extraordinarily difficult. In my view, the most positive feature of this bill is that it delivers voluntary prescription drug coverage to this Nation's Medicare beneficiaries. I find the low-income benefits of this bill to be one of its biggest strengths. It is better than anything we ran that came in at \$400 billion or below last year.

These benefits affect about 1.4 million Californians who have limited savings and low incomes and who will qualify for prescription drug benefits under this bill. Some of these are low-income seniors who do not qualify for Medicaid. Because of \$3,000 in savings, they are ineligible to receive prescription drug coverage through the California Medicaid Program. They will now have prescription drug coverage which is much better than I had hoped. So 351,000 low-income Californians who

are not eligible for Medicaid and have no prescription drug benefits now will have them under this bill. This was important to me. It is one of the strengths of the bill.

Analysis shows that this bill will increase the percentage of Medicare beneficiaries with prescription drug coverage from 79 percent to approximately 95 percent.

To begin with, this bill, as I said, expands the drug coverage to the 351,000 Californians who are not eligible for Medicaid. The reason it does that is because it has a much more relaxed assets test. So where the assets tests were so stringent for Medicaid, they are more relaxed here; and, therefore, those 351,000 people who found themselves without Medicaid coverage will now have coverage under this bill.

Secondly, the bill provides a 16-percent increase in Medicaid disproportionate-share hospital payments in fiscal year 2004. This has always been important to me. Every year we have had to fight for it because these are the payments that go to our county hospitals. In California, the county hospitals receive most of the people who have no coverage who are bereft and who are extraordinarily low income. California hospitals who qualified to receive Medicaid DSH money lost \$184 million this year due to cuts enacted in the Balanced Budget Act in 1997.

This bill restores \$600 million to California's hospitals over the next 10 years. I must tell you, with about 25 hospitals that have closed in my State in the last few years, this is a major item for me. The DSH money in this bill will go a long way toward protecting California's fragile health care safety net, which is dependent on a complex combination of local, State, and Federal funding.

Thirdly, the bill improves payments for indirect medical education in fiscal year 2004 and beyond. Teaching hospitals will receive a 6-percent increase in payments in the second half of fiscal year 2004 and will have their payments spelled out in future years so they can begin to plan ahead. Now, they do go down in some years. So there will be advanced knowledge of that so hospitals can begin to plan for that.

This is money that reimburses teaching hospitals. My State has some of the greatest teaching hospitals in the Nation. This money would reimburse those hospitals for costs associated with educating our Nation's next generation of physicians. That is important to me. I think it is essential funding, and it will allow our major hospitals to continue training tomorrow's caregivers.

Fourthly, the hospitals and physicians in California will benefit from this bill. Hospitals will see a full market basket update for fiscal year 2004 and have the opportunity to receive a full market basket update for the 3 years that follow. With more than 58 percent of California's hospitals losing money treating Medicare beneficiaries,

and all hospitals facing Federal and State unfunded mandates, the full market basket update is vital to my hospitals as they struggle to meet staffing, seismic, and privacy compliance requirements.

I have heard overwhelming opposition from doctors in my State to the projected 4.5-percent payment cut that physicians and other health care providers would have faced in fiscal year 2004. In other words, without this bill, doctors in my State—and I do not know about elsewhere—but doctors in my State were going to face a projected 4.5-percent payment cut.

This bill prevents that payment cut from happening, and it includes an increase in payments for fiscal years 2004 and 2005 of 1.5 percent each year. This means that doctors in my State will be paid more for their services. It may not sound like a lot, but we have doctors leaving California and going to other States because they cannot meet the high cost of living in the State of California and practicing medicine. So even a small amount helps them stay in business.

In my State, approximately 33 percent of all Medicare beneficiaries get their health care coverage from Medicare+Choice.

Now, Medicare+Choice has not been a positive experience in every case. I think we all know this. This bill, though, strengthens the Medicare+Choice Program, renames it Medicare Advantage, and it provides payment increases to HMOs. Some find that objectionable. I, frankly, do not, because these increased payments to HMOs and preferred provider organizations should provide some premium stability throughout the State. I intend to watch and see if, in fact, it does happen.

Now, I have many concerns about this bill. The Democratic leader pointed out some of them. This is certainly not a perfect bill. I am not on the committee. I did not write the bill. I struggled to have a little bit of input into the bill, probably much less than I would have liked.

I am deeply concerned about the number of Californians, though, who have lost their retiree health benefits as a result of rising health care costs. This is happening right now without a bill. It is projected that 10 to 12 percent of retirees who have private health care plans are losing their benefits each year. That is happening without this bill. The reality is—and I know people do not like to look at this—if we do not pass this bill, employers in my State will continue to drop coverage for their retirees at this estimated rate of 10 to 12 percent a year. Many of these employers who have chosen to retain coverage for their retirees have required their retirees to pay higher co-payments and premiums—not under this bill but today.

Through direct subsidies and tax provisions, this bill actually reduces the number of seniors in California who

will lose their retiree health coverage from approximately 431,420 in the Medicare bill that passed the Senate, that a majority of us voted for, to approximately 198,000 in this bill. These are California numbers, true. I cannot speak to other States. But what I am saying is, because of this bill, the number of retirees in California who would lose their retirement benefits will drop from 431,420 to 198,000.

Now, I wish the number were zero, but the point is, the bill makes it better, not worse. I think that is a good thing.

Now, I find it very difficult that this bill does not restore access to Medicaid and SCHIP for legal immigrant children and pregnant women at the State's option. The Senator from Florida, Mr. GRAHAM, authored legislation which I voted for which did do this. I intend to introduce—and I hope with him—legislation to restore Medicaid and SCHIP benefits to California's legal immigrant children and pregnant women next year.

I find it, frankly, troubling that this bill actually provides \$250 million per year for 4 years to reimburse hospitals for providing emergency care services for undocumented immigrants, and California's hospitals will receive approximately \$72 million a year to reimburse them for their care to undocumented immigrants, but we take away the coverage for legal immigrants.

I expressed my concern to Senator BREAUX, to Senator BAUCUS, to Senator FRIST about this issue. I was told the House would not accept this language. I hope next year the Senate will once again pass a bill to restore these benefits. This is a big item in California, and I deeply believe people who come to this country legally should be entitled to these benefits.

My State spent \$3.7 billion in 2002 in uncompensated care, so the additional money that California gets for the care of illegal immigrants of \$72 million a year at least will go some distance in covering that deficit.

In my role as vice chair of the National Dialogue on Cancer and cochair of the Senate Cancer Coalition, I have a very serious concern about this bill's Medicare reimbursement cuts for cancer care, particularly oncology physicians. It is my strong view that every suffering cancer patient should be able to have a so-called quarterback physician, an oncologist, someone who is with them who can go through all of the terrible choices and decisions that have to be made by a cancer patient and stay with them through it all.

I have talked to both Senators BAUCUS and BREAUX and also to Senator FRIST. They have all said this bill will leave the oncology community better off. I don't see that, candidly. In looking at this complicated Average Sales Price versus Average Wholesale Price issue, I don't see where they will be better off. I want the RECORD to reflect that I have received those assurances. I don't know whether they are true or

not, but I can promise my colleagues, I intend to follow very closely the impact this bill will have on cancer care up and down the State of California. My staff and I will be watching the cancer care situation, and I am certainly prepared to introduce legislation making technical corrections to Medicare reimbursement for cancer care if the bill has the impact the oncology community predicts it will.

It is my understanding that our leadership will appoint an independent commission to be headed by my good friend, former Senator Connie Mack. The commission will monitor the impact of this bill on cancer care throughout the country and will report and make policy recommendations to Congress.

I am also concerned about the impact this bill will have on 50,000 low-income Californians who are living with HIV/AIDS. We have heard a lot from the HIV/AIDS community. My concern is with their access to drug treatment therapy under the Medicare prescription drug benefit.

What happens in AIDS/HIV treatment is that very often a cocktail of drugs, three or four different drugs, proves to be the most beneficial. The type of drugs varies with the individual, just as any drug would with any of us.

I have shared this belief, and the concern is that the formularies would limit an individual to two drugs. I spoke at length with Health and Human Services Secretary Tommy Thompson Friday night about it and asked him to put in writing exactly what would happen. Directly following my remarks, I ask unanimous consent to print in the RECORD his Department's response to my concerns.

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

(See exhibit 1.)

Mrs. FEINSTEIN. I will read just a couple of key points made by the Secretary in response. Let me quote the Secretary:

The Secretary may only approve a plan for participation in the Part D program if the Secretary does not find that the design of the plan and its benefits, including any formulary and any tiered formulary structure, will substantially discourage enrollment in the plan by certain classes of eligible Medicare beneficiaries. Thus, if a plan limits drugs for a group of patients (such as AIDS patients), it would not be permitted to participate in Part D.

I also note that upon completion of this bill, Senators GRASSLEY and BAUCUS and I will enter a colloquy into the RECORD to emphasize this point.

This bill says that if a plan doesn't carry or doesn't treat a drug that is needed by a person with AIDS as a preferred drug, a simple note from a doctor explaining the medical need for that particular drug would get that drug covered at the preferred price. It cannot take more than 72 hours for seniors to get a drug under this expedited appeals process. This is my understanding based on conversations

with the Secretary. I am delighted this understanding is now in the CONGRESSIONAL RECORD so that we can all follow it.

I want to say a word about something that is very controversial in the bill that I happen to support and why I support it. That is income relating the Medicare Part B premium. Let me tell you why I support it. I have a great fear that as I watch entitlement spending grow, and I have watched that happen for a decade in the Senate, our children and our grandchildren will not have access to Social Security or Medicare. Let me tell you why I believe this.

Since 1993, at my constituent breakfasts we have been using charts to illustrate outlays, meaning the money the Federal Government spends every year. I believe they are the truest way to judge Federal spending. When I began this, in 1993, entitlement spending was \$738 million. About 50 percent of the outlays in a given year were entitlement spending. That was welfare, veterans benefits, Social Security, Medicare, et cetera. Interest on the debt was 13 percent. So 63 percent of the outlays in a given year could not be controlled by our budget.

This year, entitlement spending is \$1.174 billion. Entitlements have risen to 54.4 percent, a 4.4 percent increase. Interest has dropped some, to 7.5 percent.

Now, if we look at the projection—and this is with the \$400 billion prescription drug plan—if you look at entitlement spending in 2013, 10 years from now, you see that it is \$2.048 billion. So in 10 years it has gone from \$738 billion to \$2.48 billion. That is the problem. Entitlements will be 58 percent of the outlays, and interest on the debt, 11.6 percent. What does that mean? That means 70 percent of everything that is spent by the Federal Government in fiscal year 2013 cannot be controlled.

The other two pieces, of course, are defense, projected at about 16.9 percent, and discretionary spending, dropping from 20 percent this year down to 13.6 percent. Discretionary spending is everything else we have to do. It is everything in the Justice Department, the Education Department, the Park Service. All the rest of the Federal Government in 10 years will be about 13 percent of what is being spent. That is the enormity of the entitlement picture.

I know it is hard for people to look at this because those people who had the dream of Medicare decades ago looked at it as a program that everyone who paid in got out the same benefit. But what the income relating in this bill talks about is just the Part B Medicare premium, the cost of which today is \$3,196.80. That is the full cost of the Medicare Part B premium in 2004.

Now, what is Part B? Part B is physician care, other medical services; it is outpatient hospital care, ambulatory surgical services, X-rays, durable med-

ical equipment, physical occupational and speech therapy, clinical diagnostics, lab services, home health care, and outpatient mental health service.

The premium is \$3,196.80. The income-relating provisions in this bill are very mild, much milder than what Senator NICKLES and I presented on the Senate floor.

In this bill, beginning in 2007, individuals with incomes of more than \$80,000, or couples with incomes of more than \$160,000, will have, instead of 75 percent of their Medicare Part B premium subsidized, 65 percent of it will be subsidized by the Federal Government.

This goes up four tiers so that individuals with incomes of more than \$200,000 a year, or a couple with an income of more than \$400,000 a year, will have just 20 percent of their Medicare Part B premium subsidized by the Federal Government. Why should hard-working taxpayers pay for a millionaire's health care? That is my view.

I don't see income relating as bringing about the downfall of Medicare. I see it as making the program more solvent.

There is one significant missed opportunity in this bill that concerns me deeply, and that is the whole area of the cost of prescription drugs. I am particularly concerned about the amount of money spent on prescription drug promotion by pharmaceutical companies. Perhaps I have reached the age where I remember when there was no advertising of prescription drugs. We were just as well off then as now, and without huge costs.

Let me give you some examples. Promotional spending by pharmaceutical manufacturers has more than doubled, from \$9.2 billion in 1996 to \$19.1 billion in 2001. That is an annual increase of 16 percent.

Most troubling to me is the rapid spending growth of direct-to-consumer advertising of prescription drugs, which has increased an average of 28 percent.

Bottom line, Mr. President: I intend to support this bill, and not because it is perfect, but because I believe it brings substantial help to people who need that help in my State of California.

I yield the floor.

EXHIBIT 1

ACCESS TO DRUGS FOR AIDS PATIENTS UNDER THE BIPARTISAN AGREEMENT

Question: Will AIDS patients have access to all drugs within a therapeutic class under the Bipartisan Agreement? Can a PDP limit the number of drugs that are covered within a therapeutic class? Are dual eligibles in a Medicare drug plans losing coverage available to them in Medicaid?

Answer. In the Bipartisan Agreement there are significant safeguards in the development of plan formularies that will ensure that a wide range of drugs will be available to Medicare beneficiaries.

Plans have the option to use formularies but they are not required to do so. If a plan uses a formulary, it must include "drugs" in each therapeutic category and class under

section 1860D-4(b)(3)(C)(i). A formulary must include at least two drugs in each therapeutic category or class unless the category or class only has one drug.

The Secretary will request the U.S. Pharmacopoeia, a nationally recognized clinically based independent organization, to develop, in consultation with other interested parties, a model guideline list of therapeutic categories and classes. How categories and classes are designed is essential in determining which drugs are included on a plan's formulary. USP is clinically based and will be cognizant of the needs of patients. We expect they will design the categories and classes in a way that will meet the needs of patients.

In designing formularies, plans must use pharmacy and therapeutic committees that consist of practicing physicians and pharmacists who are independent and free of conflict with respect to the plan, and that have expertise in care of elderly and disabled. The committee has to use scientific evidence and a scientific basis for making its decisions relating to formularies.

Further, the Secretary may only approve a plan for participation in the Part D program if the Secretary does not find that the design of the plan and its benefits, including any formulary and any tiered formulary structure, will substantially discourage enrollment in the plan by certain classes of eligible Medicare beneficiaries. If a plan complies with the USP guidelines it will be considered to be in compliance with this requirement. Thus, if a plan limited drugs for a group of patients (such as AIDS patients) it would not be permitted to participate in Part D.

Under the Bipartisan Agreement, the beneficiary protections in the Medicare drug benefit are extremely comprehensive to ensure access to a wide range of drugs and are more comprehensive than the protections now required of state Medicaid programs.

For example, there are extensive information requirements in Part D so beneficiaries will know what drugs the plan covers before they enroll in the plan.

The plans must set up a process to respond to beneficiary questions on a timely basis.

Beneficiaries can also appeal to obtain coverage for a drug that is not on their plan's formulary if the prescribing physician determines that the formulary drug is not as effective for the individual or has adverse effects. As a result, there should be access to all drugs in a category or class when needed.

Because the Medicare drug benefit will be offered through private plans, plans will have an incentive to offer multiple drugs in a therapeutic class in order to attract Medicare beneficiaries to join their plans.

Because of the optional nature of the Medicaid drug benefit today, states can drop their coverage entirely. According to a recent Office of the Inspector General report, states have identified prescription drugs as the top Medicaid cost driver (FY 2002, Medicaid prescription drug expenditures totaled approximately \$29 billion or 12% of the Medicaid budget). From 1997 to 2001, Medicaid expenditures for prescription drugs grew at more than twice the rate of total Medicaid spending.

Pressures on state budgets have led to Medicaid coverage restrictions for drugs and the use of cost control measures that will not be used in the Part D program.

Eighteen states contain Medicaid drug costs by limiting the number of prescriptions filled in a specified time period, limiting the maximum daily dosage or limiting the frequency of dispensing a drug. Some states also limit the number of refills.

Six states have pharmacy lock-in programs, which require beneficiaries to fill their prescriptions in one designated pharmacy.

States already have the authority to limit the number of drugs that may be provided in a therapeutic class, and nineteen states are using preferred drug lists in their Medicaid programs. Thus, dual eligible beneficiaries will have the same access in Part D that they have in Medicaid, with expanded beneficiary protections and appeal rights.

Concerns have been expressed that the Medicare benefit will result in a loss of coverage for dual eligibles. This is not the case for low-income beneficiaries, the Bipartisan Agreement provides generous coverage.

The Bipartisan Agreement preserves the universality of Medicare for all eligible beneficiaries including those now dually eligible for both Medicare and Medicaid. Unlike Medicaid, the new Medicare Part D benefit will provide a guaranteed benefit to all eligible seniors—a benefit they can count on without fear of loss of benefits when state budgets become tight.

Dual eligibles, who currently have full Medicaid benefits, will automatically be given generous subsidies and pay no premium, no deductible and minimal cost-sharing regardless of their actual income (which can be higher than 135% of poverty based on states' special income rules).

In addition, full dual eligibles with incomes under 100% of the Federal Poverty Level (FPL) will pay no premiums, no deductible and only nominal copayments of \$1 for generic and other multiple source preferred drugs and \$3 for all other drugs. These copayments will increase only at the rate of inflation, the same rate as the Supplemental Security Income (SSI) payments on which many low-income individuals rely.

Dual eligible nursing home patients and other institutionalized persons who only have a small personal needs allowances will be exempt from copayments altogether.

The copayment levels in the Bipartisan Agreement are similar to what dual eligibles now pay in what is an optional Medicaid benefit in their states. In fact, because of the optional nature of the Medicaid drug benefit today, states can drop their coverage entirely. Current regulations permit states to increase coinsurance to 5%, which is more than what will be permitted for dual eligibles under the new Medicare benefit.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, will the Chair please advise me when I have 5 minutes remaining?

The PRESIDING OFFICER. The Chair will do so.

Mr. KENNEDY. Mr. President, during yesterday and early today, we have had characterizations and descriptions of this legislation, which is enormously important. We are doing these debates on Saturday and Sunday, and it is anticipated that we will have a vote tomorrow, Monday, on a bill that will not go into effect until 2006, and other provisions will take effect in 2010. I have right here next to me the bill, the legislation, which was put on everyone's desk. I am still waiting for a Member to come here and indicate that he or she has read it, and describe the details of it.

We are dealing with a matter of enormous importance and consequences, as we are dealing with issues of life and death for our seniors in this country—the men and women who have brought this Nation out of the Great Depression, the ones who fought in World War II, the greatest generation. They came

back and faced challenging times. We went from a 12 million, mostly man military, down to an Army of just a couple of million, with massive unemployment, and they helped to get the country back on a peaceful road. We are talking about a generation that faced down the Soviet Union and communism, and they are now in their golden years.

As the great philosophers point out so well, civilization is measured by how it treats its elderly people, whether they will be able to live in the peace, dignity, and security for their contribution to the country. I believe in that. I believe in that very deeply.

We have to ask ourselves at the end of the day whether this legislation before us, which is being rushed through with effectively 2 or 3 days of debate, is worthy of our senior citizens. I mentioned the issue of time again because my good friend, the majority leader—and he is my good friend—made reference to the fact that I believe that this legislation needed more debate than a Saturday afternoon and evening. I watched the debate going on, and the chairman of the Finance Committee and the Senator from Alaska talked up until almost 10 o'clock last night, and now we are here on Sunday afternoon.

But I wonder whether it needs more than 2 days debate. I believe it does; I do believe so. I believe that particularly after we saw what happened in the House of Representatives.

This legislation makes an enormous difference to the well-being and the security of seniors in this country. And we saw the facade that took place in the House of Representatives where the vote was called at 2 or 3 o'clock in the morning, and the vote was kept open beyond the traditional time of 15 to 20 minutes, for nearly 3 hours, in order to try to effectively coerce Members to support the proposal.

We are doing that on a measure that is supposed to benefit our senior citizens, and a measure that passed the House of Representatives by only one vote in a purely partisan proposal. Then, it passed the House of Representatives by less than a handful the second time, again, on a purely partisan proposal. It seems to me that if the House of Representatives had a full opportunity to have an open discussion and debate, and then have a reasonable vote and call them as they see them, then this process would be worth supporting. We ought to have the same here in the Senate. But, on the one hand, when we have a Republican leadership, which is effectively jamming this legislation through the House of Representatives, and then effectively wants to use the closing off of debate and discussion in order to effectively jam it through here, the Senate of the United States, we ought to take a moment or two to ask why.

I note the references of my friend, the majority leader, about who was really representing the seniors of this

country and whether some were delaying this legislation. Many of us have been fighting for a prescription drug program for years. I will not take the time today to discuss the time when it was bottled up in the Republican Finance Committee, and how it only emerged on the Senate floor when we had Democratic leadership here just over a year ago. It is not worth taking up the time because I don't have it.

But this is a Senator who fought for the Medicare Program, who knows the history of the program, and knows how important the Medicare Program is. I am also mindful—with all respect to those on the other side and in the House of Representatives—that they got 12 votes in support of the Medicare. I know that they are untrustworthy of the Medicare Program, that they have a disdain for the Medicare Program. That is a very important difference. They are obviously entitled to their view.

But what we have seen is the efforts that were made on the floor of the Senate earlier this year, where we had a truly bipartisan effort for a prescription drug program. In 1964, Medicare was defeated in the Senate. It was defeated by 12 or 14 votes. Seven months later, it passed by that number. The only intervening aspect was an election. And the important aspect of that election is that the seniors understood what the stakes were in that election.

I am saying here on the floor of the Senate that the seniors are going to understand, when they know what is in this bill, how much it risks their future and the future of the Medicare system, make no mistake about it.

Make no mistake about it, no matter the outcome of this bill in the Senate, this issue is going to continue to be debated as we go into 2004, the 2004 election, 2006, 2008—all the way down the line. This issue is not going to go away.

I was here when the Senate passed catastrophic coverage. I can remember the catastrophic Medicare changes which allegedly were supposed to be so helpful to the seniors. There was a flood of Senators who left this body and rushed down to the television and radio center to indicate how they supported it. And I remember how they all crept back into this body just a couple of months later to vote to rescind that change because they got it wrong, because they rushed it through the Senate. And that is just what we are in danger of doing with this bill.

The Medicare system is a tried and tested program. It is a beloved program. The reason we have a Medicare system is that the private insurance companies failed our elderly people. They continued to fail them. Finally, in the late 1950s, we began to have a debate about a Medicare system, and when we had the debate in the 1960 campaign and 1962 campaigns, we finally found we were able to pass Medicare legislation in 1965. It took 5 years to pass that program, and we want to risk that program in a 2-day debate in

the Senate when this is a lifeline to so many of our seniors, when we are seeing an effort to undermine the Medicare Program. I will get into that in one moment.

We had a chance to do something we failed to do in 1965. We passed the Medicare Program that dealt with hospitalization. We passed the Medicare Program that dealt with physician fees. But we did not pass a Medicare Program that dealt with prescription drugs. Only 3 percent of the private sector programs had prescription drugs at that time. Can you imagine that we would pass a Medicare Program today without prescription drug coverage? Those prescription drugs are as important as physician services and hospitals today.

We are on the verge of the life science century. The breakthroughs we are going to see in the next months and years are going to be breathtaking, and our seniors ought to be entitled to those programs. That is why a prescription drug program is so necessary.

We passed a good program in a bipartisan way, but that is not the proposal that is before the Senate. The bill before us is not that proposal. The bill that passed the House of Representatives is not the proposal we passed.

We have a major undermining of the Medicare system. There are those who say: You are really overstating this, Senator KENNEDY. Where in the world are you getting this idea?

I understand, as others do, that the position of the President of the United States earlier in March was that no one who was in Medicare would be entitled to a prescription drug program. I want our seniors to listen to that. In the spring of this year, this President indicated he supported the program for prescription drugs only when it was delivered by the HMOs.

He gave up that position. He said: Oh, no, let's try and see if we can figure out something else that may be related to the Medicare system. That was his position. That is the position of the majority of the people who are supporting this program. Make no mistake about it, that is their position. They believe that is what ought to happen: that we ought to dismantle the Medicare system, undermine it, privatize it. That is what they want to do.

You say: Why in the world are you saying that? How can you possibly say that? Read the paper this past week. The Washington Post, Friday, November 21:

Bid to Change Social Security Is Back.

They are going to get Medicare first. Social Security is next. Here it is:

President Bush's aide reviving long shelved plan on Social Security. A Presidential adviser said [Bush] is intent on being able to say that reworking Social Security "is part of my mandate."

There it is, my friends, Social Security is next; Medicare now. That is why I think we ought to have some debate because, I daresay, I don't believe the Members of this body understand what is going to be done with the proposals.

There are three major provisions in this proposal that will effectively undermine the Medicare system. The first is the premium support proposal. I have listened day after day, week after week, month after month: We have to give premium support a try. My answer is: Why? Why? We know what it means even before trying it. Committed as they are on the other side of the aisle to start off with hundreds of thousands or a few million and multiply that to millions and millions of people, we understand what the results are going to be before we even try the program. They said: Let's try it; let's understand what the outcome is going to be.

Currently, everyone in the United States pays into the Medicare system. No matter where you live, you get your range of benefits. You get to pay the same premium and you get the same range of benefits all over this country. It is uniform. Not under premium support. You are going to pay in and you are going to pay more. Even the administration has recognized that the minimum you are going to pay is 25 percent more. You are going to pay more. So that every elderly person who understands premium support, this administration understands you are going to pay more at the outset.

Secondly, you are never going to know what your premium is because it is going to depend on where you live. These are not my figures, these are the figures of the Medicare actuary. Here it is: Under the premium support program—this is the Medicare actuary—the national average under current law will be \$1,205 by 2013. It is about \$700 now. Their estimate is \$1,205. A year and a half ago they estimated the premium support would be \$1,771. The Medicare actuary estimated that every senior citizen would be paying \$500 more in premiums than they would be paying under Medicare.

This year they have gone down to \$1,501. They have gone down nationwide as starters, and we have to learn something more. That is not good enough.

The difference with premium support is there is no security. It depends on where you live. Do you understand that? Your premiums are going to be based not on the national standard that we have at the present time but on where you live.

In my State of Massachusetts, under premium support, it will be \$1,450 in Barnstable, MA, and \$1,050 in Hamden, MA; \$400 more. The difference is 100 miles. In Dade County, FL, it is \$2,000 and, in Osceola, FL, it is \$1,000; \$1,000 more.

Explain that to some senior who lived there all their life, has a house and is proud to live there, and they find that their premiums are going to be \$2,000 and their neighbors in another part of Florida are paying \$1,000.

It is very interesting what my friends on the other side say: Senator KENNEDY, you don't understand what we are going to do in this bill. We are only

going to let it go up 5 percent a year this year. That is what they say this year. Next year in the Budget Committee, or the year after, it won't be 5 percent. We will have to recalculate. It will be 10 percent or 15 percent, or let's have a free enterprise system and let it sail off. That is what is going to happen.

That is what has happened in the Metropolitan Statistical Areas (MSAs), and the list goes on: \$1,700 in Los Angeles, \$775 in Yolo, CA. Medicare actuaries—every senior citizen ought to understand that premium support is written in this legislation. One can say, well, it is written in such a way that we are not going to face it for several years. Several years? But it is still there. The only way to repeal it is to come back here to the Congress.

In Yamhill, OR, premiums would be \$1,325, but only \$675 in Columbia, OR. It is double the amount if one lives in a different part of the State.

Why do we have to experiment with premium support? We already know what the results are going to be. That is a key element in this legislation. It was not in the Senate bill. I did not hear our majority leader make much of a case for it. To be honest about it, I do not hear the President of the United States make much of a case for it.

Nonetheless, when one is talking about the House of Representatives, they understood what this was all about. They committed to it, alright.

Now one might say: Well, Senator, what about the health delivery system? We are going to have the health delivery system delivered through the HMOs. Let us have real competition.

How many times have I heard this from our Republican friends over there: Let us have competition? We are glad to have competition, but do not suggest that this bill is competition. It is not. I see the chairman of the Finance Committee. He can correct me if I am wrong about any of these figures.

We start off with every HMO getting a 109 percent increase in the cost of living over Medicare. Is that competition? Competition? Come on. Beyond that, CMS—the governmental agency that administers the Medicare program—pays an additional 16 percent in excess of Medicare's own costs to private insurance companies because seniors who join Medicare HMOs are healthier than seniors in the traditional Medicare system.

So, under this bill, Medicare is going to pay a 25 percent advantage or bonus for every senior citizen that goes into an HMO. Our Republican friends are talking about competition, the free enterprise system. Is there a business man or woman in this country who would not want a deal such as this? The tragic part is, who is paying for it? It is our seniors who are paying for it.

And you think Medicare is going to be able to hold on when they are effectively getting a \$1,936 overpayment per senior? That is what they are getting now. This is not competition with

Medicare. This is a rip-off. This is a scandal. This is a payout. And that is what is happening now under our overpayment to the HMOs.

As a matter of fact, you are overpaying them almost the amount that the average person does for the prescription drugs. You could almost make a deal and say, do not even bother with the prescription drug program. The HMOs are almost paying the whole amount. That is what the seniors pay, \$2,300. We are paying close to a \$2,000 overpayment.

On the one hand, you have the premium support that is going to undermine it. Secondly, you have this program on the overpayment of the HMOs. Given the dramatic overpayment on this, we can see what is going to happen with the HMOs.

Look at what is going to happen with the HMOs, according to the actuaries. This year, there is \$31 billion that went through the HMOs in this country. The best estimate, given the arrangement that has been made now, will be \$181 billion going through the HMOs. You call this private competition? Competition with Medicare? This is outrageous. Do my colleagues think we are having that debate here on the floor of the Senate? Do my colleagues think we have time to change that 109 percent down to 102 percent or 104 percent? Absolutely not. We do not have time to do that.

Do my colleagues think we have time to change this with regard to the 16 percent advantage? Do my colleagues think we have any time to do that? Oh, no, let's stamp it. Let's close the books. Let's say to those who would like to have that kind of debate and offer amendments, this is being delayed for our senior citizens.

This is absolutely outrageous. We know what is going on. These are the payoffs to the HMOs.

Beyond that, if that is not enough, listen to this: Not only do they have the additional 25 percent, which is almost \$2,000, there is also a \$12 billion slush fund. What did the Senator from Massachusetts say? A \$12 billion slush fund.

Well, what can they do with the \$12 billion? They can give it to the HMOs as well. This is running-around money, walking-around money, \$12 billion more. Who pays for that? The seniors pay for that under the Medicare system.

Do we have an opportunity to offer an amendment to strike that? Oh, no. Do my colleagues think we have an opportunity to go back to the Senate position that said let's take half of that and use it for good preventive kinds of medicine for our seniors, such case management programs? No, no. That was what we passed in the Senate. Do my colleagues think we can go back? No, no. We have to rush this proposal in.

In the meantime, we are telling our seniors all across this country that \$12 billion is needed to help the HMOs. Tell

that to the 10 million seniors who need Celebrex to deal with arthritis, or the 12 million to deal with osteoporosis, or the 11 million with treatments for diabetes, high cholesterol, thyroid deficiency, and depression. These are millions of our fellow citizens who could benefit from that \$12 billion. Oh, no. We have to give that as a supplement to the HMOs.

I have listened to those who say: Well, at least our senior citizens are going to be better off. Let us just look what is going to happen to our senior citizens. We have the 2 to 3 million retirees who are going to be dropped. They are certainly not going to be better off. There are 6 million people worse off. Who are these 6 million? These are the Medicaid beneficiaries who, the day this bill goes into effect, are going to be worse off. These are the people who are paying the \$1 to \$3 copays. The States are paying for it with the Medicaid. Know what? They will not be paying anymore. Why? Because this bill prohibits it.

So one might ask whether they are better off. We start right off with 9 million beneficiaries who are going to be worse off. People say: Well, Senator, what about all of those low-income people we are all concerned about in this program? I am going to come back to that.

Let's take these 6 million people, who are the poorest of the poor, who are going to be worse off. Is that really going to make much difference, because it is only a couple of bucks a week, \$3 to \$5 a week, maybe \$20, \$25 a month? But when one is talking about the average income for seniors at about \$12,000, it adds up. There are studies to show what happens to the poor when they do not pay the copays in terms of adverse health outcomes.

The PRESIDING OFFICER (Mr. AL-LARD). The Senator from Massachusetts has 5 minutes remaining.

Mr. KENNEDY. Will the Chair tell me when I have 1 minute remaining, please.

This is what happens to those poorest of the poor when they do not have the copays—serious adverse events effectively double. The emergency rooms effectively double. These findings are demonstrated by research studies published in JAMA.

Of course, the sad fact is it ends up costing hundreds of millions and billions of dollars more to pay for in these circumstances. It is bad health policy and it is bad economics.

Finally, we had a good program that passed the Senate. We found our friends in the conference knocked out 3 million of the neediest elderly people in this country. We provided for up to 160 percent of poverty, they made it up to 150 percent of poverty. That is a million people. And they reimposed the asset test for those under 150 percent of poverty. As a result of reimposing it, that is a total of 2.8 million who were included for help and assistance under the Senate bill who were wiped out in

this conference report. We had a good bill, but that is not the one that is before us.

Finally, the third part of the inclusions in this legislation, what they used to call Medical Savings Account, now referred to as Health Savings Accounts (HSAs), which have very high deductibles and low premiums. Who takes advantage of those programs? The most healthy people take advantage of those and the most wealthy people take advantage of those.

What is the problem with that? The problem with that is that if you are the working poor, working middle class, if you have some children, you can't afford to constantly pay the deductibles. So what happens to your premiums? Two studies—one study by the American Academy of Actuaries "Medical Savings Accounts: Cost Implications and Design Issues," May 1995, and another by the Urban Institute, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," April 1996—indicate that premiums will rise at least 60 percent. That is not just talking about the elderly people, that is across the country. That is undermining the employer-based system.

We have enough problems in this country with the uninsured. Now we have an additional proposal that is going to raise the cost of premiums for working families in this country? That has been included. Was that in the Senate bill? Absolutely not. But it has been in the House. It has been a matter of faith in the House. There you have it: Premium support, not a level playing field, a new form of health insurance that is going to raise the premiums for workers. What in the world does that have to do with the prescription drug program? It has a lot to do with ideology. That is what this bill is about, to undermine, to privatize Medicare. After they do that, coming right behind it is the Social Security Program, make no mistake about it.

We can do better. We should do better. We ought to take the time to do better. There are enough Republicans and Democrats alike in this body who have demonstrated over the period of the last year and a half that we can get a good bill. There is no reason to be stampeded with a bad bill. Why are we being stampeded with a bad bill? We ought to take our time, get a good bill, make a difference for our seniors, make a difference for our country. That is what I believe.

I hope we will have the opportunity to take the time so all of our Members understand it, and not just these Members but so our seniors, whose lives are going to be affected, who are suffering every single day and making choices between putting food on the table and paying for their prescription drugs, so they understand it. Don't we have enough respect for our seniors so we can provide some opportunity for those individuals to understand it? Or are we

going to be rushed into the situation with short debates on Saturday and Sunday and then have the gauntlet come down. We saw what happened over in the House of Representatives. It took them 3 hours in order to galvanize this. I think we should demonstrate in this institution too much respect for our seniors to be stampeded into a bad bill.

The PRESIDING OFFICER. The time of the Senator has expired. The Senator from Kentucky is recognized for 30 minutes.

Mr. REID. If I could offer a unanimous consent request?

The PRESIDING OFFICER. Does the Senator from Kentucky yield for a unanimous consent request?

Mr. BUNNING. I have a unanimous consent request first to propose. Then I will.

Mr. REID. That is fine.

Mr. BUNNING. I ask unanimous consent that with the previous order standing in place, the 30-minute time limit on each Senator be considered controlled time, so that any remaining time may be yielded to another Senator, and if not yielded, the time be automatically yielded back.

The PRESIDING OFFICER. Is there objection?

Mr. REID. In layman's terms, what this means is, if there are Senators on our side or the other side who want to use the 30 minutes in any way they want—10-10-10, 15-15—that is certainly permissible. The going back and forth would be unfair otherwise because someone here would use 30 minutes and only 10 there.

So what we are going to do—I think this is totally appropriate. I ask the distinguished Senator from Kentucky to allow a modification, simply a housekeeping matter over here. The Senator from Michigan, Mr. LEVIN, and the Senator from Florida, Mr. NELSON, are going to switch places, and also that Senator EDWARDS would be listed at the end of our list as the final Democratic speaker.

The PRESIDING OFFICER. Is there objection?

Mr. BUNNING. I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Kentucky is recognized for 30 minutes.

Mr. BUNNING. Mr. President, today I rise to talk about the Medicare prescription drug bill. First, let me commend the members of the conference committee who worked day and night for many months to reach this agreement. I know it was not easy, but they have done a good job that will finally bring Medicare into the 21st century.

Second, let me say how disappointed I am that it appears some Members may try to filibuster this bill. In fact, it seems as though there are Members in this body who want to filibuster just about everything we try to do, whether it is stopping judicial nominations, the Energy bill, or this Medicare bill. Just a few weeks ago we spent several days

in continuous debate on judicial nominations. On Friday, the Energy bill was blocked. Now it looks as though some are going to try to kill this bill. I call that obstructionism.

I want to show a chart because from the beginning there have been charts shown on both sides. These are 358 different groups—358 different groups that support this bill in its present form. It is headed by the American Association of Retired People—the AARP, which represents over 35 million seniors.

Seniors have been pleading for Congress to expand Medicare to include drug coverage, and this bill will do just that. It might not be all things to all people, and I am sure every Member in here would have written a different bill if it was completely up to him or her, but that is not the way we work around here and this bill is a very large compromise. Even the AARP, as I said before, has endorsed this bill and said that, although the bill is imperfect, it is an historic breakthrough. I want to repeat that—an historic breakthrough; and that we should not let this opportunity pass us by.

Today, Medicare provides health insurance to about 40 million seniors and disabled individuals each year. The number is only expected to grow as the baby boomers begin retiring. Medicare provides important medical and health and hospital benefits for seniors. However, it is a program that is still trying to provide health care as if it were in 1965 instead of the year 2003.

When Medicare was created, prescription drugs played a small role, a very small role in medical care. Today, as we all know, that is much different. In fact, for many seniors and many Americans, prescription drugs have replaced expensive surgeries and extended their lives significantly. By tying a drug benefit to Medicare, this bill makes these lifesaving and life-enhancing drugs more available to millions of Americans.

This has been a very long process, and I kind of chuckle when I hear people say we are rushing into this. I can tell you as a member of the Finance Committee that we have been working on this bill for almost the entire year, working and crafting legislation to make the best drug bill possible for all Americans.

I was supportive of our bill as it moved through the Finance Committee and through the full Senate. Today I am supportive of the bill before us. It is time to add this benefit to Medicare. Seniors have waited too long for their benefit, and I urge my fellow colleagues in the Senate to support this bill. Talk is cheap, and it is time to act and it is time to act now.

We have \$400 billion allocated for this benefit. It would be a shame if we let this opportunity pass us by. It might not come again.

This legislation provides a much needed prescription drug benefit to Medicare beneficiaries. It provides more options to seniors than just tradi-

tional fee-for-service Medicare, and it provides incentives to companies to continue offering medical benefits to their retirees.

Seniors will be able to receive prescription drug coverage under two options: Through the traditional fee-for-service Medicare and also through a new Medicare Advantage Program made up of private companies offering Medicare benefits.

Under the fee-for-service Medicare, beneficiaries will be able to enroll in Medicare drug plans. The standard drug benefit will require a \$35 monthly premium and a \$250-a-year deductible. Once seniors have met the deductible, they will pay 25 percent of the prescription drug cost up to \$2,250. Once a beneficiary has received an out-of-pocket spending limit of \$3,600, they will pay 5 percent for their prescription drugs.

I emphasize this because this is the key to the whole Medicare prescription drug benefit.

Low-income seniors will be provided with assistance paying for their drug costs depending on the level of their income. This means that seniors with the lowest income—those below 100 percent of poverty—will not pay a deductible or monthly premium and will pay either \$1 or \$3 per prescription drug up to the catastrophic limit. Once they reach the catastrophic limit, these seniors will have 100 percent of their drugs paid for.

These are the seniors who truly struggle to pay for their prescriptions. At 100 percent of poverty, a senior's income is \$8,900 per year. Other low-income seniors below 150 percent of poverty will receive additional assistance depending upon their level of income. Personally, I believe our biggest responsibility is to low-income seniors. These are the ones who struggle the most to buy their prescriptions, and they deserve a very generous benefit.

Seniors will also be able to choose to receive their health care through a private company. I hope everybody heard that. They will be able to choose. This is a voluntary program. You can choose to stay in Medicare Part B and have no prescription drugs if you choose to do that. You can choose to take Medicare Part B and add a prescription drug benefit or you can choose to go into a private company's health care program.

Under Medicare Advantage, seniors will be able to choose whether they would like medical coverage from a preferred provider organization, known as a PPO, or a health maintenance organization, or HMO, operating in their regions.

These plans will provide beneficiaries with an integrated benefit, which means seniors will receive both medical and drug coverage under the plan. They would have a single deductible for medical benefits currently provided under Medicare Part A and B. They would also be able to receive preventive care, disease management, and chronic care under these programs.

These private plans will have much more flexibility in the type and scope

of benefits they provide than traditional Medicare, and will provide many seniors with a valuable health care option.

Please notice—"option, voluntary." These are very key to this whole program.

I know some of my colleagues do not like these PPOs and HMOs because they say seniors will not be able to go to any doctor they choose. Hogwash. No one is going to force the seniors into these private plans, and they will be able to pick a plan in which their doctor participates.

Please understand that. We are not going to force any senior away from their given doctor. They will be able to choose their own doctor and stay with that doctor.

That is one of the key elements of the bill—giving seniors more choices instead of forcing them to use a health care plan created in 1965, which has changed very little since then. If these care advantage plans sound familiar, they should.

Finally, Medicare will provide seniors with a modern benefit similar to what is offered to most employees, including what the Federal Government offers to employees.

One of the biggest concerns with the legislation as it moved through the Finance Committee and the full Senate was what would happen to retirees who currently have drug coverage from their former employer. No one wants this new program to be an excuse for employers to drop their retirees' health coverage. That would be counterproductive and unfair to those seniors. To encourage companies to continue providing these benefits, this agreement sets aside almost \$70 billion of our \$400 billion for subsidies to help companies cover their prescription drug costs for their medical-eligible retirees. This is a substantial commitment by Congress to make sure companies do not have an excuse to drop their coverage.

The members of the conference committee have worked long and hard for many hours and in many meetings over the last year on this compromise. We have a real chance to pass this bill, and we shouldn't pass up this opportunity.

If we don't pass this bill now, it will be several years before we get another chance, and seniors have waited much too long already.

Again, I urge my fellow Senators to pass this bill and finally fulfill the promise that each and every one of us in the Senate has made either on the campaign trail or anywhere that we have spoken to senior groups. We have promised this benefit and we can deliver it.

I urge my fellow Senators, once again, to pass this bill providing prescription drug coverage to our seniors. We can talk about it for 2 or 4 more years or we can do it now.

I yield whatever time I have to the Senator from Iowa.

Mr. GRASSLEY. How much time remains?

The PRESIDING OFFICER (Mr. BUNNING). There are 14 minutes 50 seconds remaining.

Mr. GRASSLEY. Mr. President, we have heard in the Senate today and last night that the comparative cost adjustment demonstration project, which some of the Members refer to as premium support, would end Medicare as we know it. I want to be very clear, nothing could be further from the truth. I have 10 facts about this demonstration to explain why this is not the case. We are talking about the comparative cost adjustment.

Fact No. 1: It sunsets in 6 years. The demonstration will only be in existence for 6 years. It will not begin until the year 2010. During that time, there will be a 4-year phase-in period. Explicit authorization from Congress at the end of 6 years is necessary to extend the demonstration and/or expand it to other areas of the country. This proposal is significantly modified from the House of Representatives' original position. Congress weighs in before this becomes something other than a demonstration project and becomes policy for the entire country.

Fact No. 2: Very limited areas of the country will be affected in the demonstration. Under the agreement, the Health and Human Services Secretary may select no more than six metropolitan statistical areas to participate in the demonstration. It is not easy to be put in that list of six because in order to be selected, a metropolitan statistical area must have at least two local coordinated care plans offering services in the area and at least 25 percent of the Medicare beneficiaries must be enrolled in these plans. That means the private PPOs we are setting up beginning in 2006 must succeed. I hope they succeed. But we do not know if they will succeed, and if they do not succeed, at least to the tune of 25 percent in two local areas, there will not be one. If that does happen, according to the Congressional Budget Office, somewhere between 670,000 and 1 million beneficiaries will be included in this limited demonstration. It is a demonstration. It is not something that could ever, without an act of Congress, encompass all 40 million seniors.

Fact No. 3: Low-income beneficiaries are not affected at all. So if they are low-income, below 150 percent of poverty, none of them will see their Part B premiums increase.

Fact No. 4: Premium increases for beneficiaries above 150 percent of poverty will be limited to 5 percent. For everyone else, if premiums go up, there is a cap of 5 percent. As an example, if the national Part B premium was, say, \$100 in 2010, the fee-for-service premiums in the demonstration areas could not exceed \$105 a month. The increase, by the way, is not compounded over that 6-year period of time.

Fact No. 5: Other than the limited impact on the Part B premium calculation, the fee-for-service program is unchanged choice. Fee-for-service bene-

fits, beneficiary cost sharings, payments to hospitals, and other health care providers are unaffected by the demonstration. The Medicare entitlement to benefits and payments to health care providers are unchanged in these same areas.

Fact No. 6: Beneficiaries are not required to enroll in these private plans. The right for a Medicare beneficiary to remain in fee-for-service programs is maintained in the demonstration areas. The fee-for-service program will remain affordable for all beneficiaries.

Fact No. 7: The prescription drug benefit is unaffected. The prescription drug benefit and the drug premiums are not changed. The demonstration only minimally affects the Part B premium, and that is the maximum of 5 percent increase.

Fact No. 8: Over the demonstration period, enhanced payments to private plans are phased out to ensure that their payments to private plans are on a level playing field with the fee-for-service program.

Fact No. 9: The preferred provider organization stabilization fund, referred to on the other side by my colleague as a "slush fund," has no relationship to this demonstration. So one cannot talk about the demonstration and talk about a stabilization fund in the same breath. If you do that, you do not know what the bill does; you have not read the bill.

Under the conference agreement, the stabilization fund may only be used to provide assistance to the newly regional PPO options. However, any enrollment in regional PPOs is not counted toward the 25 percent enrollment requirement in the metropolitan statistical areas. The extent to which beneficiaries enroll in the new regional PPO opposite will have no bearing on whether a metropolitan statistical area becomes a candidate for demonstration.

Last fact, No. 10: Strict quality monitoring is required. The Health and Human Services Secretary is required to closely monitor access to care and quality and submit a report to Congress upon completion of the demonstration to determine if the demonstration has reduced Medicare spending and/or increased cost to beneficiaries; second, access to physicians and other health care providers has declined; and lastly, whether beneficiaries remain satisfied with the program. The evaluation would be on the basis of any congressional decision to extend that demonstration.

Premium support, as has been described in the Senate numerous times in the last few days by the Senator from Massachusetts and by other Senators, is not in this bill. It is not included. This bill strengthens and improves fee-for-service Medicare.

How much time remains?

The PRESIDING OFFICER. Seven minutes.

Mr. GRASSLEY. It would be good at the start of the third day of debate on

this bill to remind people of the political situation that has gotten us where we are today. That is a very positive political situation.

Last year, we were beginning to develop a bill in the Senate Finance Committee that would have had bipartisan support to get it out of the committee. Bipartisan support in the committee is a way to have a chance of success in the Senate where there can always be an extraordinary minority who can keep a bill from being passed because we protect minority interests in this body as no place else in our political system. So we must be bipartisan.

About the time that was going to happen, the majority leader—the Senator from South Dakota, last year—decided we needed to talk about this in the Senate. But the bill never came out of committee. It was brought right to the floor. When bills are brought to the floor, there is no chance of developing bipartisanship. We discussed it for 2 or 3 weeks and no one could get the bipartisan majority it takes to get pieces of legislation passed.

At that time, I surmised, and I think the outcome of the debate last year proves it, that the other side wanted more of an issue for the election rather than a product. They gambled and they lost because Republicans gained control of the Senate in that election and then we were right back to square 1 where we went to the Senate Finance Committee where there could be, even with a Republican majority, still a bipartisan working relationship that was able to report out a bill on 16-to-5 bipartisan vote. Then we brought that bill to the floor during the month of June. And it got through here 76 to 21.

We are as successful as we are because the people made a change in the Senate.

In the Senate, then, we adopted a bipartisan bill, and we were able to get through, for the first time on this issue in the history of the Senate, prescription drugs for seniors. We were able to match the House, where it had passed three times previously. We went to conference. We operated in the conference, at least from the Senate point of view, on a bipartisan basis, and we were able to produce a product where here we are doing the best improvement and the most sweeping improvement in Medicare in 38 years. We are able to do that because of bipartisanship.

Now, all of a sudden, people on the other side of the aisle, at this last minute, are filibustering. I hope they do not get away with that filibuster. But, again, they are trying to be very partisan, as they were a year ago. I hope they learned a lesson from a year ago and will not try to be partisan on this very important social issue for the seniors and the disabled of America, and that they will not repeat the mistakes of last year when they wanted an issue instead of a product.

We have a bipartisan product. I listed last night, in my closing remarks, all

of the organizations that are supporting this bill. Other Senators have put charts up saying how many organizations are supporting this bill.

We have this opportunity. Let's hope partisanship—that is demonstrated by the filibuster that was announced yesterday—does not keep this bill from passing. Democrats who want to filibuster ought to consider that is not the way to go. They should learn from the lesson of the past. That lesson is that last year when they wanted an issue instead of a product, they got a defeat at the polls.

I yield the floor.

The PRESIDING OFFICER (Ms. MURKOWSKI). The Senator from Florida.

Mr. GRAHAM of Florida. Madam President, since its creation in 1965, the Medicare Program has helped millions of our Nation's elderly and disabled when they desperately needed it, after they became ill.

It has been an extremely successful and popular program, and has improved the health of countless seniors.

Now that we are in the 21st century, it is time to reap the full benefits of the advances made over the years, and shift the focus of the Medicare Program from assistance after illness to one that promotes wellness.

To achieve that, a prescription drug benefit is mandatory. Ninety percent of seniors have at least one chronic condition; drugs are often the best way to manage those conditions.

The bill we are considering is frequently divided into two parts—one part is the prescription drug benefit, and the other part is Medicare reform.

Let me state what we all ought to know by now: A prescription drug benefit is the most fundamental reform that we can make to the Medicare Program.

If we want to truly reform Medicare, we must change the approach of the program from one of sickness to one focused on wellness. This prevention approach will require access to prescription drugs.

Modern medicine has been altered fundamentally by prescription drugs, notably by improving the quality of people's lives, ending the need for surgeries and long recovery periods.

A side benefit of this change would be that the cost to the Medicare Program could be lower by reducing these procedures.

I have introduced several prescription drug bills over the past few years because I believe a reorientation toward wellness is in the best interest of our seniors, as well as the Medicare Program.

However—and this is critical—not just any prescription drug bill will do. The bills I have authored have been constructed to provide an affordable, comprehensive, reliable prescription drug benefit to our seniors and Medicare beneficiaries with disabilities.

The bill I introduced in 2001, cosponsored by Senators ZELL MILLER and EDWARD KENNEDY, was voted on in July of that year. It received 52 votes.

That bill would have made a significant, and positive, difference in the lives of the nearly 41 million older Americans and disabled citizens who are covered by Medicare—more than 2,770,000 of whom live in Florida.

The conference agreement that we are now considering would also make a significant difference in the lives of our seniors. However, that difference will not be a positive one.

I have many grave concerns about this legislation. The drug portion of the bill is deeply flawed. It includes an enormous coverage gap. When a senior has reached \$2,250 in total drug expenses, all drug coverage stops. The drug benefit doesn't begin again until total drug spending reaches \$5,100. That is a gap of \$2,850.

And during all of the months the senior is in that "gap", the senior is required to keep paying premiums.

The bill is projected to cause 2.6 million retirees nationwide, and over 160,000 in Florida, to lose their retiree prescription drug coverage.

It will cause 6 million low-income seniors nationwide, and over 360,000 in Florida, to pay more for their drugs, and to face more restrictions on the drugs they can get.

It relies on an untested delivery system which would either herd seniors into what we know they don't like, a managed care organization, or would turn them into guinea pigs for a never previously utilized drug-only insurance plan.

Millions and millions of seniors who will not have access to drugs through the traditional Medicare Program will suffer the fate I have just described.

In addition, the legislation that was supposed to be about adding a prescription drug benefit now includes provisions that will privatize the Medicare Program beginning in the first year of implementation fragmenting the health insurance group by subsidizing health savings and increase the costs of comprehensive health insurance for our non-Medicare citizens.

I am not alone in my concern about this legislation. In a recent survey conducted by Hart Research, of voters aged 55 and older, only 19 percent said we should pass this bill. Sixty-four percent said we should go back to the drawing board. This isn't the Medicare prescription drug benefit that they need.

And although the AARP has taken the inexplicable position of supporting this legislation, the national organization may want to listen to its members. Only 18 percent of AARP members want Congress to pass the bill. Sixty-five percent have instructed us to go back to the drawing board.

The percent of seniors in favor in my State is even lower. I have received over 1,000 calls from seniors opposed to this agreement, representing about 80 percent of all calls.

Listen to what some of my constituents are saying about the bill:

Earl Dangler of Beverly Hills, FL said:

This prescription drug benefit is going to cost my wife and I an additional \$750 to \$1,000 per year whether we use it or not.

Many of my constituents have expressed outrage at AARP for endorsing this conference agreement.

One constituent said:

I'm really mad at the AARP and I am going to cancel my subscription that I've had for 20 years.

Another constituent remarked:

I've been a member of AARP for many, many years, and I can't believe that they have sold out to the pharmaceutical industry and the insurance companies.

The real test of the reaction to this legislation is a bit down the road—but it will come. The impact of the bill won't be felt until at least 18 months after enactment.

I would predict the vote we cast on this legislation will be politically inconsequential for those running in the year 2004. The stunning impact will be felt first in the fall of 2005, when Medicare beneficiaries get the notice that it is time to enroll in the drug benefit.

What choices would the senior face in 2005 when considering whether to enroll in the new, highly touted program?

Many Medicare beneficiaries will have to consider the following:

No. 1, sign up for a prescription drug plan, PDP—a private drug-only insurance plan with no limits on the premium that may be charged, or No. 2, enroll in a managed care plan.

Given that more than 85 percent of seniors today have rejected managed care, I anticipate a "1980s" catastrophic outrage. But, that is not the end of the outrage. In fact, it may be just the beginning.

As the senior considers his choices, he will soon realize that the private plans hold all the cards. They have all the flexibility, all the options, and none of the commitments.

The plan defines the classes, or categories of drugs, then decides what drug is in the class or category, and how much the senior will be charged for the drug.

The plan doesn't even have to tell the senior prior to enrolling what the charge for the drug will be, and can change which drugs are in each category at any point in the year.

But the senior? The senior has to make an enrollment decision prior to the beginning of each calendar year, based on limited and subject-to-change information, and cannot change plans at any time during the year.

The private insurance plan can make changes during the year, but the senior cannot.

Once enrolled, in the first part of the year 2006, seniors will begin to feel the impact of the deck being stacked in favor of the private plans. They will discover that the plan can make changes to the drugs covered and the price of the drugs at any time.

They will discover that the drug prices aren't all that low, and they will discover that they have to pay the full cost for part or all of January as they struggle to meet the \$250 deductible.

At this point, you may be thinking that things are bound to improve for the senior. But, hold on, because the summer of 2006 is coming. What happens then? That is when, for the first time, seniors—voters—will experience the infamous "gap." Beginning sometime after Memorial Day 2006, many seniors will reach, and fall into, the gap.

At this point the senior has been going to the drugstore for about 6 months, each month filling prescriptions for treatment of any number of chronic illnesses.

The senior has met his or her deductible, has never missed a monthly premium payment, and dutifully has been paying 25 percent of the cost of each prescription.

But when the drugstore counter is reached in July, the senior finds he is now responsible for paying 100 percent of the cost of the prescription, and yet still is responsible for paying the monthly premium.

I predict that by Labor Day of 2006, seniors will have made loud and clear their opinions about this prescription drug benefit.

And yet, there is still more ahead. In the year 2010, a vast experiment called "premium support" will be imposed on millions of seniors in several parts of the country, including Florida.

Seniors in my State, as in others, will be forced to choose between enrolling in a health maintenance organization or paying a much higher premium to stay in the traditional fee-for-service Medicare Program.

Although we are beginning to hear the outrage now, it will be nothing compared to what we will hear in the summer of 2006.

The voters have been polled and my constituents have been calling, and they all cite many concerns with the bill—many of the same issues I mentioned a few moments ago. Each of these issues should be discussed in great detail, and I hope we have the time to do so.

Today, I am going to concentrate on one of the aspects of the bill that I find to be the most troubling, and one that is shared by 64 percent of those polled: the legislation does little to contain drug costs. The legislation actually forbids Medicare from negotiating with the drug companies to reduce costs.

It doesn't seem to make much sense. A Medicare prescription drug benefit should allow the Medicare Program to do whatever it can to get the best possible prices from the drug companies. Why? Because both seniors and taxpayers would benefit.

Under this legislation, the majority of seniors would have to pay either 100 percent or 25 percent of the price of the drug—100 percent before the deductible is met, and during the time the senior is in the enormous "gap" in coverage, and 25 percent after the deductible and before reaching the "gap."

In 2001, the median income of a Medicare beneficiary was \$19,688. After cov-

ering the cost of housing, food, and transportation, there isn't a lot left.

We need to make sure the prices are as low as possible so that our seniors are able to actually purchase the drugs they need to keep them well.

Of course, the taxpayers would also benefit from Medicare serving as a tough negotiator. The taxpayer is going to pay the portion not paid by the senior.

Both parties—the seniors and the taxpayers—have an interest in keeping drug prices as low as possible. The party that does not share that interest is the pharmaceutical industry.

The interests of that industry can be the only reason for a provision included at the top of page 54 of the conference report. The provision is designed to appear helpful by being called a "noninterference" clause.

What is a "noninterference" clause? According to the authors of this legislation, it is the following:

NONINTERFERENCE.—In order to promote competition under this part and in carrying out this part, the Secretary—

(1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and

(2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

Let me get this straight. A provision that prohibits the Secretary of HHS from negotiating with drug manufacturers to lower the price of drugs—a provision that prohibits the Secretary from using the purchasing power of 41 million Medicare beneficiaries to lower the price of drugs—and thus lower costs to seniors and taxpayers alike—is "noninterference"?

I put my money on this being a form of "interference" that senior wouldn't mind. Saying this provision is about not interfering, and about promoting competition, is akin to the fox putting on the San Diego chicken costume and heading into the chicken coop to "protect" the chickens.

This may sound like dry stuff. But it has very real life implications. Take the case of Patricia Kittredge, a 71-year-old woman who lives in Tamarac, FL.

She takes 6 different prescription drugs to stay healthy, which add up to \$409 a month, or approximately \$4,908 annually. Fortunately, her former employer picks up the majority of these costs so that she pays \$65 a month, or \$781 annually.

A former credit analysis for a major employer in South Florida, Mrs. Kittredge has good retiree health coverage. Yet she is far from wealthy. She makes about \$18,000 a year when you combine her pension and Social Security income.

Because the conference bill does not allow the Medicare Program to negotiate on her behalf—should Ms. Kittredge find herself among the 4 million Americans who will lose their retiree coverage—her out-of-pocket costs, including her premium, will explode to \$3,830.

That is nearly 5 times what she currently spends, nearly 5 times what she now pays, and nearly \$4,000 in out-of-pocket drug costs on an income of \$18,000 a year. What kind of benefit is that?

But don't take my word for it, this is what Patricia Kittredge has to say:

That would really hurt me. The handwriting is on the wall. The companies that have retiree coverage will be walking away from it to save money and won't feel bad about it at all.

Were Medicare able to use its bargaining power to negotiate with the drug manufacturers, our seniors would likely see drug prices more in line with the VA drug prices. Mrs. Kittredge's drug costs under the proposed plan would decrease dramatically.

Yet the conference bill strictly forbids Medicare from using its bargaining power to negotiate lower drug prices for seniors.

How good are these VA prices? Let's compare the VA prices of Mrs. Kittredge's drugs to their retail prices.

Diazepam, which Mrs. Kittredge takes to help her sleep, costs the VA \$0.84 for one hundred 5 milligram tablets, while the same pills cost \$16.70 at the drug store.

In addition, a month's supply of pravachol which she takes to regulate her cholesterol, costs the VA \$19.80 at 40 mg per pill for the clinical equivalent, while the drug store charges \$116.75 for the same amount.

Mrs. Kittredge would face similarly high prices for her other prescriptions: a 20 mg dosage of accupril, a drug to treat her high blood pressure, costs the VA \$7.69 for 30 pills goes for \$32.00 at the drug store.

Diltiazem, which Mrs. Kittredge also takes for her blood pressure, costs \$69.20 at the drug store but only \$32 through the VA.

Metrocream, which she takes for a skin disorder, costs \$69.99 at the drug store compared to \$25.13 through the VA.

If the Medicare bill we are now considering actively negotiated on Mrs. Kittredge's behalf, she would likely pay prices more in line with the prices available to veterans. Her total bill would be \$2,188 rather than the \$3,830 as she will pay under the conference agreement.

Mrs. Kittredge's example is not unusual. Look at the price differentials between the VA price and the average retail price of some common drugs.

How is the VA able to secure such good prices for veterans?

In 1992, concerned about the prices veterans were paying for drugs, Congress passed the "Veterans Health Care Act"—a Rockefeller, Simpson, Murkowski, Cranston amendment—by voice vote.

It is interesting that an issue that was and is so controversial could be passed by voice vote. We are only asking that Medicare not be prohibited from negotiating prices for seniors.

This legislation gave the VA the authority it needed to secure better drug

prices for our veterans. What was the result of that legislation? In the first 5 years alone, the VA saved more than \$1 billion.

VA's savings have continued to grow exponentially, as both the cost of pharmaceuticals and the number of veterans seeking prescription drugs have grown. The savings represent valuable Federal dollars that have been used to provide quality health care to our Nation's veterans.

In addition, the savings on pharmaceuticals have allowed VA to provide a long-term care benefit, including nursing home care, adult day care.

What are the implications of allowing Medicare to negotiate prices? In 1998, the Inspector General, IG, of HHS, studied 34 drugs currently covered by the Medicare program.

The IG found that Medicare and its beneficiaries could save more than \$1 billion a year if the allowed amounts for just these 34 drugs were equal to the prices obtained by VA.

If the Medicare program were able to achieve similar savings on the outpatient drugs covered in this legislation, Congress would be able to provide a much richer prescription drug benefit for the same \$400 billion we are proposing to spend now, reduce the costs to taxpayers, or both.

In terms of the drug benefit: we could give seniors a lower deductible and fill in the gap; we could remove the gimmicky definition of what counts toward reaching the catastrophic limit so that employers wouldn't drop their retiree drug coverage; we could remove the assets test; We could allow the Medicare Program to pay to the cost-sharing of our low-income seniors.

What would allowing Medicare to use its purchasing power do to the pharmaceutical industry?

Some would have us believe that only the proposal we are discussing today would allow the industry to thrive and continue to develop life-savings drugs.

But in June 1999, reaching to the prospect of a Medicare prescription drug benefit, Merrill Lynch advised investors that

volume increases could overwhelm negative pricing impact. It is important to remember that a reduction in prescription drug prices, both with or without associated prescription benefit coverage, is likely to be associated with price elasticity and increased utilization.

The proposal before us fractures the Medicare market. One of the great strengths of the Medicare Program has been its universality. Seniors from Anchorage to Key West knew they would get the same benefits for the same premium.

The proposal before us also uses scarce Federal dollars in an attempt to force private insurers into a line of business they have repeatedly said they do not want to enter.

Instead, we should be using the purchasing power of the nearly 41 million Medicare beneficiaries waiting for a drug benefit to drive down prices—for

their benefit, and for the taxpayers benefit.

I ask unanimous consent to print an editorial at the conclusion of my remarks.

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

(See exhibit 1.)

Mr. GRAHAM. I'd like to quote from the November 21st Miami Herald, which editorialized as follows:

The problem: Instead of using the free market to drive down the costs of prescription drugs, the bill would protect pharmaceutical companies from competition and pay more than \$100 billion in incentives to employers and insurers in an attempt to make its flawed logic work. The bill also threatens to cap future Medicare spending.

True, the measure promises prescription-drug coverage for low-income seniors not already covered by Medicaid and would benefit seniors with extremely high prescription costs. But its coverage for middle-class seniors is modest at best.

That's just not enough benefit for a 10-year price tag of \$400 billion that will add to the skyrocketing Federal deficit, especially when it doesn't even contain the cost of prescription drugs.

A better, more logical approach would be to harness the buying power of the 40 million Medicare seniors to drive down drug costs. But this bill actually would prohibit the government from doing so. Instead it would dissect the country into 10 regions and pay incentives to companies—\$12 billion to private insurers and \$1.6 billion to HMOs—so they'll offer prescription-drug coverage.

For the Record, I'd like to make one correction in the otherwise excellent editorial. Under the latest version of the bill, between 10 and 50 regions would be allowed—further dissecting the country.

The last drug benefit endorsed by the AARP was the Medicare Catastrophic Coverage Act. We all know how seniors felt about that drug benefit, and it was quickly repealed.

If we adopt the proposal before us, we will be turning a deaf ear to history, and to the seniors across the country today who are already telling us—through AARP card burnings, through the messages they are writing on the AARP "message board", and through the hundreds and hundreds of calls from seniors we've been receiving over the last week—that we need to get back to work.

This drug "benefit" is actually no such thing. It leaves millions of seniors worse off.

Along with many others, I have worked to provide an affordable, comprehensive, reliable prescription drug benefit for our seniors and citizens with disabilities for the last several years.

It is therefore with great regret that I have no choice but to vote against a conference report that does not provide the benefit seniors need, and have been promised.

If the proposal is adopted—and I sincerely hope it is not—it will not be the last chapter. Seniors won't stand for it.

I predict voters will put Congress on the hook in 2006, and we will spend many, many years attempting to fix

this deeply flawed legislation—or will repeal it outright as we did with the catastrophic legislation.

Or we could have the worst of both worlds.

We could repeal the prescription drug benefit because the benefits are too meager, its subsidies of health maintenance organizations are too great, and its delivery system too confusing and disrespectful.

And what would be the price of repealing the drug benefit?

We would leave the privatization of Medicare in place and destroy one of the Federal Governments most effective, efficient and popular programs: traditional fee-for-service Medicare.

In the event the legislation before us does become law, I plan to use my last year in Congress working to fix it. Our seniors need better from us.

EXHIBIT 1

[From the Miami Herald, Nov. 21, 2003]

WHEN HALF A LOAF ISN'T NEARLY ENOUGH
OUR OPINION: REJECT THE FLAWED MEDICARE
PRESCRIPTION BILL

With its \$7 million ad campaign to win support for the Medicare prescription-drug bill, AARP says that the legislation "isn't perfect. But millions of Americans can't afford to wait for perfect." We agree with AARP's assessment of the bill but not its conclusion.

The proposed bill is badly flawed. It delivers too few benefits to seniors at too big a cost. Americans don't need perfect, but for \$400 billion they deserve a bill that helps more people and drives down the high costs of prescription drugs. The proposed bill does little of either. Congress should reject it and try again.

The problem: Instead of using the free market to drive down the costs of prescription drugs, the bill would protect pharmaceutical companies from competition and pay more than \$100 billion in incentives to employers and insurers in an attempt to make its flawed logic work. The bill also threatens to cap future Medicare spending.

True, the measure promises prescription-drug coverage for low-income seniors not already covered by Medicaid and would benefit seniors with extremely high prescription costs. But its coverage for middle-class seniors is modest at best. That's just not enough for a 10-year price tag of \$400 billion that will add to the skyrocketing federal deficit, especially when it doesn't even contain the cost of prescription drugs.

Don't repeat the past

A better, more logical approach would be to harness the buying power of the 40 million Medicare seniors to drive down drug costs. But this bill actually would prohibit the government from doing so. Instead it would dissect the country into 10 regions and pay incentives to companies—\$12 billion to private insurers and \$1.6 billion to HMOs—so they'll offer prescription-drug coverage.

We've tried such incentives before with HMOs, and experience shows that they didn't work. Half of the Medicare Plus Choice plans provided by HMOs have folded, even though taxpayers still pay more to subsidize a senior in a Medicare HMO than a senior in traditional Medicare.

The compromise measure also guts provisions that would have allowed seniors to legally buy prescription drugs from Canada, another concession to pharmaceutical companies, some of which now are retaliating against Canadian wholesalers who sell to Americans.

The doughnut hole

The standard coverage that the bill offers would only benefit a senior who spends more than \$835 a year, or some \$70 a month, on drugs. Then there's the "hole in the doughnut" coverage gap in which the government's 75-percent subsidy stops after \$2,200 in out-of-pocket cash has been spent. If out-of-pocket spending reaches \$3,600, the subsidy kicks in again, this time at 95 percent of drug cost. Deductibles and co-payments are complicated enough without trying to explain the "hole in the doughnut" to elderly recipients.

AARP and other supporters say that even a flawed benefit is better than nothing. They reason that once passed, bad provisions could be changed before they go into effect. But why fix later what should be fixed now?

Seniors deserve affordable prescription-drug coverage. Congress should scrap this flawed approach and come up with a plan that delivers that coverage while driving costs down.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. JOHNSON. Madam President, I ask unanimous consent to speak for 5 minutes as in morning business.

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

HAPPY 90TH BIRTHDAY, DAD

Mr. JOHNSON. Madam President, today my father, Van Johnson, is celebrating his 90th birthday. He is joined by my mother Ruth, my brother and sister and their spouses, dad's sister Ardis, and a great many wonderful friends. I had long planned to be there to join in this celebration, but the Senate failed to adjourn on time, and now is staying in session through the weekend and into next week in an effort to conclude legislative business which should have been completed months ago.

The good people of South Dakota honored me by electing me to represent their interests and values in the Senate, and I simply cannot neglect those duties by leaving Washington today.

While I cannot be with dad on this very special day in his life, I rise to express my long appreciation for a father who has always been there for me. Dad taught me about the importance of family, of fatherhood, of faith, and of personal integrity. He taught me about the importance of public service—that life is more than about the collection of things, and that helping make the world a better place is, indeed, a central purpose to our lives.

Dad was there for me, whether it involved the countless family camping trips, athletic events, school work, or church activities—all at a time when he was intensely busy with his own career as a highly regarded teacher, coach, professor, and university administrator. He and mom were and are a great team, and my brother Tom and my sister Julie and I have benefited all our lives from their loving guidance and care.

As a father of three children, and now a new grandfather myself, I continue to draw from the values imparted

to me from my father and find with each passing year how profoundly important they are.

But dad, although an educator all his adult life, did not teach exclusively in a pedagogical manner. Many of the greatest things I learned from dad came from observing his example—his commitment to our family, his love for mom, his dedication to professional excellence, and his willingness to assume leadership roles in the church and in our community.

Dad, it deeply disappoints me that I cannot be with you today, but know that I am with you in thought and spirit. Happy 90th birthday, dad.

I yield the floor.

Mr. REID. Madam President, Senator NICKLES is in the building. I do not know if he is going to speak.

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

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

Mr. NICKLES. Madam President, I rise to speak on the Medicare bill that is before us. First, I compliment a couple colleagues with whom I have had the pleasure of working on this bill, particularly in the conference committee. First would certainly be Senator GRASSLEY who, in leading the Senate conferees, I think did an outstanding job. I also would echo that for the majority leader. The majority leader seldom gets involved in a conference. This majority leader, Dr. BILL FRIST, has an interest in Medicare and he was a very influential member of the conference. In addition, Senator KYL, Senator HATCH, Senator BAUCUS, and Senator BREAU and, I would also include, Chairman THOMAS.

This was a very challenging conference between the House and the Senate. The bill that was reported out of the Senate—I did not vote for it. I thought it was very heavy on expense and very light on reforms. I did not really think it was a sustainable bill, one that we or our children could afford. So I worked very diligently, I guess, or very aggressively, trying to come up with a conference report that would meet the test, that would provide better benefits at a sustainable level.

I think the present Medicare system has crummy benefits. It does not cover a lot of things that should be covered. It is so far behind the times, I really did want to modernize it. I also wanted to add the new benefits in a way that would be affordable and sustainable.

Under the present situation in Medicare, just to give people a little thumbnail sketch—and this is without providing any new benefits—the total debt held by the public is \$3.6 trillion. Social Security unfunded liabilities is about \$4.6 trillion. Medicare is almost three times as much. It is \$13.3 trillion,

and that is without adding a new benefit, which most people would estimate to be \$6 trillion or \$7 trillion. So my colleagues can see we have an enormous challenge before us.

Then just look at Medicare today. There is a lot more money going out than coming in. Medicare is primarily financed by two things. One is payroll taxes; 2.9 percent of all payroll, not capped at the same amount that Social Security is up to the 80,000-something dollars. It is 2.9 percent of all payroll. That is the money going in. It is also financed by general revenue. We subsidize Part B.

If it is added all together and we take out the intergovernmental transfers, Medicare had net deficits last year—in 2002—of almost \$70 billion. It gets a lot worse—by 2012 the deficit will be above \$150 billion. That is present law. That is without adding a new benefit. So Medicare is in very difficult fiscal waters, a lot more challenging than even Social Security, a lot more challenging than any other program because demographically there are a lot of people who are living longer, health care expenses are exploding, and there are fewer people paying the payroll tax. So it is going to take a greater share of general revenue, money from taxpayers to pay for these obligations.

So I thought, let's provide better benefits. What do I mean by that? Medicare does not provide drug benefits. Everyone knows that. Medicare also has unaffordable deductibles. It has a deductible for the hospital of \$840. I compare this to what the private sector offers. If a person buys Blue Cross or Aetna, any of the private plans, they do not have an \$840 deductible to pay if they go in the hospital for one day, but Medicare does. All private plans certainly should—I think most do—have catastrophic. Medicare does not have catastrophic.

If a person is really in trouble, if they are in the hospital more than 150 days, it is all on them; they do not get any help from Medicare. I think that is pathetic. That is not a very good benefit. As a matter of fact, if someone is in the hospital more than 60 days, they have to pay \$210 a day. If they are in the hospital more than 90 days, they have to pay \$420 a day. So if someone is really sick, if they are really in trouble, look out, Medicare does not come through. So it is a program that has, frankly, not been modernized since its creation in 1965.

Medicare does not do enough for preventive care. It does not offer prescription drugs. It does not have catastrophic. Its deductibles are way too high for hospitalization. So I think it needs significant improvement.

I want to pass a Medicare bill that will help solve all of these problems. I want to pass a bill that will provide drug benefits. I think we are way behind the times. We should be doing it. I also want to be cognizant of the fact that Medicare is in real financial trouble, that it is not sustainable in its

present form. I do not want to be adding new benefits that will just accelerate the day where it collapses, where it is not sustainable, where our kids are going to be saying: What about this tax?

Some people say: Well, this is not a tax. And that is correct, we are not creating a direct tax to pay for the new benefits, but what we are doing is incurring enormous debt to pay for benefits. Frankly, our kids are either going to be paying for that in the form of taxation tomorrow or they are going to be paying for it in an increased interest rate because debts will increase substantially under this bill.

The budget resolution we passed last year said we should strengthen and enhance Medicare. That means make it more solvent, more sustainable, more affordable. Unfortunately, I am not sure we did that under this bill. In fact, we focused too many resources in this bill to cover the covered and not improve Medicare.

What do I mean by that? If we look at this chart, we find out that 76 percent of seniors now have prescription drug coverage, but we are going to spend billions, almost \$100 billion, to provide assistance to those people who already have drug coverage. For employer-sponsored plans, for example, we are going to spend \$89 billion to subsidize employers so they can continue providing health care benefits, drug benefits, for their employees. We are going to bribe them to keep covering the people they have already contractually obligated to cover. This is a big bailout, in my opinion, for employer plans, union plans. It is way too high of a subsidy. I know AARP wanted these subsidies and in fact wanted more money.

Now, some people were criticizing Senator BAUCUS. Mr. Hunt in the Wall Street Journal criticized him as a negotiator. I take issue with that. He was a very successful negotiator because in the last several days of negotiating the bill—we spent months negotiating—Senator BAUCUS was a very effective negotiator. He kept winning. I kept losing. We were on opposite sides in many battles. I complimented him. I said: You just keep winning.

He got more money for the employer and union subsidy, another \$18 billion in the last few days to cover the covered. It went from \$71 billion to \$89 billion by making it tax free. He also got an additional \$18.5 billion for low-income subsidies and more benefits. That makes the bill more expensive and I think will make utilization go way up. So I compliment Senator BAUCUS for his negotiations, but I also think it makes the bill less sustainable or less affordable for future generations.

So we spend a lot of money to take care of employer sponsored. I also have issues with covering the covered in the Medicaid program. We have low-income subsidies in this bill not just for those who are higher incomes than Medicaid but for the Medicaid population that is

dually eligible. We have subsidies in this bill for low-income to the tune of \$190-some billion. These are subsidies for seniors which many of whom already had drug coverage. So what is the total package? Everybody says this package is a \$395 billion package. In reality it is much more than that. In reality, this bill is closer to \$800 billion. It nets out about \$400 billion. It is \$800 billion because we have \$507 billion in drug benefits, but we also have low-income subsidies of \$192 billion, and we have employer subsidies of \$89 billion. If you add that up, it is almost \$800 billion of checks that are going to be written. The Federal Government is going to be writing those checks.

The Federal Government will be receiving money back in the form of premiums from seniors, \$131 billion, and a reach-back or call-back from the States. Since we are assuming Medicaid, which in my opinion is a serious mistake, one that was opposed by the administration and certainly opposed by this Senator, but we were not successful. It was not the Senate position to assume federalization of Medicaid. Medicaid is a Federal-State program. It is now an all-Federal program when this bill becomes law. Again, we are covering the covered. We are going to subsidize Medicaid to the tune of \$190-some billion in this bill. That is a lot.

We recoup some of the money we were paying. Now it is all Medicare, so the offset will say we will spend less in Medicaid because we are not going to do that. In the future we will make it all Medicare. The net is—we will spend \$800 billion, recoup \$400 billion—so the net cost to future generations is about \$400 billion. Yes, that meets the so-called budget restraint we put in, in this year's budget. But we didn't finance that, we don't pay for it, so we have benefits, frankly, that are certainly overpromised and underfunded. They are not funded. The \$400 billion is not funded. That is just additional debt.

I happen to think it will be a lot more than that. I happen to think once you end up paying some benefits you will find that utilization will skyrocket. This is just what CBO has told us. People without drug coverage in this age category spend about \$732 on their drugs per year. If they have drug coverage, they spend about double that, \$1,337.

I think this figure will skyrocket. I asked my mother: Do you have drug coverage? She said yes. She buys it with AARP. She pays \$140 or \$160 a month for drug coverage. I said: How much is your drug coverage?

It is 50 percent of whatever she spends up to \$1,000. She gets \$500 in drug benefits from AARP. She pays almost \$1,000 for that \$500. Maybe there are some other benefits in there I am not aware of. My point is, a lot of people have drug coverage, but they only have a little drug coverage. The reason I say this bill may not be sustainable or affordable is because 36 percent of

all Medicare seniors are going to get an enormous benefit and they pay almost nothing. They will have only \$1 and \$3 copays, or \$2 and \$5 copays; in most cases they will have no premiums, deductibles or gap in coverage.

I have heard some colleagues say we should be doing that for everybody. Let me just give you an example of who is pushing that proposition. I saw that AARP ran an ad today and is asked: Why should you vote for this bill? They had three or four reasons. If you have income less than 100 percent of the federal poverty level—for an individual, that is \$9,600; for a couple it would be \$13,000, this is the best deal you have ever seen because all you have to pay is \$1 if you are buying a generic, or \$3 if you are buying a brand-name drug, and you have unlimited drugs—no limit, no deductible, no copay other than that \$1 and \$3; no premiums, and no donut hole. That is unlimited. All you have to pay is \$1 to \$3 and all your drugs—whether they are \$5,000 or \$10,000—are all covered.

It is almost the same if you have an income of less than 135 percent of poverty. That would be for individuals with \$13,000 and a couple with \$17,600 of income. If they have less, they have the same thing, except their copay is \$2 and \$5. There is no donut hole, no catastrophic, no limitation. They don't have to pay premiums, no \$35 a month in premiums. They have a great benefit. They should be celebrating.

I am surprised to hear some of our colleagues on the other side say they can't support this bill because it is not a very good deal. If they are so-called champions of the poor, this is the most generous federalization of a government benefit in U.S. history. Maybe they are ignoring the low-income subsidies. It is not insignificant—\$192 billion according to CBO. I think it is so much more than that. I think when people find out their only copay is \$1 or \$3 or even \$2 and \$5, utilization will skyrocket. This chart will be so inaccurate.

We will find out if we have underestimated the impact of providing a federal benefit upwards of a 90 percent subsidy. In a few years we will find out. People who don't have to pay much—in other words, if the Government is paying 90-some-odd percent of it, 95 or 97 percent, which would be the case in many of these income categories, utilization will skyrocket. At least that is my opinion. Maybe I am wrong. We will find out. I am making this statement for the record because I think this benefit is going to cost a lot more than people estimate. I think utilization will skyrocket.

For individuals who have incomes less than \$14,500, or as a couple, \$19,500, between that 135 percent and 150 percent of poverty, their copay is 15 percent. The Government is going to pay 85 percent. Again—no donut hole. They will have a reduced sliding scale premium and a reduced deductible of \$50. This too is an enormous benefit that will skyrocket.

People who have incomes above 150 percent of poverty, they have a copay of 25 percent. Then you are getting into the area where it is not quite as good as what they had in the private sector. So my point is, for low income, for that 36 percent of Medicare seniors, for about 14 million seniors, this is one great package. My guess is, it will explode in cost.

Another reason I think it will explode in cost is because a lot of our colleagues will say whatever we pass, that is just the beginning. I think Senator KENNEDY alluded to that when this passed the Senate: This is a beginning and he wants to expand upon it. I believe that is what AARP says: We will take this and expand upon it.

How do you expand upon it? Well, let's just fill the donut hole. In other words, the basic benefit after you get past the low-income subsidies, the basic again goes up to \$2,250. Then above that amount you have to basically self-insure or in other words you pay the next couple of thousand dollars on your own before the Federal Government catastrophic kicks in.

A lot of people would say: Let's just fill that donut hole up. We don't have that donut hole in the private sector, we should not have it in this. If you fill that up, in other words, if Government expands its liability, the cost of this program goes up by the hundreds of billions of dollars—hundreds of billions of dollars. In fact, one does not have to predict that this will happen, it actually already did. The Conference Committee negotiated an initial benefit level of \$2,200. This was an agreement. Tuesday night, armed with a CBO score that was under \$400 billion the negotiators closed the donut by \$50. This cost \$4 billion. I have no doubt in my mind that once this passes, future Congresses will be working to fill that donut hole, and my guess is they will be successful. My guess is they will be successful in increasing the number of people eligible for these enormous low-income subsidies. It doesn't have to be 150 percent. As a matter of fact, the Senate bill passed at 160 percent of poverty. So I am sure there will be amendments year by year to increase that level up for the super government benefit. Let's make that eligible up to \$30,000 or \$40,000 so that will be happening.

I also think areas in which there are significant savings in the bill—and I was involved in this—the reach-back, where we try to recapture a portion of the savings going to States we will see slowly undone. My guess after this becomes law, States will be lobbying us extensively: You are taking too much back. We want that reduced. In fact the reach-back provision was reduced just this past week at a cost to the taxpayers of \$4 billion.

I am afraid in many cases States will continue to be successful. So that cost will explode. As a matter of fact, I will make a prediction. Within a few years, the donut hole will be eliminated, the

reach-back by States will be reduced dramatically, and the expansion of low-income definition will be enlarged tremendously, so the cost of this bill will more than double, more than double. That is just my guesstimate. I may not be in the Senate when that happens, but my guess is it will happen.

What is my other complaint about the bill? Its explosive nature in cost. I knew it would cost a lot. I knew it would explode. One of the things I really wanted to do was come up with some reforms that would help make this program more sustainable, more affordable for the future.

Presently, we have a system that is bifurcated. We have Medicare hospitalization. That is called Part A. It has Part B for doctors. It will now have a new part D for prescription drugs. The benefits are not integrated.

A lot of people also buy Medigap. Under present law they buy A and B and they buy Medigap. So it is not a very good integrated system, unlike the private sector. The private sector offers the benefits that I said that Medicare lacks. I wanted to have an integrated private-sector alternative to the present Medicare system, one that people could look at and say: Wait a minute, this works better. I think I would rather be in the everyday private sector type system, the same one Federal employees have, the same one private sector employees have.

They have better plans. They have a better package. It is more modern. It is not tied to a government-controlled fee-for-service system that does not work. Do you want the private sector to become a 1965 Medicare fee for service model? This bill is spending billions and billions of dollars to make adjustments for doctors and hospitals and providers because government is underfunding them? That is not the private market and we should not tie them to Medicare's price controls.

Senator GRASSLEY has been a champion for increasing assistance to rural areas, and he is exactly right. The present system hasn't worked very well. I wanted to come up with a more modern system with integrated benefits that integrates Part A, Part B, and Part D—hospitals, doctors, and prescription drugs—and avoid the necessity of a Medigap plan. People had to have Medigap because Medicare alone didn't pay for a lot of benefits, and it had too high of a deductible. People had to buy Medigap. They shouldn't have to do that. I was hoping we could come up with a good, reasonable integrated system. I am afraid that maybe we haven't quite attained that. I am afraid our reforms are really not adequate for the explosiveness of the benefits we are looking at today.

Let me touch on the integrated benefit. I have heard some people say this is a ripoff because we are giving money to insurance companies; that it should be done by the Government. I have already mentioned that Government doesn't do a very good job in providing

the benefits today. Now we are trying to have the private sector come in after Part D, the private sector for a prescription drug package. Nobody in the real market right now offers to Medicare beneficiaries or for that matter anyone a stand-alone drug benefit. We hope and pray they will in the future. But if they do, they will have to basically offer exactly what we told them to offer, and that is the benefit structure of 75-25 up to \$2,250. We are limiting the private sector to only offering a government-designed benefit.

There is this big donut hole in the government standard benefit and we have a governmental catastrophic, some call it Government reinsurance—which ties the hands of the private sector and denies seniors the best the private sector has to offer. For example, After you spend \$3,600 of your own money, then Government reinsurance will kick in, and individual beneficiary will be liable for 5 percent. The Government is responsible for 80 percent of all costs above the \$3,600 “true out of pocket”, the health plan is covering 15 percent and the individual 5%. The private sector is not able to assume full risk and offer the benefits they want. If the private health plans did offer increased benefits they would lose or delay government subsidies. This is crazy. All they are able to offer is basically the basic benefit up to the \$2,250, or the actuarial equivalent, but they are not able to offer both. They are not able to say they will take all of Part D—that they will assume all of Part D and combine it with Part A and Part B and use efficiencies between the system having an integrated benefit and maybe doing something better in hospitalization and doctors, have some savings and offer a more generous drug benefit. They are not able to do that because under this bill, they are required to maintain this true out-of-pocket cost. This bill puts the private plans in straight jacket.

I think that is very unfortunate. It really kind of locks in an inflexible structure. We are telling the private sector, which have extensive experience in offering comprehensive benefits for all types of individuals including public and private sector employee and individuals, that they have to sell a government benefit. They can not offer a plan with prescription drugs for our seniors without having a donut hole. We are mandating that they have that before they can get into catastrophic. I find that to be very unfortunate and very shortsighted and maybe even unworkable. It doesn't really transcend the movement to private sector. It doesn't trust the private sector. By doing that, I am afraid we have put in a rigidity that won't allow it to work as we would like for it to.

We did not get cost containment. We tried. Maybe I should say we have minor cost containment. We did put in a provision that says if general revenue contributions exceed 45 percent, the President shall come up with a plan to

fix it, and Congress has some procedures. Nothing mandates Congress do it. We tell the President he should. That is years away. I find that to be a little hollow. I wanted real cost containment. It was opposed by many—particularly on the Democrat side—and we weren't successful in getting that in. That is unfortunate.

There are several provisions in this bill that are good. I want to compliment again Senator GRASSLEY and Chairman THOMAS. We did get health savings accounts. It is not directly related to Medicare, but I think it would help reform health care as we know it. People would actually be spending their own money. I think that is a very positive and a good significant change, and it will change people's behavior. That is about \$6 billion or \$7 billion. That is very positive. I compliment Senator GRASSLEY and Chairman THOMAS especially for putting that in.

We did put in income-relating Part B premiums. Senator FEINSTEIN and I worked on that amendment on the Senate floor. We included a lot of that in the bill, not exactly as we put it in the bill on the Senate floor, but I think that is a positive change. But to my regret, it puts more money in the bill, and basically we spent that money.

We did get income-related Part B. Basically, that means we are going to have less subsidies for higher income people. Part B has always been paid for. When it was created, it was 50 percent for individuals. Over the years that has been declining. Now the individual only pays 25 percent, and the Federal Government pays 75 percent.

What we said is if you have income above \$80,000 up to \$100,000, eventually you have to pay 35 percent. If you have individual income above \$100,000, eventually you have to go up to 50 percent where it used to be. If you have incomes much higher than that, you will have to pay 65 percent, or you will have to pay 80 percent. Even very wealthy people will still get a 20-percent subsidy under this provision. I think that is good reform.

We also index Part B deductibles. It has been \$100 for a long time. Now we index that to the cost of the program. Those are good changes. They will help improve it. Unfortunately, the savings to the taxpayers as a result of these changes have already been spent in this bill. As a matter of fact, in the 2 or 3 days of negotiations, we amended the benefits and the subsidies in the bill by about \$40 billion. Most of the good done by the income-relating of the Part B premiums and the indexing of the deductible were undone.

I have no doubt that in future Congresses that the current 75 percent up to that \$2,250 subsidy will be changed and the \$2,250 is going to be climbing up. I have no doubt that people will say we need the most generous subsidies and low-income subsidies which needs to apply to a lot of other people. It will increase spending dramatically.

My point is, Yes. We made some reforms, but this program may not be af-

fordable or sustainable. Right now, it is estimated to cost \$400 billion over the next 10 years. The program doesn't even start for a couple of years; that is, over the next 8 years. The Congressional Budget Office directive said that in the next 10 years they thought this program might cost up to \$1.5 trillion to \$1.7 trillion. That is with the benefits structure as we have outlined it today. As it expands, it will be much more than \$1.7 trillion. When the donut hole is filled—and I predict it will be—when you have the number of eligibles increase dramatically to receive the low-income subsidies, when we reduce the reach-back or claw-back from States, this \$1.7 billion in the next decade will probably be much more than that.

That brings me to my final comment. Can we sustain it? I am not sure. It looks to me like we are building a brand new deck on a house with a very unstable foundation. I think we are expanding this program like it is on a solid foundation, and it is not. We are not paying for these new benefits. We are saddling our future generations with enormous liability.

I conclude by saying I have the greatest respect for the chairman of the committee. I have the greatest respect for the majority leader. I want them to be successful. I want the President to be successful, and I want senior citizens to have prescription drugs. I want them to have a modern Medicare system. This bill takes some steps in those directions, but my conclusion is that the benefits greatly exceed the reforms. Without necessary reform, I am not sure this program will be sustainable in the future. So it is my intention not to support this bill.

Also, I want to compliment some people who have worked very energetically on this bill. One is my staff, Stacey Hughes, who has just worked unbelievable hours; on Senator GRASSLEY's staff, Linda Fishman and Mark Hayes, and the Senate legislative counsel. There are a lot of people who have put in more hours than you can imagine to put forth this bill. I compliment them for their efforts. They worked in a very positive way. It is a pleasure to work with them and to work with the chairman.

I yield the floor.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. One minute five seconds.

Mr. NICKLES. I yield that time to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I certainly think the cooperation we have had from the chairman of the Budget Committee, Senator NICKLES, helped to move this bill along. Even though he has not liked some parts of the bill, he has been cooperative all the way through the process and, more importantly, through the crucial time of conference.

There is a claim that pharmacies are concerned about beneficiary access to pharmacies, pricing transparency issues, and insurance risk.

I understand the concerns of pharmacists with regard to local access. This bill provides several provisions to ensure that Medicare beneficiaries are provided with adequate choice and easy accessibility to local pharmacies.

First, the conference report provides choice to beneficiaries by containing an "any willing provider" provision. This provision requires prescription drug plans to accept any and all pharmacies willing to agree to the terms and conditions of the plan. By adding this provision, we have given all pharmacies, big and small, the chance to participate in the modernization of Medicare.

Second, the conference report provides beneficiaries with convenient access to pharmacies by adopting the TRICARE standard for prescription drug plans. In urban areas, 90 percent of beneficiaries would have a pharmacy within two miles of their residence; 90 percent of beneficiaries in suburban areas would have access to a pharmacy within five miles of their home; In rural areas, plans would be required to provide 70 percent of beneficiaries with a pharmacy 15 miles within their residence.

By adopting this standard, beneficiaries are ensured adequate convenient access to pharmacies of their choice.

The conference report also requires that plans permit beneficiaries the ability to fill their prescriptions at a community pharmacy rather than through the mail. Again, ensuring access to local pharmacies.

In addition to providing convenient, local access to pharmacies, the conference report provides safeguards to ensure fair drug pricing and protects pharmacies from insurance risk.

Under the report, pharmacy benefit manager's, PBMs, would be required to disclose all discounts, rebates, and charge backs given to them by drug manufacturers. This places local pharmacies on a fair playing field with PBMs.

The report also prevents insurance risk to pharmacies by clarifying that pharmacies could not accept insurance risk.

This conference report adequately addresses the concerns of pharmacies and pharmacists alike. It makes sure that beneficiaries have local and convenient access to pharmacies, provides transparency pricing, and protects pharmacies from insurance risk.

REVISIONS TO H. CON. RES. 95

Mr. NICKLES. Mr. President, section 401 of H. Con. Res. 95, the budget resolution, permits the chairman of the Senate Budget Committee to make adjustments to the allocation of budget authority and outlays to the Senate Committee on Finance, provided certain conditions are met pursuant to section 401.

I hereby submit the following revisions to H. Con. Res. 95, and I ask unanimous consent to have it printed in the RECORD.

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

Current Allocation to Senate Finance Committee:

	(\$ in millions)
FY 2004 Budget Authority	771,171
FY 2004 Outlays	773,820
FY 2004-2008 Budget Authority	4,618,622
FY 2004-2008 Outlays	4,627,988
FY 2004-2013 Budget Authority	10,991,722
FY 2004-2013 Outlays	11,007,116
Adjustments:	
FY 2004 Budget Authority	4,800
FY 2004 Outlays	3,800
FY 2004-2008 Budget Authority	11,725
FY 2004-2008 Outlays	11,576
FY 2004-2013 Budget Authority	-5,000
FY 2004-2013 Outlays	-5,200
Revised Allocation to Senate Finance Committee:	
FY 2004 Budget Authority	775,971
FY 2004 Outlays	777,620
FY 2004-2008 Budget Authority	4,630,347
FY 2004-2008 Outlays	4,639,564
FY 2004-2013 Budget Authority	10,986,722
FY 2004-2013 Outlays	11,001,916

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Parliamentary inquiry. This, of course, has nothing to do with the legislation. It is my understanding the action of the distinguished chairman of the Budget Committee would not be in derogation of the consent order before the Senate for debate today.

The PRESIDING OFFICER. The Chair's understanding is that changes in the allocation being submitted by the Senator are just being printed in the RECORD.

The Senator from Massachusetts is recognized.

Mr. KERRY. Mr. President, I believe we ought to reject this Medicare bill. When I look at it carefully—which has been hard because there has not been a lot of time—it is clear it is a cruel hoax for seniors and a cynical giveaway to drug companies and to the insurance industry. Even as we speak, there are lobbyists scurrying around Capitol Hill working feverishly to pass a bill that has already driven up the stock of those corporations I have mentioned, the insurance industry and drug companies across the country. The rise in that stock tells the story about the windfall profits that come with this bill.

With the help of President Bush, they produced a Medicare bill that lines the pockets of the powerful moneyed interests and it leaves America's seniors out in the cold. This bill is less about pre-

scription drug benefits and more about a prescription to benefit large drug companies. America's seniors deserve better.

As I have traveled around the country and heard from countless numbers of seniors about their health care needs, they repeat again and again how they need and they want more affordable prescription drugs. "More affordable" are key words when measured against this bill. They need and want a quality Medicare plan—I emphasize Medicare plan—that lets seniors choose their own doctors, their own hospitals, and provides prescription drug coverage.

I have met seniors across the country who have cut their medication, they have cut the dosage in half, because they cannot afford their prescription drugs. I met a woman the other day who could not even afford to start her prescription drugs because the initial bill was \$100 and she did not have the cash. I met people in small businesses who have seen their health care premiums more than double because drug prices are rising so fast. And I met seniors in New Hampshire and elsewhere who have no idea how they are going to possibly pay their rent and cover the prescription drugs they need.

When we break past the advertising bought and paid for by the special interests to sell this bill as something it is not, we will notice that America's seniors are outraged by what they have seen already about this legislation. I was at a forum the other day sponsored by AARP, and when it was mentioned what was happening in the bill, seniors booed their own leadership in the AARP. It is no wonder AARP members are tearing up or burning their cards.

For Senators who are planning to vote for this bill, I ask a very straightforward question: How are you going to explain to seniors that Congress stuck them with a Medicare plan that forces those seniors into HMOs? How are you going to explain to seniors that this plan will stick them with a raw deal that raises premiums for those who do not want to go into an HMO by \$56 to \$200 a month? What do you say to the 2 or 3 million seniors who are actually going to lose quality retiree prescription drug coverage under this bill and they are going to get something much worse?

We have to, in future years, add a real prescription drug benefit to Medicare in order to make seniors' lives better. By now accepting a phony drug benefit, Congress literally risks making it worse for those seniors.

How do you explain to seniors that Congress was not willing to let them buy cheaper prescription drugs from Canada, but Congress was willing to hand the pharmaceutical companies new windfall profits of more than \$139 billion?

How are you going to explain this bill could only be passed in the House under the cloak of darkness in the early morning hours, and only then by

stretching the rules of the House beyond almost anything in history? And that the Senate then jammed through a 700-page bill with only 3 days of debate, giving seniors very little chance to understand what is involved in the biggest and most dangerous change ever made to Medicare?

I ask those Senators who are planning to support this bill why they think it is worthy to hold a prescription drug benefit hostage to a backdoor deal to privatize Medicare, a deal that will help lobbyists, help powerful Washington interests and other interests around the country and help pharmaceutical companies but will literally make the lives of a lot of our seniors worse off than they are today?

Seniors need relief from inflated prescription drug prices, and they need it now. Nearly 40 percent of Medicare beneficiaries report having no prescription drug coverage. Yet the average amount they have to pay out of their own pocket for prescription drugs is going to more than double between the years 2000 and 2006. It is on track to be \$1,400 the year this bill is scheduled to go into effect. If you deduct the amount of money given by this bill from the amount seniors will be paying on average out of pocket, the benefit to most seniors in this country for being pushed into an HMO will not be worth the cost.

Congress ought to be demanding more. We ought to be demanding a real deal for seniors, a Medicare bill that does what it says instead of this phony bait-and-switch legislation. We ought to go back to the drawing board and pass a real Medicare prescription drug benefit. This bill does more harm than it does good. Seniors are not guaranteed that the price of their plan is not going to skyrocket. This bill prohibits the Government from even negotiating discounts for Medicare prescription drugs. It prohibits the Government from doing that. It denies the opportunity for seniors to import reasonable drugs from Canada and other industrialized countries. How extraordinary that the acolytes of free trade are closing down the ability of Americans to exercise free trade and import a product from another country at a lower price.

This bill is really about President Bush passing the buck on prescription drug coverage and passing the bucks from seniors to the pharmaceutical industry. And this bill is being pushed through Congress without adequate debate and exposure to the public light, with too many backroom deals, and with blatant contempt for the public interest.

The Republicans could not win a legitimate victory in the House, so they held the vote open for an unprecedented 3 hours of special interest lobbying, of almost \$900 million of giveaways in exchange for votes, so they could get enough people to switch over to their side.

President Bush twisted arms, twisted facts, until he finally managed to get

the vote. Time and again, the President chooses to get cozy with the lobbyists. We saw it on the Energy bill. We have read it in the newspapers in the last weeks about who gained and who lost on any particular debate each day in the debate over this bill. This administration's motto ought to be: Leave no special interest behind. This Medicare bill lays that record bare for all Americans to see.

The President goes around the country at a furious pace, fundraising at record levels. He has a group of insiders who provide his campaign with a minimum of \$100,000 of campaign cash. They have a name. They are called "rangers" and "pioneers." Well, it should come as no surprise to Americans, and particularly to seniors, that 24 "rangers" and "pioneers" are executives or lobbyists for the very companies that will benefit from this Medicare bill, and they are getting a good return on their money.

This bill makes it easier for the big drug companies to gouge seniors and jack up health care costs so that top executives can walk away with millions. I am all for people who work hard to make a living, and I want people to be able to get rich in America. But when the drug companies' CEOs are making \$40 million a year while the seniors they sell to are choosing between their medicine and their mortgage, I do not consider that just plain old free enterprise; I consider that plain old greed.

This bill smooths the way for even higher drug company profits. In the past 6 months, drug companies, HMOs, and other powerful industries have spent \$139 million in lobbying Congress to give them what they want. Now they have gotten a bill that will give them an estimated \$139 billion over the next 8 years. A thousandfold return on an investment is not bad. You can say what you want about President Bush, but it is clear that his powerful campaign contributors got what they paid for. And it is easy to see why they make so much profit, given this bill, which does nothing to control the rising prices of prescription drugs, nothing to control the rising prices.

Without an effective means to restrain double-digit price increases, this bill does nothing to protect seniors from ever-growing out-of-pocket costs. Someone needs to explain why we are in such a rush to do this. Is someone concerned that the more this cynical bill is exposed, the less likely seniors will be to accept it? What harm would be done if the Nation took some time to look carefully at what is in this bill?

This plan does not kick in until 2006 anyway. So it is not as if seniors are going to get the relief they deserve at the stroke of a Presidential signing ceremony—no indeed. For the next 2 years, seniors are going to get a discount drug card to give them a 15-percent discount. Well, it does not take an act of Congress to do that. Ask any senior today, and he or she will show

you about three or five cards they already carry in their wallets to get a discount on drugs.

Seniors deserve and expect more than a discount card with \$400 billion on the table. If we were really crafting a drug benefit and allowing the Government to institute cost-saving measures in order to tame out-of-control prices, we could deliver a benefit sooner than 2006. The Government ought to be ready to do this within a matter of months.

The entire Medicare plan was set up in 11 months. Now that it is already set up, in the age of computers, are we saying we could not deliver a prescription drug benefit in a matter of months?

Why are we waiting until 2006? I will tell you why. It is for the private, for-profit companies that need to lure people into the market. And it is going to take them time to warm up to the plan. We are waiting for 2006 for those companies.

This bill sets aside a \$12 billion slush fund for the Secretary of Health and Human Services to entice private HMO-style plans to come into the market in order to offer prescription drug plans to seniors. Larded up financial inducements are needed to attract these plans to the market because the risk is so high.

Insuring seniors for drugs usually makes about as much sense as trying to sell a homeowner's policy to someone whose house is burning down. In other words, you are going to lose money. But in the name of "private competition," and to prevent the Federal Government from running this program, this is what they came up with: a great big cookie jar from which to dole out public dollars to private companies to get them to do what we could do less expensively and at less cost to seniors.

On top of giving them extra payments to participate, the bill does nothing to require that private plans actually operate efficiently. The Medicare Program, in its entirety, now spends only 2 percent of total expenditures on administration. By contrast, many health plans in the private market often commit as much as 15 to 20 percent of their expenditures to administration. So every dollar that goes to administrative costs is a dollar not available to improve benefits for Medicare beneficiaries.

I think smart stewards of taxpayer dollars ought to demand that private plans be more efficient if they want to participate. Instead, they are being rewarded from the slush fund and given advantages that only their lobbying influence could get written into law.

In addition, this bill squanders another \$6 billion on tax breaks for wealthy Americans that is going to harm Medicare. The legislation would create a tax-free, high-deductible catastrophic health policy known as health savings accounts. That account will undermine the traditional Medicare Program because it will result in cherry-picking. The healthiest and the

wealthiest seniors will come out of the risk pool where they share the risk of coverage, and that will result in raising the premiums for everyone else—for the poorer and the sicker—and it will raise those premiums by as much as 60 percent.

The so-called cost containment provisions in the bill add insult to injury by essentially placing a cap on Medicare spending. This bill would attempt to force future Congresses to reconcile Medicare spending growth by cutting benefits, raising premiums, or increasing the payroll tax. I believe that is unacceptable.

So what do America's seniors get from this bill?

More than 2 million seniors who have good drug coverage now, through retiree health plans, are going to lose it. About 6½ million low-income seniors—the very people we need to help the most—could get less drug coverage than they have now. That is a raw deal for seniors.

Under this bill, 7 million seniors will be given this choice: Pay more for Medicare and get forced into an HMO, give up on choosing your own doctor and hospital, or watch your bills skyrocket. That is the choice for seniors.

The name of this provision in the bill is called premium support, but like Clear Skies, which means dirtier air, or Healthy Forests, which means cutting down the trees, it is an innocent-sounding name for a plan that could raise Medicare premiums from about \$60 to thousands of dollars. It breaks the compact of Medicare.

In fact, what it really means is the beginning of the end of Medicare as we know it. Those are not my words, those are the proud boasts of the author of this bill, House Ways and Means chairman, BILL THOMAS. He said:

To those who say that it would end Medicare as we know it, our answer is, we certainly hope so.

It is not surprising that Newt Gingrich is supporting this deal because he long wanted Medicare to “wither on the vine.” Most Americans and most Democrats have a different hope, that Medicare remain secure and strong. I intend to fight with everything I have to make that happen.

We need a real-world, affordable Medicare prescription drug benefit for seniors, a plan that won't force seniors into an HMO, that won't undermine the coverage for seniors who are already getting help today, that will be run by Medicare instead of an insurance company in search of a buck, and that will send a real benefit to every senior, no matter whether the costs are average or high. That is a real deal for America's seniors. But as I said before, right now this bill is a bad deal for seniors and they know it.

They know that this bill provides the skimpiest of benefits, with holes in coverage and complex rules. The coverage gaps remain too high, and seniors are still charged premiums even after their benefits shut down in the so-

called donut hole. I think we ought to go back to the drawing board. They know this bill does not adequately protect them with a guaranteed government fallback with a national premium. Until this bill stops slanting all the advantages toward the HMOs and private companies, I believe we have to vote it down.

I believe seniors deserve a guaranteed Government fallback plan. Seniors know that this bill will jack up the out-of-pocket costs in order to visit doctors and hospitals. This is supposed to be a bill to add a prescription drug benefit, but along the way beneficiaries got stuck holding the bill for an additional \$25 billion in increased out-of-pocket costs from means testing the Part B premium and increasing the deductible and indexing it to inflation.

This revenue raiser isn't done in order to improve Medicare but to give sweet deals, slush funds, and tax accounts to corporations and to the rich. It is wrong. We should vote it down.

I believe the proponents know that this bill fails to fix protections for low-income seniors—certainly low-income seniors know that across the country—and people with disabilities that currently rely on both Medicare and Medicaid for their coverage and should be defeated. They know it and you know it. This is not a good deal for seniors.

This week in November of 1945, Harry Truman sent to Congress a proposal for health care for Americans. He said:

Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. And the time has now arrived for action to help them attain that opportunity and to help them get that protection.

But powerful interests mobilized 1945 on Capitol Hill and defeated health care for Americans, Harry Truman's proposal, and especially for our seniors.

It was almost 20 years later that a young American President took up Harry Truman's cause and called for health care for America's seniors. This week in November of 1963, the House of Representatives was considering John Kennedy's Medicare proposal. The same powerful interests were swarming through this building, but there was a spirit of hope and possibility. Now those who support this bill are breaking the promise of Truman and Kennedy that was fulfilled under President Lyndon Johnson.

This has been tried before. This week in November of 1995, 30 years after Medicare became law, Speaker Newt Gingrich and his ideological allies shut our Government down for the first time ever in order to achieve their radical objective of tearing down Medicare. Millions of seniors would have been harmed by those cuts, but we stood up and we stopped Newt Gingrich because President Bill Clinton and others stood their ground and defended Medicare.

I believe we need to stand our ground today and stand on principle again. This bill will hurt seniors more than it

will help them. We should pass a bill that offers a real prescription drug benefit under Medicare. We need to rebuild Medicare, not sell it out to the highest bidders. Medicare is one of the best Federal programs we have. I don't believe it is time to shred it. It is time to strengthen it. This Congress and President Bush will be held accountable by America's seniors and American history for the decision we make now. I believe we ought to give seniors a real deal, a prescription drug benefit under Medicare that works for them, and not a phony prescription drug benefit that provides benefits only for the most powerful special interests that stand in their way.

I yield the floor.

The PRESIDING OFFICER (Mr. GRASSLEY). The Chair recognizes the Senator from Missouri.

Mr. TALENT. Mr. President, I appreciate the opportunity to speak about this landmark piece of legislation that is so necessary and has been so necessary for too long and of which we have deprived America's seniors for too long. If I may say with great respect, I had a chance to listen to the last two speakers, my friend from Oklahoma and my friend from Massachusetts. Listening to those speakers just summed up for me why we have not passed this bill in the years and years it has been necessary and that seniors have been demanding it. The last two speakers represented pretty well and eloquently, with their usual vigor, the opposite ends of the political spectrum on this bill.

For the first speaker, the bill represented too much government, too much money. For the second speaker, it represented too little government, too little money. Both speakers are terribly disappointed with President Bush. Both want more time to consider this bill and, if necessary, go back to the drawing board; if necessary, wait years more before we provide a prescription drug benefit that millions of seniors around the country need and have needed for many years.

I rise to speak in favor of the bipartisan Medicare conference agreement. I think it is necessary. Medicare is a great program. My dad passed away last October. He was 91 years old. My mom had passed away about 15 years before then in her early seventies. They both used Medicare and stayed alive as long as they did and as healthy and as happy as long as they did in part because of Medicare. It has covered tens and tens of millions of seniors, not only with good medical care but with the security of knowing that they had medical care if they got sick.

Medicare was a great program and is a great program in 1965 terms. That is when it was developed. It covers the kinds of things that good health care covered in 1965, and it doesn't cover the kinds of things that were not covered in 1965. It doesn't have very many preventive health care benefits, catastrophic coverage for long-term acute

illnesses. And it does not have coverage for outpatient prescription drugs because in 1965 you didn't use prescription drugs very often, unless you had an infection or some kind of pain killer. Now they are a part of almost every ongoing medical care treatment plan. Everybody who has health insurance—and not enough do—just about everybody who does has some kind of prescription drug coverage because it helps keep you healthy.

In providing insurance to somebody, you want them to stay healthy because if they get sick, it ends up costing more money for everybody. That is the reason we haven't had this coverage in Medicare, and it has hurt people.

There was a parade I used to be in every year when I was in the House. I like parades. You get a lot of exercise, and they are fun. It is in Hazelwood, MO. I would go down the same street. I always walk parades. I remember running up this driveway and these two seniors would be sitting at the top of their driveway watching the parade every year. Every year I would stop there for 60 seconds, and they would ask me when we were going to cover prescription drugs in Medicare.

I would say: Well, we haven't done it yet.

And they would say: We know that.

Then the issue finally moved on the front burner here at the end of late 1990s and the House began passing bills, 3 or 4 years in a row. We never passed one until this year here. The sentiments we have heard today—I respect so much the Senators who uttered them—are the reasons why.

I just do not want to wait until we get a bill that satisfies every extreme in politics and the political exigencies for everybody because we will wait forever. We will never get a bill then. I would rather go ahead with this bill, which is a good bill, and take what is good about it and then see what is working and what isn't working and then go back and fix it.

That is the reason the AARP supports this. They are tired of waiting, too. I had a hearing on this. I have the honor of sitting on the Special Committee on Aging, a great committee, with a great chairman, Senator LARRY CRAIG. The hearing was in St. Louis. One of the witnesses was Audrey Valley, a delightful lady, who attended the Route 66 Senior Center in Eureka, MO, regularly. I have been out there for lunch a couple of times. She testified about her experiences over the last 12 years. Audrey suffers from osteoarthritis, a degenerative bone disease, and she also has a sinus disease. She ought to be taking two different types of prescription drugs for these conditions, but it costs \$100 a month for 15 pills. So she often cannot take the drugs. She gets some pain relief over-the-counter pills; sometimes it makes her feel better and sometimes it doesn't. She does the best she can. She has to choose between paying for those drugs or paying her rent. Having an air

conditioner working in the summer is hard for her. All of these statements about the problems in this bill mean nothing to Audrey, who struggles month after month because of this gap in Medicare.

What would the bipartisan agreement mean for Missouri? We have over 888,000 beneficiaries in Missouri. They all have the opportunity to get a discount card—a 15- to 25-percent discount immediately. Better than that, low-income seniors get, in addition to that, \$600 a month in annual assistance to help them afford their medicines, along with discount cards. That is a total of over \$200 million in assistance for over 170,000 Missouri residents over the next 2 years, if we pass this bill—not otherwise.

Beginning in 2006, every Missouri senior in Missouri would be eligible for coverage in this bill for approximately \$35 a month. They get at least 50 percent off—or approximately 50 percent off their prescription drug costs. Of the approximately 270,000 beneficiaries in Missouri who have limited savings and low income, they will qualify for even more generous coverage. Additionally, the Government will help the State pick up the cost of the Medicaid-eligible seniors. That will help Missouri, which is in a cash-strapped situation with regard to its budget.

This bill meets the conditions that I thought was important for a Medicare prescription drug bill. It has an immediate benefit, reasonable monthly premiums, strong catastrophic coverage, targeted help for low-income seniors, quality benefits for rural areas, protections for local pharmacies, choice and access to all medicine, and participation in it is voluntary. If you like what you have, you don't have to participate.

That is the reason I am supporting this. I will be pleased to vote for it on final passage. I hope a majority of the Senate does. I hope we are allowed to vote. You never know these days. This is the most important Medicare bill in a generation and maybe we will be able to vote on it and maybe we will not. I know most of the people want to have an opportunity to vote on this bill. I think most will vote for it if they get that opportunity.

I am going to close by saying what I have said on the fairly rare occasions when I have spoken on this issue on the Senate floor. In this body, everything always gets said but not everybody says it. Once in a while, I feel maybe I should deprive the Senate of my comments on something in the service of expedition. But I have said, look, if the bill is reasonable, I am going to move ahead with it. I am tired of waiting. I would like to help these people, such as the folks I saw in that parade, and like Audrey Valley, and others, get access to prescription drugs. I think most of the people who have worked on this on both sides have done their best. As far as I can tell, they are not motivated by all the lobbyists or the special inter-

ests. I have been in a lot of meetings on this, and that hasn't come up once. They are trying to do the best they can for seniors, in a way that will work and be affordable for everybody. That is what this bill does. I am going to vote for it on that basis. I hope it passes.

I congratulate the chairman, who is presiding now, for his fine work.

How much time remains?

The PRESIDING OFFICER. There are 21 minutes remaining.

Mr. TALENT. I am pleased to yield that time to my friend from Colorado.

The PRESIDING OFFICER. The Senator from Colorado is recognized for 21 minutes.

Mr. ALLARD. Mr. President, I thank the Senator for yielding the balance of his time.

Mr. President, first I want to compliment Majority Leader BILL FRIST, from Tennessee; Chairman of the Finance Committee, CHUCK GRASSLEY; and the Conference Committee on working diligently and in good faith toward a workable prescription drug program for elderly citizens. Some have come to this floor and proclaimed it is about politics. I couldn't disagree more. President George Bush, Majority Leader BILL FRIST, and Chairman GRASSLEY have not only talked about the need for a prescription drug program but have worked hard for several years toward a workable program.

It is the Democrats who have demagogued this issue. We just have to look at last year when the prescription bill was brought to the floor by the Democrat majority leader, without having it debated and reported out of committee. I believe that it was their hope that they could embarrass Republicans in an election year. Instead, it only helped point to the failures of a Democrat-led Senate that couldn't even pass a budget because they did not want to deal with the tough votes they would have to face on this floor.

I believe this Republican-led Senate is wrapping up one of the most successful sessions since 1994. There have been long hours and a lot of hard work that has paid off, despite filibusters on judges and attempts to slow down and kill many provisions, such as the budget. But Republicans passed a budget. Republicans are still working hard to pass an energy bill that was blocked through the efforts of key Democrats, and the Republicans are now working hard to pass a prescription drug benefit that is facing a possible filibuster on the Senate floor by the Democrats.

Mr. President, I am very disappointed that we have had to face all this obstruction on the floor, despite the concerted effort to work responsibly and respectfully through the Senate committee system, then bringing the prescription drug bill to the floor and passing it. Now, here we are again, facing a threatened filibuster by the Democrats. Mr. President, we need to have an up or down vote on this conference report. Again, I know that the conferees worked hard in a bipartisan way.

I plan on voting for cloture because I want to see the conference report on Medicare voted on the floor of the Senate. I have stated that I am undecided on final passage. That is because, as a general rule, in the process of negotiations, legislation doesn't get less expensive, it gets more expensive through spending to attract more support and votes. I hope to act as a counterbalance with the clear message that, if spending gets out of hand, I will not vote for the bill.

I am not happy with creating a new program that could lead to a monstrous program in the future. That is why I opposed the bill as it left the Senate, because it was not limited to just the most needy and I felt it broke the budget. It was later proved that I was right in the assessment that it would break the budget, and with more accurate budget figures the conference committee set to work to reduce the scope of the program to keep it below \$400 billion for 10 years and within the parameters of the budget. This, in effect, forced the conference committee to means test the program and keep certain provisions that would hold the user accountable by forcing that patient to participate with a deductible and the so called "donut hole."

In my view, it is very difficult to have a third party pay system and yet maintain accountability. Users feel that they have already paid for the system and are going to utilize it to its maximum to get their just return, and providers feel that it has already been paid for and creates no particular hardship on the individual so they charge with little restraint the third party. So utilization is regulated. And we end up with regulations like we have now in the current Medicare system, which prevents a patient from paying for their own medical care if they want, and it prevents the physician from receiving cash outside the system that could reduce the burden on taxpayers. It ends up creating a system where the close patient-doctor relationship is disrupted to where the patient can't use whomever they desire to care for their medical needs. So what we have today is a Medicare system that is not actuarially sound and, if not reformed, will lead to much higher payroll taxes and huge demands on the general budget. That is why I was pleased to see some reform proposals on Medicare emerge from the conference committee, such as health saving accounts.

When I served in the Colorado State Senate, I sponsored, with State Representative Phil Pankey, a bill to put in place an individual medical saving account; and Colorado became the first State to have such a program.

Unfortunately, in an effort to pass the bill, we allowed the program to become so limited that the risk pool became too small to function as insurance against future liabilities. Consequently, when Colorado moved to a modified flat tax, this program became a victim of tax reform.

This Congress puts forth a health savings account that will work. Individuals can put in \$5,000 a year or a family can put up to \$10,000 per year and save on their taxes. The income builds up within the health savings fund without tax liability and, finally, can be pulled out to pay for the family medical needs without paying additional taxes.

This is wonderful reform because it reestablishes the doctor-patient relationship and makes individuals responsible for their own health care with much fewer regulations, and it brings common sense to the decisionmaking process. It builds upon previously enacted medical savings accounts that have been limited to small business and the self-employed by Congress.

One other attractive feature in this bill is that the elderly are not forced to participate. It is voluntary. It also tries to prevent large businesses and local governments from dumping their current prescription programs into the Federal system to save themselves future liabilities and further burden the Federal prescription drug program.

The other side has repeatedly made the claim that this bill is full of giveaways to Republican contributors. This is simply not true. That is simply more absurd "medi-scare" tactics by the opponents of a bipartisan drug benefit for our Nation's seniors and the disabled.

The argument I find most amusing is the claim that this bill will lead to increased drug company profits. The reason this bill is so desperately needed is because our Nation's seniors and the disabled, particularly those with low incomes, are unable to afford their prescriptions today. Let me stress that again. The reason this bill is so desperately needed is that our Nation's seniors and the disabled, particularly those with lower income, are unable—to afford their prescriptions today. Today they are forced to choose between food and rent and taking their medicine. We have all heard the stories of seniors cutting their pills in half to get by and in so doing taking a lower dose than their doctor prescribed.

When this Medicare prescription drug benefit goes into effect, they will be able to get their prescriptions filled. Of course, this is going to lead to increased drug sales. Surely, this is no surprise to anyone. With new technologies and new medications, invasive procedures become less likely. Any prescription drug bill that works is going to lead to increased drug sales. That is just common sense.

Where are the medicines supposed to come from except the manufacturers of those medicines? Every single medical prescription drug bill introduced by these naysayers would also increase drug sales and the bipartisan conference report has the same basic drug benefit structure that passed the Senate by a vote of 76 to 21.

The Congressional Budget Office has concluded that the competitive approach in this bipartisan drug benefit

will do better at controlling drug costs than other proposals. To suggest that no one should support a Medicare drug benefit because it will lead to increased drug sales turns logic on its head. If this were our basic principle, then we should not have food stamps because this will lead to increased profits by grocery stores and farmers. How about housing subsidies? This might lead to profits by construction companies and utility companies and increased sales of lumber, bricks, and nails. This is just an absurd issue, and it is easy to see why.

I am here to tell you that this bill will strengthen and improve the Medicare Program. The spending on this bipartisan prescription drug bill goes to better benefits for America's seniors and the disabled.

As I draw to a conclusion, unfortunately, those who want universal health care and the big Government solution to drugs, making people more vulnerable to Government control, are vehemently opposed to this conference report.

The conference report lays out a plan for Medicare reform and a way to help the most needy. It is a balance that does not come easily and not without a lot of discussion on both sides of the aisle. We should at least have a vote on the bill. It is time to put partisan obstruction aside and think about what is good for America.

I ask my colleagues to join me in voting yes on cloture to stop the filibuster and to help hold down costs to within the budget limits.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. TAL-
ENT). The Senator from Oregon.

Mr. WYDEN. Mr. President, as Congress considers Medicare and prescription drugs, I keep remembering the older people whose stories spurred me to choose a career in public service. For 7 years, before I came to the Congress, I worked with seniors and spent many hours visiting with them in their homes. During those visits, seniors would often bring out shoeboxes full of health insurance policies that were supposed to fill the gaps in their Medicare. It was common for a senior then to have seven or eight of these policies, and many of them were not worth the paper they were written on. Slick, fast-talking insurance hucksters kept coming around and scaring the older folks, and it was heartbreaking to see seniors ripped off this way.

After working all their lives, seniors would go without each month because they were paying for junk health insurance policies with the precious funds they needed to pay the heating bill or buy some groceries.

When I got elected to the Congress, I vowed to stop this fleecing of America's seniors. I helped to write the first and only tough law to stop the ripoffs of private health insurance sold to the elderly. This statute has worked to drain the swamp of fly-by-night Medigap policies that used to rob seniors blind.

The days of the shoebox full of health insurance policies are gone, but the skyrocketing drug costs and lack of access to medicine—two of the problems that plagued seniors even back then—are more of a problem today.

During those home visits I made with seniors, I saw firsthand the pain they felt when they couldn't afford life-saving medicine. Their anguish was physical, and it was emotional. They feared for their futures. They worried that the choices that financial constraints forced on them would not be the right ones.

We are very familiar with those stories today. Caseworkers in every office in the Senate hear them constantly. A senior is supposed to take four pills, but because they can't make ends meet, they take three or two. Eventually, that senior ends up in the hospital where the hospital portion of Medicare, known as Part A, covers drug treatment, but often it is too late.

I have tried to rewrite stories such as that since I came to the Congress. That is why I worked with Senator PRYOR's father so that States could bargain aggressively and get more for their Medicaid dollar when buying prescription drugs that would help the low-income elderly. I have tried to expand coverage for generic drugs. I have worked to supplement those efforts by creating new health care options for seniors, including in-home care and increased payments for providers in low-cost areas, funds that can be used to offer prescription drug benefits to some of the elderly. Because of my history, I am acutely aware that there is so much more to do. The reason the debate on this bill is so important is that Government has the obligation to do right by a generation that deserves our respect and care and not give those seniors the runaround.

My years working with the older people have governed the decision I have made on this bill. I have tried to keep the focus on determining whether this prescription drug benefit legislation would make a genuine positive difference for a significant number of older people or whether it falls short of that objective.

As part of the process, I have developed a set of criteria to evaluate this legislation. I would like to describe the questions I believed were key and the answers I have found.

The first question I asked was: Does this bill help a significant number of older people with low incomes or big prescription drug bills? In their editorial endorsing this legislation, the New York Times stated:

The bill is strongest when it comes to the most important target groups: Elderly people with low incomes or very high drug bills.

It is not my job to take the word of editorial writers simply because they are just one voice in a chorus that comes from both sides. So I have gone to some length to examine the figures and data from all perspectives. I looked at the data that has been available

from those strongly in favor of the legislation, such as the Federal Center for Medicare and Medicaid Services. I looked at the information from those strongly opposed to the bill, such as the nonprofit Center on Budget and Policy Priorities.

The critics say the legislation has significant gaps in coverage for seniors, especially those of modest income. Proponents of the bill claim that millions of seniors will have coverage they did not have before. There does seem to be truth on both counts. So I have tried to keep the focus on figures that were beyond any doubt. Using data from the 2000 Oregon census, my staff and I have determined that 78,829 older people in Oregon had prescription costs that exceeded \$5,000, and under this bill these seniors would have their prescription drug costs reduced by one-half.

Using 2001 data from the nonprofit Kaiser Family Foundation, my staff determined that Oregon has 106,765 seniors on Medicare with incomes at or below \$12,123 for an individual or \$16,362 for a couple.

Under this legislation, this low-income group would pay no premium for their drug coverage and would be responsible for a copay of no more than \$2 for generic drugs and no more than \$5 for brand name drugs. The least fortunate would pay only \$1 for generics and \$3 for brand name drugs.

Most seniors with low incomes and high drug costs are likely to be eligible for both Medicaid and Medicare. These older people are known as dual eligibles. This legislation assures that they receive at least some measure of prescription drug coverage through Medicare so they are not left at the mercy of perennial State budget crises and so they will not have to compete against other vulnerable groups in State budget battles.

Another factor I considered was the expectations for this legislation. What I hear from seniors at senior centers and at meal sites is that expectations are very high. I know some seniors will find that this bill does not offer benefits that match their expectations. Some seniors fear this bill is going to fence them in and require that they participate in a program they do not support. So at the very least, because this program is voluntary, it strikes me as a plus that no senior will be forced to accept the terms of this legislation.

So on this particular issue, with respect to who benefits, what we found that seniors in my State with very high drug bills would have their costs reduced by half. We found a great many low-income people who would receive very significant benefits with no premium and a very modest copay for their drugs.

The second question we asked was: How does this bill affect seniors who currently get their prescription drug coverage through corporate retiree benefit packages? Almost every day now we pick up a newspaper and read

about another employer dropping their retiree benefits or cutting them back significantly. There has been a dramatic reduction in corporate retiree health benefits, and it is taking place right now before the enactment or rejection of any legislation.

The percentage of large employers offering retiree health benefits over a relatively short period of time has dropped from 66 percent to 34 percent. Consistently, the employers who keep coverage have required the retirees to shell out for higher copayments and premiums. Employers say they have to make these cuts because of the rising costs of health care and the effects of a lousy economy. Now along comes the Congress with a bill that many believe will dramatically affect retiree plans in the future.

It seems to me that with legislation offering \$71 billion to employers to keep their coverage, these funds can only be a plus in developing a strategy for getting more employers to retain existing coverage. This is a subsidy the companies are not going to see absent this legislation.

So I ask the Senate: Will companies not be less likely, not more likely, to drop coverage if they get the funds offered tax free under this legislation?

I would also note that corporate retiree provisions in the conference report are better than the provisions in the original Senate bill which was approved by more than 75 members of this body.

Bernstein Research says employers spend about \$1,900 per year per senior on retiree drug benefits. Based on my calculations, this bill gives corporations a significant tax-free incentive to cover not only retiree drug benefits but other senior health care costs as well.

The next question I asked was: Does this bill significantly undermine traditional Medicare? Critics of the bill have focused on this issue, and I share their view that seniors believe in Medicare, want to modernize it, and do not want it undermined.

The critics seem to believe that any effort, however, to create more choices outside the basic Medicare fee-for-service program is a mistake. I disagree. I believe seniors need good quality choices beyond fee for service. I simply believe those choices must be accompanied by strong consumer protections and that it is essential to strike a balance, making sure that the new choices never, ever cut off access to traditional Medicare that seniors know so well and a program with which they feel so comfortable.

I have never been opposed to private sector involvement with Medicare. In many Oregon communities, upwards of 40 percent of the elderly get their Medicare through private plans. The law I wrote stopped the rip-offs of private health supplements to Medicare, standardized 10 private sector policies to help seniors fill the holes in Medicare, and consumer advocates across the country believe that law is working.

The key to making the private sector choices work is a combination of strong consumer protections and a level playing field between the private sector choices and health services offered by the Government. I have considerable ambivalence about how this legislation will affect that balance.

In the bipartisan prescription drug legislation I drafted with Senator SNOWE, we offered private sector options for seniors that contain strong consumer safeguards. Our bill was known as SPICE, the Senior Prescription Insurance Coverage Equity Act. It did not tilt the playing field toward the private sector the way the legislation before Congress does today with its health savings accounts and premium support. Unfortunately, the health savings accounts in this bill, which are tax breaks for purchasing health care, are structured to disproportionately benefit the healthy and the wealthy. Seven billion dollars of tax subsidies are directed to these accounts. This has gone from a demonstration project to a major expense, one that siphons away funds that could go to beef up the drug benefits.

Another drawback of the legislation is the premium support provisions, which are designed to test competition between traditional Medicare and private plans. These could drive seniors out of the fee-for-service programs they want. Premium support demonstrations could allow insurance companies to cherry-pick the healthy seniors, leaving the truly ill to go to poorly funded Government programs that are sicker than they are. Even though premium support doesn't start until 2010, I don't believe it has a responsible role to play in this legislation.

I don't believe this legislation is going to wipe out traditional Medicare. I do believe that Congress is going to have to be extraordinarily vigilant with respect to ensuring that traditional Medicare can coexist and prosper along with the new choices. Without careful management, it is certainly possible that health savings accounts and premium support could tilt the Medicare Program away from providing traditional fee for service for all the seniors who want it. If this legislation passes, it will be the job of the Congress to make sure that does not happen.

The next question I asked is especially important. Virtually every senior in America wants to know: What will this legislation do to keep their prescription drug bills down? In my mind, the key to effective containing of prescription costs is to make sure older people have bargaining power in the health care marketplace. Today, when a senior gets his or her prescriptions through a health plan with many members, that plan has significantly more bargaining power than that same senior would have by walking into a Walgreen's, a Safeway, or a Fred Meyer to buy medicine. Getting seniors more purchasing power by getting them into

large buying groups is an absolute prerequisite for a long-term strategy for keeping prescription costs down for older people.

That was the principle behind the Medicaid drug rebate law that I helped author with the first Senator Pryor. That is the principle that Senator SNOWE and I have proposed in our bipartisan legislation. We looked to a market-based proposal that was built around the Federal Employees Health Benefits Plan, a program that has been proven to contain costs because of the sheer size of the group of Federal employees for which it bargains.

I think it is very unfortunate that this legislation did not put in place a model like the Federal Employees Health Benefits Plan to contain costs. But I think it has to be noted that some baby steps in the right direction have been taken with respect to cost containment. The bill begins to leverage the potential bargaining power of 30 million seniors by giving older people the opportunity to join large managed care plans and big fee-for-service plans that can use their sheer numbers to negotiate discounts for older people on their medicine. The bill also removes some of the barriers to getting cheaper generics to market faster.

It also recognizes that there is great value in comparing the effectiveness of similar drugs so seniors, providers, and the Government can spend funds on the best medicines at the lowest cost. This is very much in keeping with the way my own State has approached cost containment.

I do wish this bill went further on cost containment. There should be a way to bargain for even bigger segments of the elderly, not just the fractions of the population who end up in HMOs or various private health plans.

I am concerned that while private plans have the power to bargain under this bill, the Medicare Program is barred from giving seniors the kind of bargaining power that Senator SNOWE and I wanted them to have in our model that looked to the Federal employee program for seniors.

I am also concerned that there is not ongoing monitoring to assure that drug prices are not increased unfairly before the bill takes effect, or in the first few months after it does.

So the legislation does not contain costs the way Senator SNOWE and I would have liked. It does take some modest steps in the right direction. It borrows from the principles of our legislation, but in the end I strongly believe that more and better cost containment measures with respect to prescriptions are going to be needed in the future.

Next, I asked: Does this legislation address Medicare's broader challenges, including the large number of retirees that will join in the near future? A demographic tsunami is about to occur in our country. As the baby boomers come of age, there are going to be extraordinary pressures on our health

care system. Health care advances mean that seniors will live longer, and many of those advances will come in pill form. What is exciting is that the more researchers learn about the way medicines affect individuals, the more personalized treatments, emphasizing pharmaceuticals, will become. Drugs that work one way for Bob will work differently for Mary. In the years ahead, I believe a new field known as "personalized medicine through pharmaceuticals" is going to help to increase the quality of patient care and cut down on wasteful spending.

As of now, however, baby boomers face the prospect of joining a Medicare Program that is already short of funds. That is why the \$400 billion authorized in this legislation is a lifeline for the baby boomers who are going to retire in just a few years. Those funds provide some measure of security for future retirees, and some tangible evidence that Congress is laying the groundwork to support the growing Medicare population which will need both prescription drugs and the broader program.

There are several modest benefits in this bill, in addition, that sounds exciting to me for Medicare's future. One would focus on an approach known as disease management. This is going to be attractive in the years ahead because it will allow many of our country's future seniors to have better, more cost-effective care for chronic conditions. Medicare has lacked this benefit.

In addition to these direct benefits for seniors, the legislation helps gear up Medicare for the baby boomers with significant increases to many deserving health care providers. Over 10 years, hospitals in my State will receive almost \$95 million. I am especially pleased that a number of medical providers, a number of our hospitals that now see a small number of patients and those that have a large share of patients who are too poor to pay for their care, would get help.

In addition, doctors across the country who are expecting decreases in Medicare reimbursements in 2004 and 2005 would find this reduction blocked in this legislation. In fact, the legislation increases Medicare provider payments in both of the years where otherwise there would be cutbacks. This is important because Government cost shifts have already cut reimbursement to doctors, many of whom have large numbers of low-income patients, to record lows.

I would also note that these benefits to providers will be especially useful in rural areas where we have the nationwide crisis with respect to declining access as a result of providers simply not being able to stay in business.

Finally, I ask one last question that looked beyond the issue of prescription drugs. I asked: Is there any way this legislation could provide a path to a health care system that works, not just for older people, but for all Americans?

There is a provision in this bill that offers health care hope, not just to seniors, but for all Americans. It is a provision that I helped to write with Senator HATCH, based on our Health Care that Works for All Americans Act. This legislation would ensure that, for the very first time, the American people would be involved in the process of comprehensive health care reform. There would be a blueprint for making health care more accessible and more affordable, not just to seniors, but for all Americans.

Senator HATCH and I have been able to convince those on the Medicare conference committee that the key is to make sure that the public understands what the real choices are with respect to health care, how the health care dollar is used today, and how it might be used in the future.

In 1993, then-President Clinton announced his intention to create a health care system that worked for all Americans. But by the time that 1,390-page bill was written with no input from the public, sent to the Congress, and torn apart on the airwaves by special interest groups, the people couldn't distinguish the truth from the special interest spin, and the effort died. Without public support, the opportunity for change was lost.

The bipartisan leadership of the Senate at that time has told Senator HATCH and I that, had our bill been in effect in 1993, our country would be well on its way to implementing a system that ensured coverage for all our citizens. So I think it is of additional benefit that this legislation gives us a chance to restart the debate that died in 1994. Our legislation creates a Citizens Health Care Working Group that would take steps, through on-line opportunities, townhall meetings and other forms, to involve the public; and then there is a requirement, after that public involvement, that the Congress follow up on the views that come from the citizens' participation.

There are tough calls to be made in today's health care system, including in the Medicare Program. But it is time to make them together. I think if one lesson has been learned in the last few months of discussion about prescription drugs, it is that health care is like an ecosystem. When you make changes in one area, such as prescription drugs, it can affect many other areas, such as corporate retiree benefits, provider payments, and various other parts of the health care system.

The legislation Senator HATCH and I have put together and which is included in this conference report treats health care as an entire and a system-wide concern for the American people. Nothing is taken off the table. I believe there is in that legislation a path to making sure this Congress helps not just older people but sets out ways to ensure that all Americans have access to good quality and affordable health care.

Finally, let me note that collegiality hasn't exactly been one of the watch-

words of the debate over this legislation. There have been some very cold considerations entering into this discussion. I know that some believe passage of this legislation will hand the President a great victory. Others on the other side of the aisle say Democrats who oppose this bill shouldn't dare raise questions. Those aren't the concerns that ought to drive the debate on Medicare at a time when the country has to get ready for a demographic phenomenon. Polarization and division do not do our country any good.

This legislation is a very tough call for me and I think for many others.

Congress could make a mistake by believing the \$400 billion available in this legislation will still be there in February of 2005. As a member of the Budget Committee, I know how hard it has been to get funding for this benefit. When Senator SNOWE and I began in 1999 to work for funding for a drug benefit, the Senate thought we lassoed the Moon when we successfully got \$40 billion in the budget. How then can you argue that Congress should walk away from \$400 billion?

I wish there were a better bill. I wish it didn't include medical savings accounts and premium support and had done better in the area of cost containment.

There are going to be various procedural considerations that may come out, and I intend to weigh each of them before I vote on those procedural concerns. If it finally becomes clear that the bill, as is, represents the Senate's sole opportunity to inject \$400 billion in long-sought prescription drug benefits in Medicare, I will vote yes.

At the end of the day, I will not vote to let the last train that leaves the Senate go out without \$400 billion that can be used to help vulnerable seniors and those who are getting crushed by prescription drug costs. I will continue to fight to make this legislation better and for better health care for all Americans.

I yield the floor.

THE PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, the opponents of this bipartisan Medicare bill have made the claim that 6 million seniors are hurt by this bill. The other side has also claimed that 25 percent of seniors will be forced to pay more for their prescription drugs under this bill.

I want to be very clear that this is not accurate at all. I'm here to tell the American public the truth.

The truth is that 14 million lower income seniors and disabled Americans are benefited greatly by this bipartisan bill. These 14 million people will get very generous prescription drug coverage through Medicare in this bill.

First, as you can see on this chart, 7.8 million seniors and disabled Americans get full coverage with no deductible, no gap in coverage, and would pay only \$2 for generic drugs and only \$5 for brand name drugs. And if these seniors reach the catastrophic coverage

limit, then they will get their prescriptions fully covered with no copays. That's right, no copays at all.

Next, as you can see on the chart, an additional 4.4 million lower income seniors will get even more generous coverage. These Seniors will pay only \$1 for generic drugs and only \$3 for brand name drugs. And if these seniors reach the catastrophic coverage limit, then they too will get their prescriptions fully covered with no copays.

In addition, some of these people are enrolled in both Medicare and Medicaid and are living in a nursing home—about 1.3 million of them. This bipartisan bill creates a special benefit for these people. For them, Medicare will cover 100 percent of the prescription costs. They pay nothing.

These groups of seniors in total represent 12.2 million seniors and disabled Americans.

The bill also provides coverage to about 2 million more lower income seniors and disabled Americans. These seniors have 85 percent of their drug costs covered after meeting a \$50 deductible, and if they hit the catastrophic coverage limit, they would pay only \$2 for generic drugs and \$5 for brand-name drugs.

This is full coverage with no coverage gap and 85-98 percent of drug costs covered for about 14 million seniors and disabled Americans. That is about 36 percent of all Medicare beneficiaries.

That is what this bill does. It provides very generous prescription drug coverage through the Medicare program for about 14 million lower income seniors and disabled Americans. And it provides this full coverage to 8 million lower income seniors who have no coverage at all today.

On top of that, of course, this bill provides all beneficiaries with access to basic prescription drug coverage with protections against catastrophic drug costs. The average beneficiary who does not qualify for the low income benefits I have just described will still have about half of their drug costs covered under this bill.

Finally, no one is forced into this drug benefit. It is a purely voluntary benefit. No one is forced to enroll and any senior or disabled American that does not see the drug coverage offered as a good deal for them does not have to enroll.

So this bipartisan bill before us does not harm seniors. That is an absurd charge to make by the opponents of this bill.

This bill provides an affordable, voluntary and universal drug benefit for all seniors and disabled Americans in this country. And it provides very generous coverage to those 14 million lower income beneficiaries.

It is time to put the partisan rhetoric aside and approve this bipartisan bill that the AARP calls "an historic breakthrough and [an] important milestone in the nation's commitment to strengthen and expand health security for its citizens."

I yield the remainder of this half hour to Senator DOMENICI.

The PRESIDING OFFICER (Mr. ENSIGN). The Senator from New Mexico is recognized. He has 23 minute 20 seconds remaining.

Mr. DOMENICI. Mr. President, today I rise in support of the Medicare Prescription Drug and Modernization Act. I thank the Senate and the House conferees, as well as the leadership of both bodies, for their work over the past few months. Their perseverance has paid off. This bill represents a major step forward for this body on behalf of the seniors of this country.

Experts and fair-minded people have known for many years that the Medicare Program must be reformed. For more than 6 years, Republicans have led efforts to overhaul the Medicare system and ensure American seniors continue to have access to high-quality, comprehensive health care in the future. First, a little history. The Budget Act of 1997, when I was chairman of the Budget Committee, created the National Bipartisan Commission on the Future of Medicare. This Commission was created to address the issue of modernization. The Commission supported changes to the program that would have provided an additional prescription drug benefit as well as modernized the Medicare system—not one without the other, but both.

Unfortunately, that Commission failed in part because of lack of support from the previous administration's appointees to address the fundamental problem of the program's design. A majority of the Commission was for it, but we structured it where 60 percent was required, and the President withheld his support after all the work that was done. The point is, clearly even back then we were tying modernization to prescriptions.

In 2001, again as chairman of the Budget Committee, the budget resolution provided \$300 billion, and we are now up to \$400 billion. The budget resolution said \$300 billion for prescription drug benefits and it required modernization of the program. It said \$300 billion way back then. DON NICKLES, as chairman, took it up to \$400 billion. It did not say for prescription drugs, it said for prescription drugs and modernization. Why? Because one without the other is never going to work. If you have a prescription drug benefit for the seniors and do nothing to the underlying Medicare Program, you have taken care of one of the problems for a couple of years but you will be back with a bigger problem. That bigger problem is the Medicare system itself. With the great change in demographics this country is going to be experiencing, we will be in big trouble.

Medicare beneficiaries have waited too long for prescription drug coverage. I am pleased this year appears to be a breakthrough year. Before we are finished, there will be many Senators we will be able to thank. This will be the year we finally help millions of Medi-

care beneficiaries obtain affordable prescription drugs. The bill will also provide substantial relief for those with the highest drug costs. It will also provide prescription drug coverage at little or no cost to those with low incomes.

When this bill passes, we will be providing seniors with prescription drug coverage for the first time since the program's creation in 1965. Across America, there are still millions of people who do not know that Medicare provides by law not one nickel's worth of prescription benefits. It is not that the benefit is inadequate or that it is written wrong, it just did not provide for a benefit; that need was not contemplated in 1965.

It has been hard to get a bill that really has a chance. This bill has a chance. It contains new accounting safeguards that put the program on a stronger financial foundation. The legislation contains preventive care measures, including screening for diabetes and cardiovascular disease. It provides benefits for coordinated care for people with chronic illnesses. None of these benefits was provided under the 1965 act because the need was not contemplated as part of the health delivery system. These benefits are needed today, but they are excluded from the current Medicare system.

This is by far the best opportunity, speaking on behalf of my constituents in my home State, that New Mexico has had to get doctors, hospitals, home health care providers, nursing homes, and Medicare beneficiaries fair and equal treatment. Before this bill, each of these groups had been shortchanged by the health care laws of our country.

I am particularly pleased this bill contains \$25 billion in initiatives aimed at providing health care in rural areas. We can thank Senator GRASSLEY for being so steadfast on that provision. The Finance Committee estimates my home State of New Mexico can expect approximately \$140 million over the next 10 years in increased doctor and hospital reimbursements. That is because we are so low. This brings us to parity and fairness.

This bill includes \$50 million to equalize payments between large urban hospitals and rural and small hospitals, \$15 million to increase payments to disproportionate share hospitals, \$1 million in payments to critical access hospitals, \$50 million in increased payments for doctors, and \$3 million in incentive payments to encourage physicians to practice in areas where there are shortages.

Beginning in 2006, again for my State, all 250,000 Medicare beneficiaries living in New Mexico will be eligible to get prescription drug coverage through a Medicare-approved plan. This bipartisan agreement will give 55,000 Medicare beneficiaries in New Mexico access to drug coverage they would not otherwise have. Nearly 17,000 of those beneficiaries will qualify for reduced premiums, lower deductibles, coinsurance,

and no gap coverage. Unquestionably, these provisions will help improve access to health care and treatment for seniors.

We have a great opportunity, fellow Senators, to fulfill our promise to the American people and provide our seniors with high-quality prescription drug benefits. I believe prescription costs will be manageable, even with the baby boom generation that will then be retiring. Some worry about the costs of this bill, but I am confident about the future of American ingenuity and competition, America's science achievements, and America's wellness achievements.

As I said this spring when we were debating this bill, we are not living in a stagnant world. American scientists today are reaching for health care breakthroughs linked to the mapping of the human genome. Advances in nanoscience and microtechnology will change medicine and health care as we know it today. However, while that work continues, this long-awaited prescription drug plan is what we need now. I am suggesting when I talk about the future breakthroughs that we may be astonished at how much we are going to be able to do that we cannot do today that may save lives and save money.

I encourage my colleagues to put their differences aside today and, most of all, to put their politics aside, and do what is best for the American people. Overwhelmingly, my constituents have contacted me and asked that I support this legislation.

Seniors need affordable prescription drugs, and if Congress fails to act this year, it will likely be many more years before beneficiaries are able to access prescription drugs through Medicare.

It is for those reasons—all of them; the national reasons and the parochial New Mexico reasons—that I have indicated that lead me to saying I will support this bill. And I hope we do it quickly.

Now, we have an additional Senator. Mr. President, how much time do we have left in this block of time?

The PRESIDING OFFICER. Thirteen minutes fifty seconds.

Mr. DOMENICI. Mr. President, I understand we have a Senator who is coming over to use that time. Until they do, I will yield that time to Senator GRASSLEY.

Mr. REID. Mr. President, if I could just be heard briefly.

Mr. DOMENICI. Sure.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. We had a Senator who took an extra 5 minutes today because of various reasons, so it is my understanding that the distinguished Senator from Kentucky wants an extra 5 minutes. We would be happy to agree to that. So we would just add that on to what time he has.

Mr. DOMENICI. I say to the Senator, Senator GRASSLEY is in charge. I will just wait to see what he says.

Mr. REID. Is the Senator on his way down?

Mr. GRASSLEY. I say to the distinguished Democratic whip, it is my understanding the Senator is on his way to the Chamber from Senator FRIST's office right now.

Mr. REID. We would agree to give him that extra 5 minutes.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. MCCONNELL. Mr. President, finally, after 38 years, Medicare will finally give our most frail citizens help in acquiring the miracle of modern medicine: prescription drugs. They save lives, but they are not cheap.

After decades of talking, while our seniors waited, tomorrow we vote yes or no on a Medicare prescription drug benefit. It is now or never for our seniors. And for their drug benefit, this is the bill and this is the time.

On one side stand 40 million seniors, the American Medical Association, the AARP, and hundreds of other citizen groups. On the other side stand some Senate Democrats itching to kill this bill. Do not be fooled by those who think we can do something better at some point later. We are already 38 years late, and this is as close as we will ever come.

So for our seniors to get a Medicare drug benefit, it is now or never. Incredibly, there are those in this Senate who say never. They plan to filibuster the Medicare drug benefit or use procedural measures designed to do the same thing as a filibuster—kill the bill.

Let me repeat that. Some of our Democratic colleagues are trying to kill this bill. For 38 years there has been no prescription drug benefit, none. Now, when it comes time to actually pass a drug benefit, some of our Democratic colleagues are filibustering. That is truly astonishing.

Now, we will hear a lot more debate about whether there is too much or too little Medicare prescription drugs. And we will hear a lot of talk that there is too much or too little reform to preserve Medicare.

Mr. President, I believe we do more for Medicare prescription drugs than most could have ever expected. We do more to preserve Medicare for the future than most presently expect.

Before I discuss the reforms to preserve Medicare, I would like to focus on the new Medicare prescription drug benefit. The facts are that we provide \$400 billion for a Medicare prescription drug benefit over a decade, about a third more than our Senate colleagues proposed just 2 years ago—a third more than was proposed just 2 years ago—and one and a half times more than President Clinton proposed for a Medicare drug benefit.

This unprecedented investment in our seniors' health translates into an incredible amount of relief for our seniors.

Back home, in my State of Kentucky, for example, there are about 650,000 seniors who will share in that relief. So what does this relief mean to them? The first comfort is that all 650,000 Kentucky seniors—whether rich, poor, or in between—will never again face the fear of being wiped out—completely wiped out—by catastrophic drug costs.

Under this plan, Medicare will cover a minimum of 95 percent of all catastrophic prescription drug costs.

Next, all Kentucky seniors currently paying full retail drug prices will be able to cut their prescription drug costs by an estimated 50 percent or more once they enroll in this new plan.

For those 235,000 Kentucky seniors with low incomes—low-income seniors—they will never again have to choose between food on the table or medicine in the cabinet—never again. They will get 95 percent to 99 percent of their prescription drug costs fully covered. None of those 235,000 Kentuckians will pay more than \$2 for generic drugs or \$5 for brand-name drugs, and most will pay even less than that.

Another 56,000 Kentuckians, with moderate incomes, will get assistance with their premiums, deductibles, and coinsurance.

While the full drug plan will not start until 2006, all Kentuckians can benefit from an immediate helping hand thanks to the Medicare prescription drug discount card available as soon as April of next year. This prescription drug benefit card will be available by April of next year. Through group purchasing power and negotiated prices, this card can save seniors between 10 and 25 percent of their drug costs, starting, as I indicated, just next April—right around the corner.

Finally, also starting next April, about 123,000 low-income Kentucky seniors will be credited up to \$600 on that same prescription drug card to help tide them over until the full plan takes effect.

So this is real relief, and it is just around the corner. But we did not just give Kentucky seniors that real relief, we also gave them real choices.

Today, Medicare offers no prescription drug benefit and few choices in health care. All that is offered is the traditional hospital and doctor benefit, with a limited managed care option called Medicare+Choice.

Tomorrow, Medicare also could provide seniors a prescription drug benefit and almost unlimited choices in health care. If we act now, every senior on Medicare will soon have the choice of two prescription drug benefit plans, along with a Federal backup.

But if not now, then when will seniors get that benefit? Or, if we act now, every Medicare senior can choose from a variety of Medicare+Choice plans,

with a full drug benefit added. But if we do not offer that to them now, when will we offer it to them?

Another choice is every Medicare senior can choose from three or even more preferred provider organizations. But if we do not offer this choice now, when will we? Or, if we act now, every Medicare senior can get help to maintain their current employer-based drug plan. But if we do not offer that now, when are we going to offer it? When would be a better day than now? Or every Medicare senior can do nothing at all and keep exactly what they have today. Every senior, I repeat, can stay in exactly the same coverage they are in today, if they choose to.

That is a lot of freedom and a lot of choices—much like those which Federal employees and Members of Congress enjoy today. But if we do not offer these choices now, when are we going to offer them?

This bill provides an excellent prescription drug benefit, a great array of choices to get that drug benefit, and a host of new benefits, such as preventive care, disease management, and comprehensive chronic care.

But after all we did for prescription drugs, what did we do to secure Medicare's future, you might ask? The reforms may not have gone as far as some would have liked, but the good news—the paramount good news—is for our Medicare system, a little reform can go a long way.

So how far can it go?

When a scam artist can make \$7 million by selling gauze pads that cost a penny but sell them to Medicare for as much as \$7, a little reform can go a long way.

When a shakedown artist can bilk Medicare for as much as \$300,000 by allegedly providing health care services to a deceased patient—I repeat, a deceased patient—a little reform can stop a real abuse. When two rented mailboxes and a beeper is all one fugitive needed to scam Medicare out of \$2.1 million, a little reform can go a long way. When Medicare imposes 110,000 pages of regulations, a tower of paperwork 6 feet tall that requires a regiment of clerks to handle, a little reform can mean real savings. When estimates suggest that as much as \$33 billion a year is wasted in Medicare and Medicaid—\$33 billion a year in waste in Medicare and Medicaid—a little reform can do a lot of good.

When computational errors at Medicare cost \$4.5 billion a year, when \$2.2 billion is paid out annually to phony businesses, when \$23 billion is annually overpaid to doctors, hospitals, and other health care providers, and when study after study shows not just poor business practices but rampant and outright fraud, waste, and abuse throughout Medicare, costing tens of billions of dollars a year, year after year, decade after decade, then a little reform can do enormous good.

The reform in this bill is real. We infuse real competition, market forces,

and private sector dynamics to provide the best health care at the best price for our seniors. A wide array of health care providers, insurers, plans, and organizations will compete to offer the best health care at the best price, and seniors will be free to choose the best plan for themselves.

With all of these choices, with all of this competition, ordinary people providing health care across this land are soon going to do a very extraordinary thing. They are going to figure out how to provide seniors all the quality health care they want without all the waste, fraud, and abuse in Medicare that no one wants.

And who will benefit? Of course, our seniors will benefit. And so, too, will our children. When our seniors get a quad cane such as this one for \$15, like the Veterans Administration pays—the VA pays \$15 for this quad cane, but Medicare pays \$44 for the very same cane—stopping this kind of abuse is going to save our parents and our children. When our seniors get a catheter for a dollar, as most Federal Employee Health Plans pay, instead of the \$12 Medicare typically pays, our parents and children both win.

These potential savings are not conjecture. This is not guesswork. We know that under imperfect—if not hostile—rules and regulations, the health care providers in the Medicare+Choice Program were able to give our seniors all the services of traditional Medicare and wring out enough savings to provide seniors an average drug benefit of about \$857 a year. With this bill, the power to convert Medicare waste into Medicare benefits, which we only saw a flash of in the Medicare+Choice plans, will now be fully unleashed.

There was always a riddle to the Medicare drug benefit. That riddle was: Could we help our parents without harming our children? Could we add a prescription drug benefit to Medicare today yet still preserve Medicare benefits tomorrow? The answer to the riddle was always reform. In this bill, we have done enough reform to rein in the waste I have touched upon earlier.

To my colleagues on this side, I would agree there could be more reform in Medicare than we have in this bill. But there can be no reform of Medicare without this bill. We could have more reform than we have in this bill, but we will have no reform without this bill. The reforms are more than a first step. They reflect a bold, new direction. That new direction for Medicare flows from the market-based incentives in this bill that I believe will do more good to reform Medicare than our colleagues can possibly imagine.

Our colleagues need to recall that every time we have placed our faith in the ability of free market forces to provide for our people, our Nation has been richly rewarded. When we infused our energy markets with market com-

petition, the gas shortages and economic stagnation of the 1970s were replaced by energy stability and two decades of solid economic growth. When we reformed Welfare-to-Work, we relied on the private sector to provide the best welfare program man had ever devised—a job. And the welfare reform of 1996 has worked better than we could ever have imagined.

Today we tap those same forces that saved our economic security and improved the well-being of the neediest to save Medicare for our children and improve Medicare for our parents.

I believe this new drug benefit will meet the needs of our seniors. I believe the reforms will meet the needs of our children. Now is the time to act. Now is not the time to filibuster. Our seniors deserve better than that from us. Thirty-eight years of waiting is long enough. We must not filibuster and kill the bill providing a prescription drug benefit for 40 million seniors.

Doctors, hospitals, and seniors have all said this Medicare prescription drug plan is the right plan at the right time. They all strongly support this. We should support it, too. Our seniors, the greatest generation, have been there for us. Now we need to be there for them.

I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. Mr. President, here it is, about 675 pages of a bill. I have spent the better part of this past week trying to comprehend all of the nuances in this legislation, and of course a lot of that was difficult since the conference committee was still negotiating up through Thursday night, and some of the final things that are in the legislation we didn't find out until late in the game.

But having spent a considerable bit of time, I believe I have a fairly comprehensive knowledge of it. I want to give my comments and conclusions as to why this legislation is not in the best interest of this country and is it not in the best interest of our seniors. Therefore, I am going to give my reasons why I am going to vote against this legislation.

At the end of the day, what we need in America is a health care delivery system that is organized in a logical manner. The way we organize health insurance, as it has grown up historically around employers, if the employer is large enough, then the group of people who are insured for their medical expenses, you can spread the health risk over that large group. That brings down the per-unit price or the costs, the premiums that people pay.

But all employers are not large. Indeed, in my experience for 6 years as Florida's elected insurance commissioner, what I found was that not only was it very difficult for individuals to get health insurance and pay the prohibitive costs of the premiums but

there was a gaming of the system that went on by some insurance companies. By having group coverage, a group was established, a rate was set for that group. Usually the rate was a very low rate or premium in order to entice people into that group to be insured for their health care. And then, as the group got older and it got sicker, they would not expand the group, so the size of the group began to contract. Yet people in the group are getting older and sicker, and you can guess what happens to the cost of that health care; and as those costs rise, so do the premiums and those people in that group had no other choice. They could not go out and get into another group, unless they happened to join an employer who had a large one.

That is the way the system in America is organized. That is not a logical system. What we ought to do is be creating the largest groups possible, the largest pools, so that you can take the health risk and spread it over that large number of people—young and old, sick and well, geographically disbursed—so that the cost of that health care is spread over the larger number and, therefore, the cost per person, the premiums, are much lower.

One of the reasons I oppose this legislation is that it is the beginning of the violation of that principle of insurance, for what this legislation is doing is beginning to fragment the seniors as a group and beginning to create groups where well senior citizens will be encouraged to join, leaving the sicker senior citizens for the traditional fee-for-service Medicare and for the prescription drugs that go along with that Medicare.

For example, what we have in this bill is that prescription drugs will be provided in an area. I think the country is divided into 10 areas. I heard it said earlier that it may be as many as 50. But whatever it is, the whole country is divided. In that particular area, there has to be a prescription drug plan for Medicare, as the basic underpinning of fee-for-service, and also the opportunity for managed care, either a PPO or an HMO.

Now, here is what is going to happen. First of all, the PPOs and the HMOs, under this bill, are heavily subsidized by the U.S. Government. There is \$12 billion in this bill that is a subsidy to PPOs, money to be released at the discretion of the Secretary of HHS. This money would be to help the PPOs, managed care, to become more competitive. And guess what. It is going to help them go out and recruit senior citizens to come into the PPOs.

So, too, there is a subsidy here for HMOs. Medicare fee-for-service is reimbursed at 100 percent. In this bill, a kicker is given to HMOs of 109 percent; they are going to be reimbursed for those medical expenses.

So, by this legislation, we are setting a policy that says we are going to encourage seniors to go into those managed care plans—managed care plans that, in fact, will then take away a lot of the choice for seniors to select their own doctor.

What is that going to leave then? As they recruit the more well senior citizens, then Medicare, with its own prescription drug plan, is going to have all others. And guess what is going to happen to that \$35 premium that has been promised. It hasn't been promised that it is going to stay the same. To the contrary, that \$35 premium per month is going to start escalating. It is going to be hiked. Therefore, what is going to happen to the poor and the sick among our senior citizens? It is not going to be as it has been represented here.

So I see this as a giveaway to HMOs and PPOs. I see it as pushing seniors into managed care, where they will lose their choice of doctors. That is my first objection.

Of course, there is a lot in this bill that is salutary. I voted for the bill when it came through the Senate because I believed that it was a first step in what I thought was a very important policy goal—that we modernize Medicare with a prescription drug benefit.

But what has been added has made it too onerous for me to support. Let me tell you about the second reason I am not going to vote for this legislation.

It is widely acknowledged by several very respected studies that the private sector employers who are covering the prescription drugs for their retirees, from their private employment, are going to drop that drug coverage that is now coming from the private sector. It is estimated by several, including CBO, the Congressional Budget Office—an arm of the Congress of the United States—that some 2.7 million seniors in this country are going to be dropped, which means they will only have the choice of getting prescription drugs under the deficient plan that comes under this bill. So they are going to be getting less.

You talk about being mad. You talk about being upset. When they have a very robust plan and they could go to the pharmacy and have their former employer, under that retiree plan, pay for their drugs and suddenly they get dropped because now there is an inadequate prescription drug plan, well, in my State of Florida alone, it is going to be 166,000 people who are going to be dropped. There is going to be, indeed, some increase under the bill of those who are not covered now up to 150 percent of the poverty level of senior citizens, and I salute that.

You would think that in a State such as mine, which only covers poor seniors with Medicaid, a Federal and State health care program, you would think, since our State of Florida only covers up to 88 percent of poverty level, that would be a big benefit—to go from 88 to 150 percent of poverty level. Yet, in fact, there is some help there, but it is

not much because this 675 pages includes a new assets test that is going to drop a lot of those people who are not covered by Medicaid in Florida, who would be covered under the bill—they are not going to be eligible because there is now a new assets test and there is a part in this 675-page bill that will not allow them to receive all of the brands of drugs that they want because there is a limitation in here on the class of drugs, and how it is defined.

Let me tell you, Mr. President, there are going to be some upset seniors who think they are in the range of 150 percent of the poverty level and below, and they are going to get covered and then they are going to suddenly realize they are not. That is going to happen a lot in my State of Florida. This is another reason I am not going to vote for the bill.

A third reason is that there is no competition for the prescription drug plan. I happen to think if we want to have a comprehensive, overall health insurance plan in this country, it ought to be as wide as possible with the biggest possible pools, and there ought to be private sector competition so we get the efficiencies and economies through competition.

That is not what happens in this bill. What happens in this bill is if you don't have two prescription drug plans attached to Medicare in that particular region of the country, there is no competition between the two. You can't say there is just going to be competition with the PDP and the PPO or the HMO. No, they are going to siphon off the more well seniors so if you don't have two prescription drug plans competing in price and there is only one, what do you think is going to happen to the cost? What do you think is going to happen to the monthly premium that was set initially at \$35 a month? It is going to go one way. It is going to go up because the cost of those drugs is going to go up.

This bill is not pro-competition. This bill is pro private plans.

Another reason 35 bucks is going to go up is the fact that right now under the Medicare system, Medicare Part B, seniors pay the same premium throughout the country, but we know in some parts of the country health care costs are higher than in other parts. The costs in South Florida are higher than the costs in Iowa. But now the country is going to be divided up, in how many regions? I thought it was 10. I heard earlier in the debate it is 50. However many regions, it is going to be divided up, it is going to more reflect the cost in that region.

You might say that is a good thing unless you come from a State such as mine which has a higher percentage of the population of seniors than any other State because, why? When they retire they want to come to the land of sunshine and enjoy the benefits of our environment.

So because there is no competition and because the universality of the

Medicare premium that has been in effect since 1965 is going to be abolished for prescription drugs, what is going to happen? The prescription drug premium is going to get hiked all the way to the Moon.

A fourth reason for opposing this legislation is that \$400 billion is a lot of money, indeed, and if we were getting a true comprehensive drug benefit for \$400 billion, it would well be worth it because Medicare needs to be modernized. If we were doing Medicare again in 1965, would we include a prescription drug benefit? Of course we would, because of all the wonders of these miracle drugs.

So \$400 billion is a lot of money, but it is not being efficiently spent in this bill. Why? Aside from all of these provisions I talked about—about splitting up all of the groups and making them inefficient and siphoning off well seniors and leaving the sick seniors for the remainder—we cannot do anything in this bill about the prices of drugs.

In this bill, there are two little paragraphs that do not allow Medicare to negotiate the price. I always thought the free market was about economies of scale, of being able to get better prices. That is the whole theory of Wal-Mart. In bulk purchasing, they bring down the price. This is an anti-Wal-Mart policy bill because it does not allow bulk buying, as has been stated many times before, which has been done with other agencies of Government, particularly the Veterans Administration.

Mr. President, I supported the bipartisan bill we crafted in the Senate earlier this year. Unfortunately, this agreement does not adequately protect seniors' retire coverage, moves too many seniors into private plans, and fails to do anything about the escalating costs of prescription drugs.

When Medicare was passed 40 years ago, we promised our seniors they would have access to medical care as they grew older. As a matter of fact, since the passage of Medicare, seniors' life expectancy has increased about 25 percent.

The agreement that we will be voting on has little to do with providing a prescription drug benefit to seniors and a lot more about enticing private insurance companies to take over for the Government.

The financial incentives to private companies and creative trappings inserted in the bill will do nothing less than limit seniors' choices—mostly because of cost. Seniors may be forced into HMOs or PPOs because it may be the only affordable way to at least have access to a prescription drug benefit. Affordable, because the bill provides a \$12 billion subsidy for PPOs and a reimbursement rate of 9 percent above Medicare for HMOs.

Since 1999, in Florida alone over 260,000 seniors and people with disabilities were abandoned by their private Medicare HMOs. As Florida's former insurance commissioner, I recall having to beg these plans to stay in our

State and continue providing care to our seniors.

This conference agreement, with its various incentives—from a \$12 billion slush fund, to its risk buyout, is nothing more than a give-away to insurance companies.

Private health plans are in the business of making money, and have routinely blamed low profit margins as their reason to drop seniors. In comparison to Medicare, they have failed to be as effective in controlling their own costs.

HMOs have managed to lure the healthiest of our seniors in order to maximize their reimbursement from the government. Currently, they receive about 16 percent more per beneficiary than is paid out through the traditional Medicare program. If these savings aren't enough to feed their profit margins, then the increased payments included in the bill will.

The agreement proposes payments to HMOs of 109 percent of the fee-for-service rate. This cumulative effect results in our government paying private plans 25 percent more than what it would cost Medicare to provide that same care. How can that be considered competition?

I am also concerned that the agreement before us could create premium variations across the country, and even within my own State of Florida.

While we all keep hearing about this \$35 monthly premium, there is nothing written in the law that limits the premium to that amount. That number is simply an average which between now and 2006 could certainly increase just as the rest of the costs of health care are.

In addition, I am envisioning a scenario where seniors who do not have access to a fallback because there is one HMO or PPO plan and one prescription drug plan are left without any real choice. Then, if the drug plan, PDP, has no competition, it can raise the annual premium at will.

Since there are no limits and the premium from a private drug plan could be hiked to the moon, they could essentially create a situation where a senior has no other choice—based on costs—but to join an HMO or PPO and give up their choice of doctors.

Again, we see an example of this bill's failure to allow true competition to take place.

Under the fallback plan included in the Senate bill there would be at least two of the same kinds of plans competing in each region. This would have created an incentive for the drug plans to keep their premiums competitive.

During a careful examination of this agreement, I also became aware that the private drug plans are allowed the greatest flexibility possible. Little consideration is given to the particular needs of the beneficiary.

For example, each Medicare drug plan could have its own list of covered drugs, or formulary. The only requirement is that the private drug plan cov-

ers at least one drug in each "therapeutic class." The definition of a therapeutic class; however, is left up to the plan itself. A plan might choose to exclude certain high-cost drugs for financial reasons, leaving seniors who depend on those drugs without coverage for them.

I am also very disappointed that this agreement prohibits Medicare from negotiating better prices from drug manufacturers.

In 2001, the cost of prescription drugs rose more than 15 percent—the seventh straight year of double-digit increases.

When we consider the fact that drug prices have been increasing by double digits in recent years, it does not make any sense to let these prices go unchecked.

In light of our limited resources, wouldn't our seniors have been better served if we had addressed the issue of drug costs? We even have a proven model for success in the Veterans Administration, which has used its bulk purchasing power to negotiate with the drug companies for dramatically reduced prices. Medicare could do the same, saving our seniors and the taxpayers billions of dollars.

Our Nation's seniors, when unable to afford their own drugs, turned to Canada for relief. This bill continues the stalemate between supporters of importation and the FDA by including the poison pill provision requiring a certification from the Secretary of Health and Human Services before medications can be legally imported.

At a Commerce Committee hearing last week on this exact issue, supporters of importation argued that in the absence of trying to control the increasing prices of drugs, importation should be at least an option to provide short-term price relief.

In making my decision to oppose this legislation, I considered who would be better off versus who would be worse off.

One-third of Medicare beneficiaries have no drug coverage at all, another one-third of them have access to prescription drugs through their retiree health care plans.

The legislation before us will cause private employers to drop 25 percent of their retirees. In the State of Florida, that could mean over 166,000 retired seniors would lose the coverage they worked all of their lives to earn.

Another group that fares worse under this agreement are those seniors who are over 65 and also eligible for Medicaid. We fought long and hard to have these dual-eligible seniors covered under Medicare. However, provisions in the agreement raise the asset tests and restrict the Medicaid program from paying the senior's copayment, and that leaves seniors worse off.

Medicaid beneficiaries in Florida have access to all classes of drugs and all drugs within those classes. Should patients have trouble getting their medications, their physicians are allowed to appeal directly to Medicaid.

The limited formularies allowed under the agreement for Medicare could jeopardize a senior's access to the drugs they need.

Despite our best efforts in trying to minimize cuts to cancer care in this legislation, the agreement will result in an \$11.5 billion cut. The ripple effect of these cuts and the reaction of private sector insurers will threaten community cancer centers' ability to continue treating patients.

I reiterate my support for the providers of care to America's seniors. To our doctors, our hospitals, and nursing homes—I support the provisions in this bill that will allow them to continue to serve our seniors.

For Florida's hospitals alone, this bill means almost \$740 million in improved Medicare reimbursement over the next 10 years, and I am pleased about that. But these reimbursements to health care providers should not be held hostage in a 675-page bill that has many defects.

In the final analysis, this agreement fails to fulfill my promise to provide comprehensive prescription drug benefit to seniors. We can do better. Regardless of whether this bill passes or fails, I intend to keep working to provide that comprehensive benefit. Our seniors deserve nothing less.

I want to yield the rest of my time to one of my colleagues who needs some time. I wanted to state at least these reasons and try to give the comprehensive overview of the health insurance marketplace, where we need to go eventually to straighten out the mess so that all people can be insured and not just the ones who have it and the 42 million people in this country who don't have it. Indeed, this bill is not the first step toward that kind of health care reform.

I yield to the Senator from North Carolina the remaining time that I have, which should be about 13 minutes.

The PRESIDING OFFICER. It is about 10 minutes. The Senator from North Carolina is recognized.

Mr. EDWARDS. Mr. President, may I inquire how much time the Senator from Florida has remaining?

The PRESIDING OFFICER. About 10 minutes.

Mr. EDWARDS. Mr. President, I thank the Senator from Florida very much for yielding time and allowing me to speak tonight.

Medicare was created 40 years ago with the idea of giving seniors health care to allow them to live out their lives in dignity and self-respect. It was a promise that they could choose their own doctor and afford their health care.

We clearly need a real prescription drug benefit under Medicare, there is no question about that. The problem is that this bill does a great deal more harm than good. It is very good for the drug companies, it is very good for the HMOs, but it is very bad for seniors and very bad for America as a result.

Here are some of the reasons: First, it has billions of dollars in giveaways to HMOs and insurance companies, money that could be and should be used to provide a better benefit to seniors who desperately need prescription drugs.

Second, it does almost nothing to control the skyrocketing costs of prescription drugs which seniors all over America face every single day when they go to the pharmacy.

Third, it contains billions of dollars in tax breaks for millionaires, for the wealthy, which is part of a long pattern by this President of trying to shift the tax burden. The President is in the middle, as I speak, of shifting the tax burden in America from wealth to work. He wants to get rid of the dividends tax, capital gains tax, taxation of the largest estates, and shift that tax burden right on the backs of middle-class working Americans who are already struggling, already having a difficult time saving, putting money aside, having any level of financial security. And here we go again, the President of the United States is in the process of putting an additional burden on the very people who are struggling and who are so critical to getting this economy moving again.

This is just another in a long series of efforts by this President and this administration to shift the tax burden. There is no question the lobbyists all over Washington are popping the champagne corks as we speak. The drug company stocks are going up. The HMO stocks are going up. Do not the drug companies and HMOs make enough already? For all the seniors who go to the pharmacy to try to buy medicine and cannot afford it, is the really nice thing for us to do right now to help the HMOs and drug companies? Are they not doing all right?

The truth is we ought to forget the drug companies, forget about the HMOs. They are doing a terrific job of taking care of themselves. We in the Senate ought to be focused on trying to help seniors who are struggling.

Let me say a word about the giveaways to the HMOs. This bill contains something that is called a stabilization fund of \$12 billion, which is nothing but a giveaway to HMOs. The idea is we have been hearing all along that it is important to have competition and the HMOs can be more cost-effective than Medicare. I am missing something. If they can be more cost effective than Medicare, why in creation are we giving them \$12 billion of taxpayer money? At least where I come from, you do not have to give somebody \$12 billion to be more cost effective. That is taxpayer money that could be used to help seniors who desperately need prescription drugs. But, oh, no, we are going to give them \$12 billion, money that could go to the seniors, money that could give them a decent benefit. Instead, we are going to give it to HMOs. I guess they are struggling so much, they need our help.

Then on top of that, we see that the justification for this is that they need money so they can "compete"? What in the world is that all about?

On top of what is being done for the HMOs, we have the drug companies. This bill does almost nothing to control costs. We have been fighting in the Senate to bring down the cost of prescription drugs for months and years now. The battle is always uphill because the drug companies have more lobbyists in this town than people who live in my hometown where I grew up. They are all over the place.

So we are trying to bring down the cost of prescription drugs. The Wall Street Journal itself calls this a big win for the drug companies. Their stock is going up.

Why have we not been able to do the things that need to be done to bring the cost of this program under control and, more importantly, to bring the cost of prescription drugs under control? I will tell my colleagues why. Because the drug companies are against it. It is just that simple. It is the answer to everything we try to do on the Senate floor to bring down the cost of prescription drugs.

We try to do something about misleading drug company advertising on television. No, no, we cannot do it. The drug companies are against it.

We try to allow the reimportation of prescription drugs from Canada to bring down costs for everybody, but we cannot get it passed. Why? The drug companies are against it.

We try to do all of this, to allow the market power of the Government to be used to negotiate a better price to bring down the cost of prescription drugs. We cannot get it done. Why? The drug companies are against it.

We are never going to get health care costs under control in this country until we stand up to these people, stand up to the drug companies, stand up to the HMOs.

I know in Washington, DC, they are powerful, but out across America, the American people have a great deal more power in this democracy than these lobbyists in Washington. We need to stand up to drug companies and HMOs and stand up for the American people.

In the middle of not controlling costs, billions of dollars of taxpayer money going to HMOs and drug companies, we have another effort to shift the tax burden in this country. It is not as if working, middle-class families are not struggling enough. It is not as if over the last 20 years we have not gone from them saving money, having financial security, to today not being able to save, having negative savings as a matter of fact, with one medical emergency or one layoff keeping them from going under.

Here is a good idea: Why do we not take another step to shift the tax burden away from the wealthy and to the middle class and working people? That is exactly what is happening with these

medical savings accounts. The only people who are going to be able to afford to take advantage of it are the wealthy. Regular folks cannot save anyway. They are not going to be able to put money away in one of these accounts.

The bottom line is, this is a bad bill. It is not a first step; it is a misstep. It takes this country in exactly the wrong direction. We need to stand up and say so. The American people need to hear our voices loudly and clearly. They also need to know what it is we actually need to do to provide a prescription drug benefit because they deserve one.

I will tell my colleagues what we need to do—put controls on the cost of prescription drugs by allowing reimportation from Canada, by doing something about misleading advertising on television, by cracking down on some of the price gouging that is going on. We ought to provide this prescription drug benefit under Medicare. We can give people choices and still stand by the very program that has provided seniors with health care for 40 years now, that so many seniors have depended on for four decades now.

At the end of the day, the American people, seniors, want us to do something about prescription drugs. We ought to do it. We ought to give them a real benefit. We ought to bring down the costs. We ought to make it cost efficient in terms of taxpayer dollars. In order to do it, we are going to actually have to have the backbone to stand up to these drug companies and these HMOs and their armies of lobbyists all over Washington.

I, for one—and I believe some of my colleagues will join me in this—intend to stand up to these people, and I intend to stand up for the American people and fight with everything I have for a real prescription drug benefit under Medicare that does not give billions of dollars to HMOs and drug companies.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Senator BAUCUS is the next scheduled speaker. I will ask for a quorum call, but I also ask unanimous consent that the time be taken off his time. It is not fair to wait because we have 4½ hours' worth of speakers.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. 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. Over the last couple of days there have been many assertions from my colleagues on the other side of the isle that this bill does nothing to lower the cost of prescription drugs.

I would like to take this opportunity to set the record straight.

The conference report contains a number of significant reforms to lower the cost of prescription drugs for not just Medicare beneficiaries, but for all Americans.

This bill provides immediate relief to 40 million Medicare beneficiaries by providing a discount drug card starting in April 2004.

The voluntary drug card program will save beneficiaries an average of 10 to 25 percent on the cost of their prescription drugs. Beneficiaries will have the choice of at least two Medicare-endorsed drug discount cards.

The drug discount program included in the Medicare Prescription Drug and Modernization Act also provides low-income beneficiaries with an additional subsidy of \$600 to help with the costs of their prescription drugs.

This program provides immediate relief to Medicare beneficiaries now paying extremely high prices for their prescription drugs.

This bill also lowers the price of prescription drugs for Medicare beneficiaries, by eliminating the Average Wholesale Price, AWP, paid for prescription drugs.

This provision significantly reduces the prices that Medicare and many private insurers pay for physicians-administered drugs.

Under this agreement, Medicare reimbursements will now be based on actual prices paid by physicians, rather than fictitious numbers reported by manufacturers, providing a ripple effect lowering the cost of prescription drugs for not just Medicare beneficiaries but individuals in the private market.

The conference report also contains a "non-interference" provision that will protect patients and deliver lower prices through market competition.

The conference bill specifies that the Government "may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors" and "may not require a particular formulary or institute a price structure." It is right here on page 53.

Opponents claim that this provision, which originated with Democratic proposals, is a concession to the pharmaceutical industry. That is plain wrong.

The noninterference provision is at the heart of the bill's structure for delivering prescription drug coverage through market competition that gets a good deal for consumers, rather than through price fixing by the CMS bureaucracy. As CMS Administrator Tom Scully explained in the November 21, 2003 issue of the Washington Post, if Medicare negotiated prices, "I wouldn't be negotiating; I'd just be fixing the price. Let's get seniors organized into big purchasing pools that get bulk discounts and see how they fare."

Ironically, this provision was created by the Democrats and first appeared in May 2000 in a bill sponsored by Senator DASCHLE and 33 Democratic cosponsors.

In June 2000, Mr. STARK included the same language in his motion to recommit H.R. 4680. That motion received the support of 203 Democrats and Mr. SANDERS.

The provision protects patients by keeping the Government out of decisions about which medicines they will be able to receive. Under this section, CMS will not be able to dictate that drugs must be excluded from a PDP formulary or subjected to reimbursement limits that effectively deny access.

The bill relies on market competition, not price fixing by CMS, to deliver the drug benefit. The bill's entire approach is to get seniors the best deal through vigorous market competition, not price controls.

CBO scores the bill's approach of relying on at-risk private sector plans to deliver the prescription drug benefit as getting a higher cost management factor for Medicare than bills where private sector competition is handicapped by Government. The noninterference provision protects this approach, by preventing politicians and bureaucrats from getting into the middle of the very negotiations that drive these savings.

Private plans have strong incentives under the bill to negotiate the best possible deals on drug prices, because they are at risk for a large part of the cost of the benefit. They also will have the market clout to obtain large discounts. By driving hard bargains, they will be able to offer lower premiums and attract more enrollees.

The alternative is a command-and-control system that would not be responsive to consumer desires or marketplace realities. Bureaucrats would swing between adding benefit requirements without a means of paying for them and restricting choices and access in an effort to contain costs. This bill wisely rejects that approach. The noninterference provision is the fundamental protection against it.

Finally, the conference report lowers the cost of drugs for all Americans by reforming the Hatch-Waxman drug pricing laws.

The agreement will speed the process of allowing generic drugs to come to market, which will significantly reduce drug prices.

The agreement will provide brand drug companies only one 30-month stay on the approval or a generic competitor.

Generics would be forced to forego their 180-day generic exclusivity if they do not bring a product to market within a specified time period.

These reforms are the most aggressive since Hatch-Waxman laws took effect in 1984.

These reforms have also earned the strong endorsement of the Generic Pharmaceutical Association and dozens of allied groups who are advocates of increased generic usage and low drug prices.

So to my colleagues who say there is nothing in this bill to lower drug

prices, they are not talking about this bill.

My friend and colleague on the Finance Committee, Senator BAUCUS, has come to the floor. He is primarily responsible for the legislation that is before us because he has been very willing to work in a bipartisan way to get things done. We would not be here today if it was not for the hard work of Senator BAUCUS, the ranking Democrat on the Finance Committee, and a person with whom I can work very well.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, first I deeply thank my good friend from Iowa, Senator GRASSLEY. I know people in his home State greatly respect him. I read somewhere that he has the highest approval rating of any politician in the State of Iowa. I am sure that is true and I can understand why. It is because he is straight, down to Earth, and honest. He tells it like he sees it, no guile. I want Senators to know that this is my impression, as well. I say this because when he explains the provisions of this bill, I hope people listen. Senator GRASSLEY is not one to gild the lily, not one to indulge in inflammatory rhetoric, not one to exaggerate. He is someone who tells it like it is. This is a very important personal quality of his, and one that I revere deeply.

I thank the Senator for allowing me to work with him as the chairman of the Senate Finance Committee.

I would like to take a few minutes to discuss the Medicare conference report before us. I am sure a lot of people across the country have heard statements by many Senators and House Members and are wondering who is telling the truth. They hear a set of allegations from one side and lots of responses from the other side. It must be incredibly difficult to determine the truth.

A few days ago, Senator BREAU and I met with 20 or 25 House Democrats. The group is known as the New Democrats. Senator BREAU and I explained to them what was in the bill.

Over and over again, the New Democrats asked: What is going on here? Our leadership tells us one thing and you are telling us something else. Whom are we to believe?

Senator BREAU and I explained the bill to the best of our ability. We tried to be honest and straight with the facts. It is my belief that the facts are usually controlling. Once people understand the facts of a bill or legislation, they can make up their own minds. It was our intention to just give the facts so these House Members could make up their own minds.

I suspect that a lot of them were in a difficult place: stuck between their leadership, which was pressuring them to do one thing, and the facts which were inclining them in the other direction.

I further suspect that many people watching across the country tonight

are wondering the same thing. There are compelling speeches on both sides of this debate. Who is telling the truth? After all, that is what it is all about.

I am going to do the best I can to explain why I am supporting this Medicare legislation, why I personally think it is a good bill. I am going to use the facts, as opposed to rhetoric. I am not a great rhetorical speaker. As with the Senator from Iowa, I tend not to embellish. Maybe it is because we are from agricultural states. We have learned to accept that we cannot control everything—we cannot control the weather for the crops and the livestock; we cannot control the market price. We accept reality for what it is and tell it like it is because that is the way we have grown up. I will do my very best to give a fair take on facts of this bill.

Why do I support this bill? For many years, Congress has been trying to pass legislation that gives prescription drug benefits to seniors. For many years we have been talking about it. Some years we have come pretty close. Last year, for example, we were very close. I can remember a meeting I had convened in my office with the key Senators: OLYMPIA SNOWE, TED KENNEDY, CHUCK GRASSLEY, Senator GRAHAM, and four or five or six other Senators from both sides of the aisle—liberals and conservatives. We came very close.

But in the end, partisan politics dominated—I think because some wanted an issue, not a solution. We were pulled apart, and in the last moments, we were unable to pass a prescription drug bill.

Here we are again today. We are even closer this year because we have actual legislation that has passed both bodies of the Congress, and a conference report before us. It is not possible to get any closer. If we do not pass legislation this time, I do not know if we ever will. And this would be a tragedy. This bill provides \$400 billion over 10 years to create a prescription drug benefits for seniors. This is what the debate comes down to.

We know the importance of this bill because drug prices are increasing rapidly, while at the same time, drugs are becoming ever-more important. They oftentimes replace expensive hospital procedures. And new medications are constantly being developed. New, so-called miracle drugs are being developed today that will help treat many different illnesses in the future.

Many of our seniors with low incomes and fixed incomes simply cannot afford the drugs they depend on. It is critical that we pass this legislation. Every other country in the industrialized world provides prescription drug benefits for their seniors. We are the United States of America. Why in the world do we not provide prescription drug benefits for our seniors?

We should.

And we now have the opportunity before us. I do not know when we are going to get this opportunity again. If

we do not act now, the chances of passing prescription drug benefits for seniors in the next several years is very slim. Next year we will be faced with higher budget pressures: The national debt is increasing; our deficits are rising due primarily to uncertainties overseas—Iraq and Iran; due to terrorism; and due to greater domestic needs. If we do not pass prescription drug benefits now, we are unlikely to have another opportunity again. If we do not act today, the \$400 billion will not be there next year.

I also support this legislation because of its very generous low-income subsidies for one-third of all senior citizens. These senior citizens, one-third of all senior citizens, will have 90 percent of their drug costs paid for. Under this legislation, 90 percent of their drug costs are going to be paid for by the federal government.

This is a very important measure in this bill. It provides very strong low-income protections. I do not know if we are going to have these protections again in future Medicare legislation, if we even have future Medicare bills. When are we going to again have such generous assistance for our low-income seniors?

An additional reason I support this legislation is that it contains a strong government fall-back plan. This is a technical term which means that when there are not two private drug plans available in any region, a senior is able to access a guaranteed government fall-back plan for their drug benefits.

The only question is: Are there two private plans in any given region of the country? If there are, your prescription drug benefits are covered through the private plan with all of the guarantees that are written in the legislation to ensure that seniors are not taken advantage of. If there are not two private plans in the area, then the Government fall-back plan goes into effect.

The bottom line is that all seniors in America will get a prescription drug benefit. All seniors in America are covered by this bill, whether it is in a private drug plan or through the government fall-back plan. This is what we mean by a strong Government fall-back—all seniors will get the prescription drug benefit.

It is true that the House bill did not include a strong government fallback. But we are talking about the Conference report. And in this legislation, all seniors will have access to the drug benefit.

The fourth reason I support this legislation is rural payment equalization, as well as other strong provider provisions.

During the many years I have been in this body, I have worked hard to make sure that Montana and other rural States get the same payments for hospitals and doctors as urban States, as the big States.

We have been fighting for this for years. Finally this legislation addresses this inequity. If this bill does not

pass, I do not know when we are going to be able to address this issue. Nothing is guaranteed in the future. Times change. Congresses change. It is difficult to predict the future. A bird in the hand is worth two in the bush. We have a bird in the hand now.

We have strong rural provisions in this legislation. If it does not pass now, the chances of rural areas getting a square deal and a level playing field are going to be in serious jeopardy.

I say to those Senators from rural states, how can you vote against a bill and deny increased payments to your home states when you are probably not going to get them again, when you have been fighting so hard to get them for so many years?

I would now like to turn to another issue that has been discussed frequently and which is of great concern to many Senators, and well it should be.

As indicated on this chart, employer-sponsored retiree coverage is declining.

Eighty percent of companies offered retiree health care coverage in 1991. In 1996, it fell to 71 percent. In 1999, it fell to 66 percent. In 2001, it fell to 62 percent, and 2003, 61 percent. There is a steady decline of companies dropping or reducing their retiree coverage.

You might ask, Why is that happening? It is happening because of competitive pressures. Companies want to cut back on costs wherever they can to maximize their profits. Retiree health benefits is one area where they are cutting down their costs. They are reducing coverage for their retirees. It is inevitable and it is happening.

Why do I mention this? What does this bill do to address this phenomenon? This is an extremely important point, and I hope Senators and staff are listening. This bill discourages employer retiree dropage; discourages, not encourages, it. It provides tax-free subsidies for companies to discourage them from dropping their retiree benefits.

This bill provides \$88 billion—\$88 billion—to companies for their retiree plans. Eighty-eight billion dollars is going to companies to discourage them from dropping their retiree plans.

The Congressional Budget Office said under the Senate bill that there would be about a 37-percent dropage rate; in the House bill, about 32 percent.

But in this Conference report, we have provided additional funding. The rate is now down to about 22 percent. But that 22 percent would be higher if this additional money was not provided.

The actual number in the conference report is 17 percent. This number reflects a more accurate calculation. 22 percent is apples to apples to the 37 and 32 percent in the Senate and House bills. The 17 percent is a more accurate figure.

The net effect is the dropage rate is about 50 percent less as a consequence of the provisions in the conference report. Companies are getting \$88 billion to maintain their retiree coverage.

I ask my colleagues, if you vote against this bill, what are you going to say to those employees who lose their retiree coverage when you had the opportunity to vote for a bill that would have provided funding to address this problem? What are you going to say to those retirees when you tell them you voted against a bill which would have discouraged retiree dropage? What are you going to say to them? I don't know; it wasn't perfect.

This bill has the effect of discouraging—not encouraging—retiree dropage. I hope Senators pay very close attention to this point. This issue concerns many Senators.

I would like to address another issue—the impact of this bill on dual eligibles.

We have heard criticism that the effect of this bill is to make drugs more expensive than current law for dual eligible senior citizens.

This is completely inaccurate. The assumption behind this argument is that this bill has a \$1 and \$3 copay for drugs for dual eligibles. For seniors who are under 100 percent of poverty, this bill has a \$1 copay for generic drugs, and a \$3 copay for brand-name prescription drugs.

The assumption behind the argument that the 6 or 7 million dual eligibles will be worse off is that these seniors do not currently have copays under Medicaid. That is not true. Most States, at least 38 States, already have Medicaid copays. The 6 or 7 million worse off is simply a false figure.

In fact, most States are under tremendous pressure to reduce the costs of their Medicaid programs. One of the ways they decrease costs is through increasing copays.

For those Senators who have been claiming that 6 or 7 million will be worse off, please look at the Medicaid copays in many States and anticipate what will be the situation in the year 2006. It will be worse; 38 States have copays. Not all are greater than \$1 in \$3 now, but if States continue to cut back on Medicaid to balance their budgets, then the copays will rise.

Today, Illinois already has \$1 and \$3 copay. The bill does not hurt low-income seniors in Illinois. In Maryland, there is a \$2 co-pay for brand-name prescription drugs. In Massachusetts, it is for all drugs. The same is true for Nevada. I see my good friend Senator REID is here. He knows more about Nevada than I hope to know. North Dakota is \$3 for a prescription. South Dakota, about the same. And these are just some examples.

If you look at the facts, the 7 million figure is closer to about 1 million.

Another inaccurate criticism is premium support. There has been a lot of talk that premium support will undermine Medicare as we know it. I would never vote for a bill that I thought would undermine fee-for-service Medicare. I would not do that because I know how important it is to seniors, certainly in my State of Montana.

In the year 2010 there will be six demonstration projects. That is far better than the House bill which wanted a full-blown nationwide premium support. We have heard a lot of horror stories about premium support, but that is based upon the House bill, which had full-blown, nationwide premium support. This is not a fair criticism. People are talking about another bill, not the Conference report before the Senate.

What is before the Senate is a bill which says in the year 2010 there will be up to six MSAs, metropolitan statistical areas, that could test this concept of premium support. I might add, as I have said before, that Medicare fee for service is held harmless. People in these areas who want to stay in fee for service can. There is no requirement they get out of fee for service.

Remember, the President earlier proposed legislation that would have required people to join private plans to get a drug benefit. That was then. This is now. This bill does not say that. This bill says, if you want to stay in fee for service, that is fine. You do not have to join a private plans.

Some Senators also worry that Part B premiums might rise because the private plans will take the healthiest seniors, forcing up the fee-for-service Part B premium.

This argument is not true.

All low-income people are held harmless in Medicare fee for service. Their Part B premium cannot go up. They are held totally harmless. As I mentioned earlier, a third of America is classified as low income in this bill.

What about those who are not low income? This bill limits any premium increase to 5 percent. This is significant.

Part B premiums for next year, 2004, are going up about 13 percent for all senior citizens. Why is that? Because this Congress, using its best judgment, has decided to increase dollars to doctors. Seniors pay for 25 percent of this increase through higher Part B premiums.

In this bill, the premiums cannot go up by more than 5 percent in the premium support areas.

Another point: A maximum of 1 million beneficiaries may be affected. I mention this number because there are a lot of other figures being discussed, including that 10 million senior citizens will be affected by premium support. Ten million is not an accurate figure. It is not true. We went to an objective source to find out what is true and accurate. We went to the CBO. CBO told us that between 670,000 and 1 million people could be affected by this bill in the six areas. Even so, these people can stay in standard fee for service. They are not required to go into private plans. There is no incentive, unless a premium support plan does offer a much better package, much more in benefits, much lower in costs. That is possible. I don't think it is likely, but it is possible.

The main point is that very few people could be affected by premium sup-

port. It is not the 10 million figure we have heard. Take the figure of 10 million, cross out the zero, and you get the real figure of 1 million or fewer.

Next, this legislation limits the number of sites to six. There can be no more than six MSAs in the Nation. The Secretary has no discretion to add more.

In addition, this legislation says these demonstrations are limited to 6 years. That is in statute. That is not regulation. The Secretary cannot change that at his discretion.

It takes an act of Congress to extend or expand these six. After 6 years, the issue will be before Congress to decide what to do: Do we want to extend the premium support areas? Do we want to eliminate them? Do we want to change them? This cannot, by regulation or the Secretary's decision or by the President's decision, be changed; it takes an act of Congress to change.

I might add, as well, that there are payments in this legislation that go to preferred provider organizations to see if they can work.

But preferred provider organizations have to be regionwide. They have to serve the whole region. They cannot pick and choose individual MSAs. As we know of today, HMOs pick and choose. They go to the counties they like and avoid the counties they do not like. They cherry-pick the healthiest people. They do not go to the counties they don't like, those with the less healthy people. This is not the American way.

This legislation provides for additional funding for the regionwide PPOs which go into existence in the year 2006. There is a \$12 billion fund which helps get these plans up and started. But again—

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

Mr. BAUCUS. Mr. President, may I ask for a few more minutes?

Mr. REID. Mr. President, we have 4½ hours of speeches still tonight, and that is why we have limited it to half an hour each.

Mr. BAUCUS. If I could just have 1 minute?

Mr. REID. Sure.

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

The Senator from Montana.

Mr. BAUCUS. Mr. President, I will just sum up by saying, I have spent a lot of time on this legislation. I am not going to do anything to hurt senior citizens. It would be foolhardy, foolish, stupid. And this bill does not hurt senior citizens, it helps them.

There have been a lot of charges against this bill. It is very easy to be negative. It is very easy to find fault with anything.

This bill is not perfect, but it is very good.

I urge all of us to remember, this is a very good bill. It gives great assistance to our seniors. We have subsequent years to work on it, build upon it, and to make changes. But if we do

not pass it now, the chances are very slim we will be able to pass prescription drug benefits for seniors again.

So I strongly urge my colleagues to support this bill and oppose procedural motions which will impede passage of this bill.

The PRESIDING OFFICER. The assistant Democratic leader.

Mr. REID. Mr. President, first of all, I want to underscore the comments about the Senator from Iowa, Mr. GRASSLEY, which were made by the senior Senator from Montana.

Senator GRASSLEY is a dedicated Senator, a gentleman, and I have great respect for him. So I appreciate the Senator from Montana saying those nice things about the senior Senator from Iowa, Mr. GRASSLEY.

But I also want to say that on our side we have two people who have been so heavily involved in getting a bill here. One is the ranking member of the Finance Committee, Senator BAUCUS, who, as he said, is my friend. I have the deepest respect for him, and I know how hard he has worked on this legislation. He has kept me apprised of his progress and slippage on occasion.

Senator BREAU and I, of course, came to the Senate together. There is a bond of friendship between us that will last forever.

So even though I do not agree with my two friends, Senators BAUCUS and BREAU, on this legislation, no one can take away how hard they have worked on it and how they believe they are doing the right thing.

Mr. President, the Presiding Officer knows that my father was a hard rock miner. As I look back, the best times we spent together were when I was a little boy.

My dad worked in a number of mines, but the mine that I remember is a mine called The Elvira. My dad worked underground alone, which was, of course, against the law. No one ever prevented him from doing that. The mining inspectors rarely came to Searchlight.

It was during the summertime, when I was out of school, the first summer I can remember going down with him, keeping him company.

As I look back on my father, those were times we had together underground. I had my own little hat, with a carbide lamp. I was not much help to him, but I kept him company.

My dad was a very quiet man, but he would talk to me. We had wonderful times. I would have my own lunch. My mom would pack my lunch.

But my dad taught me a lot of things. As I indicated, the finest memories of my dad are from those days we spent together underground.

As I got older and stronger there were things I did later, as I became a teenager, that I could do to help him physically other than just keep him company. But those days were not like the days I spent alone underground with my dad.

He taught me a lot of things. But one of the things he taught me how to do

was to pan for gold. Of course, we never had much. He never found much for what he did. There was not much gold there.

But I knew how to pan for gold. You would take the rock and grind it up real fine into a little metal bowl. Then you would put it in like a frying pan, a pan that was made just for that, and shake it with water coming down. And gold, of course, is very heavy, and the gold would be at the bottom. You could see if there was any gold there.

The other way, of course, you could find if there was gold is you could send it to an assayer and find out. But the first preliminary thing you did was pan for gold.

Mr. President, one of the things I learned as a boy in Searchlight is there was a lot of something called iron pyrites. It is fool's gold.

I have this little rock in my hand. It is the same kind of rock I have pictured on the right side of this chart. If you were up close, you could see this glittery, gold stuff on the rock. It is all over the rock, and it looks like gold. It glistens like gold. The only way that you can find out if it is real gold is if you either pan it or assay it.

What I have shown on the left side of this chart is gold. And what is shown on the right side of the chart looks like gold, but it is fool's gold.

I say to my friends within the sound of my voice, even though this product looks like gold, I think if you examine it, if you assay it, you will find it is not gold. It is like the iron pyrites in the mines of Searchlight. It is something we call fool's gold.

This legislation started as a Medicare prescription drug benefit for seniors. Now, this large bill we have here, of approximately 700 pages—approximately 700 pages—about 150 pages of it deal with prescription drugs for Medicare. The rest of it is something that I never thought was to be part of the legislation; it is to reform Medicare.

Now, my friend, JOHN BREAU, has spent a lot of his legislative life talking about the need to reform Medicare. And I have not talked in detail with Senator BREAU, but I am confident he was much more involved in and concerned about reforming Medicare than the prescription drug aspect. That is not necessarily bad, but that is what he was focused on.

Senator BREAU believes that Medicare needs reform. During the Clinton years, he was the chairman of a committee to come up with some Medicare reform. And he came up with it. He was the chairman of that committee. More than 50 percent of the people who served on that panel believed that his program was good that they had come up with. But under the rules of engagement, it took a supermajority to do that, and he could not get that.

So Senator BREAU, as I have already said about my friend—Senator BAUCUS and Senator BREAU, fine people, wonderful Senators, but I think this legislation, which started out as a prescrip-

tion drug benefit for seniors, has gone way beyond that and is now a bill mostly dealing with Medicare reform.

This legislation is OK at first glance, but if you look at it closely, I believe, as I have indicated on this chart, it is really not the gold, shown on the left, but it is the fool's gold, the iron pyrites, shown on the right.

This summer, we passed a bipartisan prescription drug bill, which was not perfect. As it returned from the House, though, the prescription drug bill that passed the Senate has taken a step backward. It is not imperfect; it is bad.

I think there are millions of people worse off. It gnaws away at the foundations of Medicare.

Seniors have trusted this program for 40 years. My position has been that we should make health care available to every American, we should cut costs, we should improve quality, and we should expand access. Upon review of this legislation, we don't have that. We have what I believe is an image, an image that looks like gold, but it isn't, it is fool's gold.

All you have to do is look at the facts. In Nevada, 20,000 low-income seniors will have to pay more when this legislation goes into effect. This bill contains an unfair and confusing assets test. Why would we charge someone negatively because they have planned ahead and have a burial plot, maybe a car, maybe some furniture? This bill contains an unfair and confusing assets test. More affluent seniors are going to be punished. That is not right.

I have been through this once before as a Member of Congress. On catastrophic, I introduced legislation in the Senate that the chairman of the Finance Committee, Lloyd Bentsen, personally criticized me for introducing. That legislation was to repeal catastrophic. I did it because the seniors of America were up in arms. I was a relatively new Senator, and I won't say my colleagues shunned me, but they weren't happy for a while. But that legislation passed. It repealed catastrophic.

Catastrophic was directed toward people who had taken care of themselves, had provided for the future. They were being punished for having done a good job, taking care of the future. They rebelled. And that is what we are going to find here.

Clearly, they will pay more in Medicare premiums. The costs of Medicare will go up for them. They already pay more than their share of payroll and income taxes. They already pay the greater share of Medicare costs.

I have received some letters from people in Nevada, constituents of the Presiding Officer and me. Let's note what some of them say.

Mrs. Betty Sweet of Las Vegas: Don't sell the seniors out to big business HMOs. The HMO plan will be a step down in our care.

Martha Pruter of Reno: This plan is only going to benefit the pharmaceutical companies. It will not benefit consumers.

Mary Ann Brim of Henderson: I oppose the Medicare bill. Has anyone done the math? I can't believe they would support this bill if they had. Certainly you can come up with something better than this.

Now, these people, Mrs. Brim in particular, actually did their homework on the math. The actual drug benefit created by this bill is confusing and offers seniors only a meager drug benefit. Someone who spends approximately \$5,000 a year on drugs will be stuck with almost 80 percent of the bill.

People have come to me and said: Vote for this. Nothing is going to kick in for a couple of years. You are protected. You can talk about the benefits of this bill. Maybe they are right. But in a couple years I would look back on this vote saying, I didn't do the right thing because thousands of retirees in Nevada will lose their coverage as a result of this bill.

In Nevada, tens of thousands of seniors stand to lose their current retiree drug benefits. The Nevada senior prescription program that Governor Guinn of Nevada tried, it was one program, and nobody even signed up for it. He has one now that is good, people like it, and we don't know what is going to happen. We don't know what is going to happen to this program.

We heard the distinguished ranking member of the Finance Committee, Senator BAUCUS, talk about demonstration projects, six of them. We could get as many as three of them in Nevada. I don't think we should be used as guinea pigs in an ideological experiment that would force them to give up their doctor and join an HMO or pay higher premiums to remain in traditional Medicare. Those who opt for private plans would have to use a doctor approved by the insurance company in these areas. Over time the seniors who remained in the traditional fee-for-service Medicare would likely be the oldest, the sickest, and the poorest. They would have to pay an ever-increasing premium to maintain their coverage.

This bill would make a wide range of seniors worse off than they are today, from seniors who are eligible for Medicaid, seniors who have coverage through former employers, seniors enrolled in State pharmacy programs, to seniors who will be forced to pay higher premiums to stay in traditional Medicare. That is not the type of prescription drug coverage our seniors deserve. It is fool's gold.

Many of my colleagues support this bill because they like the concept of competition. I like competition, too. But I am in favor of competition where there is a level playing field. This bill does not provide for fair competition.

This rigs the rules in favor of private insurance companies by paying them off to serve a patient whom Medicare would also take care of without the additional incentive that these companies get. It siphons off \$12 billion that should be used to help our seniors. It

pushes it off into a fund for private insurance companies. That is why we have read in all of the papers around the country that the insurance industry is wild about this legislation. The pharmaceutical companies are wild about this legislation. They wiped out the reimportation we had in our bill, something that went to the House, where we could reimport drugs which are much cheaper in Canada. That is eliminated, and that is too bad. It was a concept that both the House and the Senate approved. This is something that is hard to comprehend.

This bill even says that when Medicare becomes the largest purchaser of prescription drugs, it is expressly forbidden to negotiate prices with the drug companies. That is why we want these large purchasers of pharmaceuticals, so they can go to the drug companies and get lower prices. In this legislation, they are forbidden from doing this. If we really believe in a free market, why shouldn't Medicare also be able to bargain for good prices? It is no wonder big insurance companies and big drug companies are spending millions of dollars on lobbyists and ads to support this bill.

I have to say they have done a good job. I want everyone to know that the drug companies and the insurance companies have spent their money well. Because the lobbyists have really done well by them, this bill is a dream for the insurance industry and the big drug companies. It tilts the playing field in their favor at the expense of senior citizens. That is not competition, it is corporate welfare.

This bill is not what it claims to be, and seniors are smart enough to see this bill for what it really is, fool's gold. Betty Sweet, Martha Pruter, Mary Ann Brim, they all did their homework and understand that this legislation is not good.

As I have indicated, the actual drug benefit created by this bill is confusing and offers seniors only a meager drug benefit. It is a poor trade when you spend approximately \$5,000 a year on drugs and you will be stuck with 80 percent of the bill. When we talk about a pharmaceutical benefit for Medicare, people think they are going to get the drugs at a reasonable price.

The Medicare conference agreement would make fundamental changes to Medicare as we know it, changes that have nothing to do with a prescription drug benefit or building a stronger foundation for the program. It would use our senior citizens as guinea pigs to test the theories of Newt Gingrich and other ideologues.

Am I off base on this? I carry this with me because I have used it on a number of occasions, and now it is kind of withered and dilapidated. I have seen Newt Gingrich, with whom I served in the Congress—a fine person. I like him. I think he has a great mind. And he has been able, with his great mind, to do some things with which I don't agree. But I have here some statements made

by leaders. I believe their whole concept is what is behind this legislation.

First of all, this is Senator Bob Dole's direct quote:

I was there fighting the fight—

He was 1 of 12 against Medicare—

because we knew it would not work in 1965.

He and many colleagues believed it would never work. Senator Dole was 1 of 12 who voted against it then.

Former House Speaker Newt Gingrich, said:

Now, we didn't get rid of it in round one because we didn't think it was politically smart, but we believe Medicare is going to wither on the vine.

Former House Member Dick Armey said this:

Medicare has no place in a free world. Social Security is a rotten trick.

He goes on to say:

I think we are going to have to bite the bullet and phase it out over time.

Those are direct quotes. I think part of what we have behind this legislation is an effort to have Medicare wither on the vine, and it will be withering on the vine. I think we should understand that this legislation is not what it purports to be; it is not. As a result of that, I believe we should vote against this legislation.

Mr. President, how much time do I have left?

The PRESIDING OFFICER (Mr. ENZI). The Senator has 11 minutes.

Mr. REID. Mr. President, I yield that time to my colleague from Nevada, Senator ENSIGN.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, I want to talk about one Senator's journey through this bill, trying to make a decision based on the facts and trying to get through the rhetoric, because there is a lot of that going on in any piece of legislation. So I am trying to write down the pros and the cons of this legislation and go through them in a systematic fashion and try to make a decision based on policy and not based on politics, a decision based on what is in the bill, not on what people are saying is in the bill.

As I have gone through this, I have a whole list of general principles that I believe are good. I have still not made up my mind on this final piece of legislation because it is really a balancing act. There are good things and there are things that are not so good. Just to mention a few of the things that I believe are good in this bill, probably the best thing is something called the health savings account, which has nothing to do with Medicare today. It has to do with reforming the overall insurance system in our country for health care. It is something I have been fighting for, for many years and introduced legislation on when I was in the House of Representatives on the Ways and Means Committee.

We passed it several times, but unfortunately, when we passed the final version, we had to water it down so

much that we enacted a piece of legislation that did not work. So the health savings accounts in this piece of legislation, I believe, are going to be one of the most significant reforms we can possibly enact for the future of bringing the patient back into the accountability loop. When you have a third-party payer system—what I mean by that is the person receiving the care doesn't directly pay for the care; it is a third-party payer system.

So when you walk into a doctor and the doctor says we need to run this test and that test, the person doesn't even say how much do those tests cost or is there a cheaper place to go get an MRI, for instance, or is one place better or cheaper or is a certain specialist better than others or is one cheaper than others, and maybe of the same quality—none of those kinds of discussions happens because they are not paying the bill. The health savings account allows them to put money into an account tax free. It builds up in the account tax free, and when it is taken out for health care expenses, it is taken out tax free. Then that person directly pays the doctor.

Now, why is that significant? It is significant because in our current system, whether it is traditional Medicare fee for service, or even the HMOs or the PPOs, all the payments go through some kind of bureaucracy, whether it is a Government bureaucracy or a private one. Anybody that has experienced our health care system today knows that maybe companies are not trying to deny payment but it certainly seems like that in a lot of cases.

My in-laws are dealing with this right now. My father-in-law had cancer last year. They have been battling for almost a year now on whether the insurance company should pay for a large part of their coverage or not. That takes a lot of time for people to process, to answer phones, go through the whole process. If somebody is paying out of their own pocket to the doctor, none of these conversations has to take place, and that money that is saved through the bureaucratic process can go directly to health care. I believe health savings accounts are one of the most positive things in this bill.

Mr. President, will the Chair please notify me when there is 1 minute remaining?

The PRESIDING OFFICER. The Chair will do so.

Mr. ENSIGN. Second is the means testing idea of Part B, the affluence testing, as it is being called. I think it is wrong. This is not a part of Medicare where people are paid in their taxes over the year. Part B is something that younger generations—such as the pages we have here—people paying taxes out there are paying for seniors, and we should, at least for those wealthy seniors, have them pay for that benefit they are getting, instead of shifting the benefit on to middle-class taxpayers. That is also very good.

Another part that is good in the bill is this idea of a disease management

pilot project. Right now in Medicare, you go to one doctor and Medicare pays, and maybe you have diabetes and you have to go to several specialists, internists, or whatever; there is nothing really coordinating care. So you get different prescriptions and different doctors. There is no real coordination of care and also not a lot is being done preventively. So we end up with poor-quality care, poor outcomes, and we spend more money.

We have a great demonstration project, a pilot project that Republicans and Democrats actually should like in this bill on the disease management part of it. In the future, I believe it will improve outcomes for seniors healthwise, and it will also save costs.

As to some of the negative parts of the bill, first of all, it does not kick in right away. A bill that I introduced would have kicked in as soon as the drug discount card kicks in. That is the only thing that really kicks in, in the next 5 or 6 months—the drug discount card. The legislation I had introduced actually would have fully kicked in. The Democrat bill and Republican bill we had debated, none of those kicked in right away, and neither does this bill.

The other problem with this bill is there is a cliff at 150 percent of poverty. After that, you kind of drop right off the cliff. So for those below 150 percent of poverty, this is too generous. With a \$1 and \$3 copay, we are going to incentivize people to overutilize drugs, pure and simple. You are going to see overutilization of drugs. We see it in Medicaid today because of the low copays and we are going to see it here. That was a huge mistake that we didn't once again have people receiving the drugs having anything financial at stake. And \$1 and \$3 copays will not change behavior in any way whatsoever.

The other thing that actually we have to consider—and we should at least go into this with open eyes—this is the largest wealth transfer since Medicare was first put into effect. We just have to know that. The \$400 billion is being taken from younger people and given to older people. The older people didn't pay for it. We are giving that. So we have to go into this with open eyes.

The other thing I believe is a problem with the drug benefit we have in Medicare is that it is giving it to the wealthy. I don't believe we should be. We should be helping and putting almost all the benefit into the people who are literally having to choose between prescription drugs and rent and maybe whether they are going to eat that month or what kind of food they are going to eat that month.

Instead, this bill gives coverage for everybody on Medicare. I don't believe that is right. When Bill Gates turns 65, I don't believe he should be getting a prescription drug benefit that is paid for by some union worker who worked hard all of their life and paid taxes. I don't believe that is right. So I believe

the prescription drug benefit should be means tested. That is another negative in this particular piece of legislation.

Just mentioning a couple of the things, there are some really good pieces of this bill, but there are some major negatives in this bill.

When we are going through all of the rhetoric, I think all of us have to be honest. The supporters of the bill should be honest that there are some problems with it, but the people who are against the bill should also be honest. This does not end Medicare as we know it. This is a bill incredibly generous to low-income seniors. Even if I vote against this bill, I have to say this is incredibly generous to low-income seniors. That is just being honest. All seniors pay out of pocket is a \$1 copay for generics and a \$3 copay for brand name prescription drugs. That is an incredibly generous benefit.

In conclusion, as I go through this next 24 to 48 hours—whenever we are going to vote on final passage of the bill—it is a 700-page document we got a couple of days ago. I think we have to take our time to go through the bill.

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

Mr. ENSIGN. Taking our time to go through the bill is very wise to do because my biggest fear—and we see this happen with legislation all the time—when we have this kind of complexity in a document is the law of unintended consequences.

We enact bills all the time. When we enacted HIPAA—and the majority leader is on the floor and he knows better than anybody—the HIPAA law is a terrible piece of legislation, and we are suffering consequences today. We are driving up health care costs unnecessarily because of that legislation. That is why I am still trying to go through this legislation to make up my mind.

I thank my colleague, the senior Senator from Nevada, Mr. REID, for yielding me the time to speak tonight. I look forward to hearing the majority leader's comments on this legislation as I am still battling through what I am going to do on it.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, I will be speaking for about 30 minutes. I ask that the Chair notify me when I have used 25 minutes.

The PRESIDING OFFICER. The Senator will be notified.

Mr. FRIST. Mr. President, we are at a truly historic time. A lot of times we exaggerate a bit to make a point. It seems as if on every bill somebody says: This is a historic bill.

As a physician, as someone who has had a great privilege in life, a blessing in life to have served as a physician and to have taken an oath to serve humankind in such an intimate and personal way, I truly believe it is an historic time because with the action we are almost certainly going to take tomorrow night, we are going to change

the lives of 40 million seniors and also 77 million baby boomers who will be seniors over the coming years by this single piece of legislation.

It is rare we can say that. It is so rare. Everybody gets sick at some point later in life—everybody. If it reaches a certain threshold, you seek medical care. This bill will affect the type of care you receive, whether or not you have appropriate access, the quality of that care, and the response of the type of care that is given to you. That is why I say it is a historic bill.

I am confident we will pass this bill tomorrow night. I know there are a lot of statements that have been made: We are going to obstruct; we are going to filibuster; we are going to use procedural moves. But at the end of the day, nobody from this body, I believe, can go home and say—when we are an eyelash away, after 6 years of hard work of trying to put together the very best bill possible—that we would go home having denied the President, with the leadership he has shown, and the House of Representatives, with the leadership they have shown, and the hard bipartisan work on this floor, and then tell seniors: It is not going to happen. Once again the promises that have been made have been denied you.

Why do I say that? That is the question I wish to answer over the next few minutes.

I want to start from afar and then come down to some of the specifics of the bill and paint a picture, paint a portrait that I think helps, at least in my own thinking, to explain to the American people why this is a pivotal time, why we have to act now, why we can't wait another year or 3 years or 5 years, why at this moment in history events have come together in conversion. There is a reason, and when we act, we will have a much more dramatic impact in improving health care and improving health care security than if we were to wait.

In 1965, Medicare began. I didn't start practicing medicine until the eighties, but through that period of time, it is just amazing. We have seen health care advances that are remarkable in terms of medicine, science, and technology. The half-life of medicine—that is a statistical way of looking at medicine and advances. It got smaller and smaller and smaller and smaller because of our knowledge and understanding. Advances have been made in both health services delivery—that is how health care is delivered and how it is organized—as well as scientific and technological advances.

I am going to show three graphs using this same format. On this Y axis is change. It is fairly arbitrary in describing change, but it is improvements, it is how things change over time. Along this X axis, it starts in 1965 when Medicare started and ending in the year 2005, as we project ahead.

We can see this change came along pretty steadily, and all of a sudden it started to go up, up, up, and I would

put it way up off the chart. That is where this change is going.

The first successful heart and liver transplant was in 1965. That is a fascinating history. That is the field I ended up going into, heart transplant surgery.

Coronary angioplasty, when people have drug-eluting stents, and we hear about it all the time. It wasn't that long ago. That was just in 1977. We had the first open heart surgery cases in the 1960s.

In 1974, the HMO Act was passed in this body. Prozac, a drug many people are on today, was first used in 1988. It is interesting, when the PPOs—and I will talk more about PPOs shortly—began in 1985, 1 million people were enrolled. Within 13 years, 90 million people are enrolled in these PPOs.

We had the human genome project, a fantastic project which just finished this year. It was a successful public-private partnership. This chart shows all the advances. The point is, these advances are getting faster and faster.

The next chart uses the same format, but it shows what Medicare has done. Has it changed as well? Medicare has not changed very much. It started in 1965. It was enacted into law in 1965. It is a great program, a fantastic program. I had the opportunity to treat thousands of patients in Medicare. It has given them health care security.

But, contrast Medicare to all the health care advances, and we can see it hasn't changed much over time.

In 1972, it was expanded to include end-stage renal disease and dialysis. That was a good advance.

There was a good advance in 1985 with prospective payments for patients who are actually in hospitals. It was pretty revolutionary at the time.

We have had people refer to catastrophic coverage. Notice line went up and went down because catastrophic coverage was repealed. A lot of people said: Is this bill going to be repealed? If I have time, I will comment on that because there is a clear answer to why that is different.

There were prospective payments for physicians 1990. In 1997, we added the Medicare+Choice Program and other prospective payments.

Now we are in 2003. And tomorrow night are we going to improve and change Medicare in a positive way. People say you can change Medicare and that is bad. That is not bad; that is good.

We are going to strengthen and improve Medicare, and that is the whole purpose. The next chart shows very clearly the advances in technology go on up, but Medicare is too rigid. It does not change. We are not capable of changing the structure of Medicare fast enough in this body and therefore that rigid structure cannot adapt to new drugs, new pharmaceutical agents, new ways to deliver health care, new types of PPOs. We just do not change.

So the gap, is what we are addressing. If we do not pass this bill tomorrow

night or tomorrow afternoon—the sooner the better on my part—I think we are not going to fill this gap, and we are going to be stuck down here when all of these advances are up here and these advances are being denied seniors.

That is why when people say “filibuster,” use procedural moves to stop this, do they mean they want to stay down here when we have the opportunity, to catch up and let these health advances be delivered to our seniors? So that is the way I think about things—in terms of what is at stake.

I do not think anybody can defeat this bill and go home from here. They cannot face 40 million seniors and say we are not going to give them the advances that are available to the rest of the world. It is not right, if that is the case.

Now, why today? I have heard from the other side of the aisle again and again: Let's do it next year, 2 years from now, 3 years from now.

It is because we have this earthquake, or this mountain, moving towards us, defined in 1945 by the baby boomers. This is a fertility curve. We know after the war, fertility went up 3.5 births per woman. Then it fell back down. This is moving through the system to the point that in about 2008 or 2010, this curve will begin to move through the Medicare program as these baby boomers age, beginning in about 4 to 5 years.

When they hit the system, what happens is potentially catastrophic if we have not prepared the system for that.

To explain that, I will use the following several charts. No. 1, let's say I am the Medicare system right here. I have seniors who are taken care of over here, and I have people who are paying—that is all the working people today—to support the Medicare system which takes care of these seniors. Well, what is happening is we are having a doubling of the number of seniors because of the baby boom. So the population is getting bigger because of the baby boom demographic shift. It is this point in history that it occurs. It was not 10 years ago, and it is not 30 or 40 years from now. It is beginning right now. We have a doubling of the number of seniors.

At the same time, because there is a big curve moving through, we have fewer people working to pay. So we have fewer and fewer people paying the health care of more and more people over time because it is a pay-as-you-go system. The people supporting the system today are the people working today.

I will show my colleagues graphically exactly what I said. Medicare enrollment—that is the number of seniors over 65 years of age—in 1970 it was only 20 million. What is important is that there are 40 million people today, but because of the baby boom—look at this curve going up—we are going to have twice that in 2030, right at 77 million, this chart says, but it will be right at

80 million. So we have a doubling of the number of people we are going to be taking care of over the next 30 years.

What about the people who are actually taking care of each one of those? In 1970, there were seven people over here working to take care of every senior, but because the fertility curve is moving through in the year 2000, it was about four people working. So for every person working to support one, they are having to work a lot harder. There are fewer people. Instead of seven working, four are working for each one.

What is even worse is that over the next 30 years, instead of four people, it goes to two people. So they are going to have to be working twice as hard for every one person that is benefiting. Yet we have twice as many people who are benefiting. That is the challenge that we have and that is the reason for "why now." That answers the question as to why we should do it in this Congress. We should have done it 2, 4, even 6 years ago. If we do not do it now, it is too late.

That is the reality of Medicare. So people say, why do we not give a drug card and leave it at that, take care of a group of people and give them 50 or 70 percent on the card? The point is, that does not address everything that I have said to date. It does not address the challenge of having a rigid, inflexible, outdated, antiquated Medicare Program, and that is why not just a drug card, though a drug card is important, and I will come back to that. But that is why that is not the answer.

A lot of people say we should not be spending \$400 billion. They say we should spend \$100 billion and take care of the people who need it the very most. But, that approach does not address the fact that we have an outdated system.

I have said on this Senate floor many times the most important tool a physician or a nurse has today to treat a patient is not the surgeon's knife that I used every day. It is not the hospital bed. It is not even the hospital. It is pills. It is medicines. It is prescription drugs.

Why today? Why are we acting today? That was not true 10 years ago. It was not true 20 years ago. But today it is the most important tool a physician has. Yet it is denied seniors in the Medicare Program. Seniors cannot get outpatient prescription drugs through Medicare today. It is the most important part of health care. Yet we deny it to our seniors. That is why nobody can filibuster this bill in good conscience because we are denying our seniors the most important tool in medicine today.

Tomorrow, after we pass this bill, since it has been passed by the House, and the President is going to sign it, for the first time in the history of this Medicare Program we are going to have the most important part of health care as a tool. The most important tool in a physician's armamentarium is prescription drugs. It is being denied seniors today.

Now, just an example: Cancer, diabetes, rheumatoid arthritis, osteoporosis—there are drugs for all of these diseases. There are 402 drugs right now in clinical development for cancer. So whatever we do, we do not want to destroy the research that is going on in this country. If drugs are the most important part of health care today, we want to make sure that we promote research and development. That is why we do not engage in governmental price fixing, setting prices by Government, because it destroys all of this in terms of research.

NIH does a good job, and we can fund it. We fund several billion dollars through our NIH, but the private sector's contribution to research is many fold what the government provides. So we have to continue to support that private sector research.

So what do we do? Where are we today? Here we go in terms of how we modernize this system, and at the same time address the issue of prescription drugs. How do we marry it? This bill does it in a bipartisan way.

I predict this bill will pass tomorrow with a bipartisan vote. I know a lot of people are bringing partisan issues to the floor and saying we are going to stop it with such things as procedural votes, but this bill is going to pass with a strong bipartisan vote tomorrow.

Again, what are we going to do? Today, a senior right now has a choice. They can stay in traditional Medicare, just like 35 million have, with good care and a strong system. It is antiquated, it is out of date, and it is inadequate compared to other options that people have today. It does not include prescription drugs, for example. Or a senior can go into Medicare+Choice. Five million seniors have chosen to go into Medicare+Choice. They do get some prescription drugs. Prescription drugs are in green on these charts. For my colleagues who are in the Chamber tonight, they can see the green.

So seniors can get some prescription drugs, but there are no prescription drugs in traditional Medicare today.

No. 1, I mentioned the drug discount card. In this legislation, maybe 6 or 8 months from now, after we pass this bill and the President signs it, seniors will have access to a drug discount card. It will last for a 2-year period. What it says is while we are developing this system, they can get immediate relief through a card. This card will allow a senior to go to the local pharmacy and get an additional 20-percent discount. Maybe it is a 10 or 25-percent discount, but however a senior gets the drugs they might get today, they will have an additional discount.

It is voluntary. This word "voluntary" is key because everything that we put into this program today in terms of prescription drugs or giving a choice of a health care plan that might better suit a senior's needs is voluntary. They can keep exactly what they have today—and this is important for people who are listening. They can

keep exactly what they have today, with no change in their benefits. They might already have prescription drugs so they would not want prescription drugs. All of this is voluntary. It is not mandatory. Nobody is making any senior even make a decision to do anything. They can keep exactly what they have if they are satisfied.

In addition to this discount, there is a \$600 value if a senior is low income, less than 135 percent of poverty. The chart I just showed my colleagues was Medicare today. Remember, the senior could choose either traditional Medicare, which 35 million people have, or Medicare+Choice. After this bill passes, we are going to expand the opportunity to choose, so seniors for the first time can choose the health care plan that best suits their individual needs. If you have Alzheimer's you might choose a plan that specializes in Alzheimer's. If you have Parkinson's disease or coronary artery disease or you have had a stroke or you have seizures, there may be plans out there that can best suit your needs that for the first time you will have access to. That is not available in traditional Medicare.

So a senior can choose under new Medicare. Either the traditional Medicare, keep what you have, don't change anything. If you stay in traditional Medicare, for the first time, if you want it—you don't have to take it—you can choose from one of two and maybe three or four drug plans. They will have equal value, but you can have that choice.

People say what if the drug plans don't show up? If they don't show up, there is a fall-back Government plan there. Everybody can have this new choice, but if you don't want to, keep what you have.

In addition, you can choose Medicare+Choice, which are primarily HMOs. HMOs are maligned on the Senate floor a lot. You talk to these 5 million people who are in them, they really like them. But if you want to, you are also going to be able to choose, from a preferred provider organization or PPO or C. There may be five, there may be three, there may be two, there may be one PPO. These PPOs are integrated health care plans. They have disease management. They have this little green down there showing all of them will have access to prescription drugs.

People say sick people may stay here or they may go into here or they may go into here. You don't really know. My heart transplant patients, who are among the sickest patients going in—before they get their transplant they are all going to die. Coming out, they require a lot of medicines. I would encourage a lot of those who are among the most challenging to take care of, I would encourage them to go into these PPOs. Why? Because they can have a health care plan that is tailored to their needs, that is able to respond to infectious disease, acute care, chronic

care, disease management, coordinated care, none of which is available under traditional Medicare. So this is the design. Opportunity to choose all of this. Nobody is forced to choose at any point in time.

Transformational: I won't go through all of this, but I wanted to show this because it is hard as you listen to everybody. Everybody is talking about little pieces. Using the same format, let me show some of the things we do.

In the PPOs, in the choice over here that we are going to give for the first time—I say it is FEHBP-like. What that simply means is we in the Senate have a choice among a group of plans. I happen to take the Blue Cross/Blue Shield plan. That might be one of these plans. But seniors will be able to choose, just like we choose, a plan that might best suit their needs.

These are integrated plans; that is, acute care, chronic care, preventive medicine, coordinated care. You have a choice. You can choose among these plans. There is competition in that these plans will compete one versus the other based on quality, access, and cost. They give the same benefits as traditional Medicare, but there will be competition among those plans based on any of the issues that I just mentioned.

The flexibility: What that really says is that this PPO may be different than this PPO, different than this PPO. It may give a different range of benefits, although all of them will give at least the benefits given in traditional Medicare.

If you look at the drug plans, I have down that they are risk bearing. Risk bearing means the Government itself shares the risk with the plan. That plays into the marketplace. That is the way the private sector works. It captures the dynamism of the marketplace and, over time, and with the element of competition, that can bring the cost of drugs and Medicare down. These are competitively bid. Again, they have the flexibility.

Traditional Medicare: You have heard people talking about income relating, means testing. For the first time, the very rich, the Ross Perots of the world, will no longer have their assistants or their secretaries subsidizing their Part B premiums, their health care. For the very rich, they are going to have to be responsible for more of the subsidy—not all of the Government subsidy for them but more. There is cost containment built in. There are disease management programs that are going to be part of the traditional Medicare.

Quality is going to be rewarded. This is fantastic. I will come back to this if I have time. For the first time, the hospitals, for example, if they report the quality data, they will get their full, what is called, market basket update. The important thing is if they don't report that quality data over time, they are not going to get paid as much. Quality is being rewarded.

It is amazing; as a heart specialist, 50 percent of people in this body are going to die of heart disease, probably. It is higher for women than it is for men. A lot of people don't realize that, in terms of morbidity. More women will die of heart disease than men this year.

Right now there is no screening test reimbursed. Your cholesterol level right now, as a screening test, in Medicare is not reimbursed. Once we pass this bill tomorrow, and it is implemented, cholesterol screening and lipid profiles, preventive tests will be reimbursed for the first time. People say, come on; it has got to be reimbursed today. It is not reimbursed today. That is just an example—prevention.

As to physical exams, people know that is important as a screening measure. A lot of people get to 65 years of age and have never had a physical exam. For the first time in Medicare, everybody is going to have available to them, under Medicare, an entry level physical exam. Before, it wasn't there. It is not there today, but it is going to be there under the bill.

Information technology, I mention that because it has to do with medical errors. Right now we know there are too many medical errors that are being made. We need to facilitate, and adapt information to come into the system and be handled in a way that is consistent, in which the data can be assimilated and reported back. There will be e-prescribing for prescriptions with incentives—not mandatory, but incentives to encourage physicians to be able, instead of writing each prescription and have it go through 10 or 15 different hands and come back where mistakes can be made, by computer it can go all the way through the system where the mistakes are less likely to be made.

It is a complicated chart, but it gives my colleagues the feel for everything that we are accomplishing in this bill—not everything, but how important the various elements of this bill are.

Senator KENT CONRAD in this body is the person who is probably as focused as anybody on this particular issue. I agree with him 100 percent.

How much time do I have?

The PRESIDING OFFICER. The leader has 5½ minutes.

Mr. FRIST. Five and a half. OK. I will move fairly quickly.

The issue is that most people in Medicare today are not very expensive, in terms of their health care. But 6 percent are.

In this body there are 100 people. Not everybody is here right now, but 6 of the 100 people in this body would account for 50 percent of all expenditures in Medicare. That is amazing.

Wouldn't it be great if you could identify which 6 it is, and if you identified them you could focus resources, coordinate their care, get preventive medicine, give them disease management, and that would take care of 50 percent of the cost? In this bill we establish data collection to identify and begin that disease management.

This bill is good for doctors and hospitals. Physicians right now, if we don't do anything today, are going to be cut by 4.5 percent, under current law, as to what they are reimbursed. When we pass this bill, it will increase, instead of being cut, by 1.5 percent.

Hospitals, if they give us the quality data—which they should give do—will get full market basket.

Paperwork: You hear physicians all the time, and hospitals, complain about the regulations and the paperwork. We have significant paperwork reduction in this bill.

Back in Tennessee, the most common request is: What is this bill to me? What does it mean to me?

To seniors, it means a lot. To individuals with disabilities, it means a lot. But in addition, the State of Tennessee, above current law, is going to receive for hospitals, \$655 million more; for doctors, \$240 million more; and for our Medicaid Program, almost \$700 million more, because of this bill.

We hear regarding prescription drug costs that there is nothing in this bill to control prescription drug costs. That is not true. It is simply not true. I encourage my colleagues to read that bill and continue to read it tonight.

We speed generic drugs to the market. All of us know brand-name drugs are expensive. Generic drugs are not very expensive. What we do through this bill and the work of Senator SCHUMER and the work of Senator JUDD GREGG is speed generics to the market in this bill.

We have competition. All the competition, the marketplace dynamics—competition is the only thing we know that over time can slow the growth of, whether it is drug prices or any prices. Price fixing simply does not work. It hasn't worked in Germany, it hasn't worked in England, and it hasn't worked in this country when we tried it in health care. I am going to keep moving here.

Are we helping the people who need it the most, poor people? The answer is yes. Below 100 percent of the poverty level: If you have \$100 in monthly drug spending, 95 percent of the cost of drugs is paid for through this plan.

Let's take another example. If you are below the poverty level and you have \$500 a month in drug spending, you have 97 percent of all of the costs taken care of by this plan; \$1,000, you have 98 percent.

These are the people who need it the most. This plan is generous to the people who need it the most.

In closing, again, I will keep it very short. Hopefully, I can speak for a couple of minutes tomorrow morning.

We are providing access to prescription drugs, the most important tool in medicine today. Seniors don't have it today. They are going to have it after we pass this bill.

This program is voluntary. If you do not want to change anything, if you like what you have today, then keep what you have. Nobody is forcing you to choose. All of this is voluntary.

Private health plan choices: Why? Because private health plans today capture the advances I showed you earlier—coordinated care, disease management, and integrated care. That is what it is in private plans today that is being denied to our seniors. Seniors don't have access to them.

Appropriate reimbursement and regulatory relief to providers, to doctors, to hospitals, to nurses—I just mentioned what the impact is for a State such as Tennessee. Payment linked to quality is not done today. It is not done today in Medicare. For the first time, reimbursement is being linked to quality care.

Lastly, preventive care, physical exam for the first time, if we pass this bill; lipid profile; improvement in mammography screening; chronic care management and disease management.

I know my time is up. Let me close by saying this bill does four things. It strengthens and improves Medicare; it offers prescription drugs for the first time in the history of our Medicare Program; it does it on a voluntary basis; and for the first time in the history of this program it gives seniors access to plans that better suit their needs.

I encourage every Member in this body to vote for this bill.

Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, would you notify me when I have 5 minutes remaining?

The PRESIDING OFFICER. The Senator will be notified.

Mrs. MURRAY. Mr. President, I have been fighting for a real prescription drug benefit for years. In the 106th Congress, I helped draft the MEND Act, and year after year I have used my seat on the Budget Committee to set aside money for a good drug benefit. I voted for several Medicare prescription drug bills, including S. 1 last June and the Graham-Miller-Kennedy bill in the last Congress. I have written and I have introduced legislation to make Medicare more fair to the people of my home State of Washington. I have worked to improve health care for seniors on the HELP Committee, on the Labor-HHS appropriations subcommittee, and here on the Senate floor.

After all of these years of work, no one wants prescription drug benefits more than I do. But I am very troubled by the proposal that is now before us.

I am unhappy at the prospect that this plan could force seniors and the disabled into an overly restrictive health care rationing regime in which they could lose their choice of doctors just to get a pretty meager drug benefit.

I am unhappy at the prospect that this plan could tell our seniors they must give up the good retirement health plan they have worked all of their lives to earn.

I am unhappy at the prospect that this plan could leave our seniors and

disabled at the mercy of ever-increasing premiums.

I am unhappy at the prospect that this plan could tell patients who have complex medical conditions they cannot get direct access to specialists they need to see.

I am unhappy at the prospect that this plan could tell patients with MS, or Parkinson's disease, or ALS they can't get the drugs they need because their plan will not cover them.

I am unhappy at the prospect that this plan could tell our rural seniors they will have to roll the dice on how they receive health care coverage because this is not a real choice in their communities.

I am unhappy at the prospect that this plan would tell disabled Americans who are fighting poverty that the drugs they get today can be off limits tomorrow.

I am unhappy at the prospect that this plan would tell seniors if their drugs cost more than \$2,300, they won't get a dime of help until they pay \$3,600 out of their own pockets.

I am unhappy at the prospect that this plan could break the promise that Medicare has had for our seniors and our disabled since 1965.

This isn't just about plans and formularies and medical services areas; this is about people. It is about our parents and our grandparents and generations of Americans coming behind us.

I have sat down with seniors in my State, and I have heard how badly they need a real drug benefit. Just last August, I met with more than 200 seniors in Edmonds, WA, at the South County Senior Center. They told me in their own words just how important the drug benefit is.

During this debate, I have listened to my colleagues. I have listened to seniors and the disabled in Washington State. I have heard from doctors and hospitals at home. I have read the key provisions in the package, and I have reviewed the Congressional Budget Office estimates. Without a doubt, this is one of the most complex and controversial proposals this Congress has considered.

One needs only to review what happened in the House a few days ago to see how controversial and political the vote was. What occurred during that vote speaks volumes about the failures of this bill and the lengths the majority will go to in order to pass this flawed measure.

At the end of the allocated time for that vote in the House, the bill had been rejected. But the majority leadership refused to close that vote. They held it open for many more minutes, and those minutes turned into hours, and finally at about 6 o'clock in the morning, after holding that vote open for 3 hours, the majority managed to pressure a few Members to switch their votes.

An issue this important deserves a thorough debate. I am troubled that it

appears as though this bill is being railroaded through Congress on twisted arms and backroom pressure.

When I look at Social Security and Medicare, I don't just see a program, I see a promise. It is a promise from one generation to the next. It is a promise from our Government to our seniors. And it is a promise that reflects our values.

Coupled with Social Security, Medicare is the most important antipoverty program ever. In fact, before Medicare, in 1963, 44 percent of our seniors were uninsured. Today, it is just 1 percent. In 1966, 29 percent of seniors lived in poverty. Today, it is down to about 10 percent. Since 1960, life expectancy for those over 65 has increased by 25 percent.

Medicare is a success story. It promised our seniors that they will have health care security, regardless of their ability to pay, regardless of where they live, and regardless of their medical condition.

Not only has Medicare helped seniors, but it forms the foundation of all of our health care. Medicare helps train our doctors. Medicare payments help keep our rural hospitals open. And Medicare helps keep emergency rooms and neonatal units operating. Medicare is open to every doctor and every hospital. It doesn't force providers into restricted networks. It lets doctors make decisions based on what their patients need—not on some mandate from some accountant.

It is troubling to think of what rural America would be today and whether inner-city trauma centers would even be in existence today without Medicare.

Let us not forget the reason we created Medicare in the first place. The market failed our seniors.

I approach this debate with a clear understanding of the importance of Medicare to our seniors and to our entire health care system. When I look at this bill, I want to know what it means to the seniors I represent. So far, I have found five big dangers for Washington State seniors.

First, this plan jeopardizes the health benefits retirees have earned during their working years. In Washington State, 47,250 seniors could lose their retiree health benefits. In return, they get much less coverage and they will pay for more than they had planned.

This plan is an unpredictable benefit that requires huge out-of-pocket costs and has massive gaps in coverage. This bill changes the ground rules on seniors in the middle of their golden years, and that is just not right.

Second, seniors could be forced into an overly restrictive health care rationing regime if they want a drug benefit. On paper, it looks as if seniors have a choice. That is what the proponents keep repeating. When we take a closer look, we see what is going on. Supporters claim that seniors can stay in traditional Medicare, but that is

only if insurance companies decide to offer drug-only plans. They could offer drug-only plans, but the affordability of those plans is unknown and unknowable. That is because there is no limit on how much a plan can charge, so seniors will not be protected from price gouging.

On paper it may look as if seniors get a choice, but in reality many will face a new system that rations their health care in exchange for a very small drug benefit. Seniors could get fewer choices and less coverage than they have today. They will face fewer choices because of an imposed system of rationing that may not let them pick their own doctor, and they will have less coverage because the plans they will be forced into do not need to cover every drug that is medically necessary.

Third, if you get a chronic, life-threatening disease such as cancer or AIDS, you are not guaranteed the drugs you need. Here is what one client of The Lifelong AIDS Alliance in Washington State had to say:

The current bill as it is written will affect me personally as it limits the drugs I can have access to because it only allows for up to two drugs under the prescription part of the bill. Since I am on a multiple-drug regimen, I will not have access to the other life-saving drugs that I will have to take to stay HIV healthy.

Those are the chilling words of one of my constituents who is HIV positive and understands what this bill will mean for him. That is why AIDS service providers in my State oppose this bill.

In addition, if you need access to a clinical trial, forget it. This bill does not require any plan to give you access to experimental treatments.

This plan will mean fewer choices and less coverage for millions of seniors.

Fourth, this bill is especially bad for seniors and disabled Americans who are fighting poverty. Today, about 6 million Americans are eligible for both Medicare and Medicaid. Through these two programs, they get the coverage for the drugs they need. But this new bill we are looking at strips away what is known as wraparound coverage. In Washington State, that means about 92,000 people will get less coverage than they have today. That is just in my State. Those are the most vulnerable among us, the very people Medicare and Medicaid were designed to protect.

Fifth, there is a huge gap in coverage. Many seniors will see a big hole in their coverage. Payments will not stop. What you have to pay will not stop, but your coverage will. If your drugs cost you more than \$2,250 a year, you will get zero help until you spend a total of \$3,600 out of your own pocket. You get no coverage, but you still have to pay the premium.

When you look at what the average Medicare beneficiary spends for drugs, this coverage gap gets even worse. According to the Kaiser Family Foundation, in 2003, the average Medicare ben-

eficiary paid \$2,322 for prescription drugs. If you spend the average, you are already in the coverage gap. Those figures were included in the Los Angeles Times article that appeared in the Seattle Times on November 21. They show that the average senior will end up with a gap in coverage from which few seniors will ever emerge.

When I ask, what does this bill mean for the seniors I represent, I am pretty troubled by the answers. I am troubled this could force 47,000 seniors in Washington State to give up the retiree health benefits they have worked for their entire lives. I am troubled this could force seniors in Washington State into overly restrictive health care rationing, to get a limited drug benefit and to lose their choice of doctor. I am troubled this could force patients with cancer, AIDS, and other life-threatening diseases into a system that will deny them the drugs they need. I am troubled this could force 92,000 low-income seniors or disabled Washingtonians out of Medicaid into a market where they lose access to the drugs they get today. I am troubled this could force millions of seniors into a coverage gap where they have to spend more than \$3,600 out of their own pocket without getting coverage or benefits.

This bill is also bad for Washington State in seven ways:

It could result in unequal benefits throughout Washington.

It could force providers and seniors to reevaluate their participation every single year, and they will get very little in return for that added unpredictability.

It could encourage seniors who are healthier and financially secure to leave traditional Medicare.

It could undermine Medicaid in Washington State.

It could require my State to send to the Federal Government a very large chunk of the savings it realizes.

It could force Washington State to manage new bureaucracies to test the assets of seniors in my home State.

And it could put Washington State even further down the list in Medicare reimbursements per beneficiary.

Let me walk through how this program would work to show how it is bad for my home State. Under this plan, the country will be divided into as many as 50 regions. States such as Washington could be divided into as many as three regions. Within these new, undefined regions, private insurance plans would be able to run the Medicare Program—not just the drug benefit, but Part A and Part B of the Medicare Program as well.

Washington State will be an attractive market for the PPOs and HMOs because we have areas that are healthier and wealthier and a tradition of health care delivery.

Currently, Washington State has one of the highest Medicare+Choice participation rates in the country with 18 percent of Medicare beneficiaries receiv-

ing Medicare through a Medicare+Choice plan.

Washington State also has a long tradition of managed and efficient care, so we will be a prime target for the new PPOs and HMOs. That means Medicare benefits in my State, just within my State, will vary from region to region and county to county depending on where you live. In theory, seniors in my home State may have more choices, but they give up a guarantee of a defined benefit.

Providers in Washington State could also face the same changes and uncertainty. Every year, seniors in Washington State would have to evaluate each insurance plan to find the one that best meets their needs.

Here are some of the things seniors every year in my State will have to figure out. While not knowing what medical conditions they may confront, they will have to figure out how much they have to pay out of pocket. Without knowing what their future holds, they will have to predict what providers they will be able to see. Without knowing, they will have to figure out what doctors have dropped out of their plan or may drop out, what restrictions will be on drug coverage, what their copayments will be, what plan formulary includes expensive new drugs, what hospitals are in their network.

That is an awful lot to figure out, especially since health plans, as we all know, are never written in plain English and no one knows what medical conditions they may confront in their future.

Today, Medicare provides predictability. An 85-year-old woman in her home knows what Medicare provides. Under the Medicare+Choice plan, seniors got more than they gave up.

I do want to state there have been some managed care success stories in my home State. We have some great providers in Washington State that led the way in providing innovative, comprehensive care that puts the focus on patients, not profits. But overall, we need to think how this plan would expand the Medicare+Choice model.

Medicare+Choice has worked only in limited parts of Washington State. A total of 131,391 seniors in Washington State participate in these plans. But they are not open to all seniors and they are limited to a very few select regions. Even in this limited program, we have seen significant changes and instability just within Washington State. I am not at all convinced this is a model we should now expand for all seniors and disabled.

If these new plans that are coming in attract higher income, healthier seniors, we need to ask, what will be left of traditional Medicare? I am afraid traditional Medicare will begin to look more and more like Medicaid.

The prospects for this plan are deeply troubling. They could have a massive financial impact on Washington State.

I will turn to how this plan will affect Washington State and its Medicaid Program.

I received a letter from the Democratic Governors' Association. It is signed by three Governors, including Governor Locke of Washington.

Mr. President, I ask unanimous consent that letter be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered. (See exhibit 1.)

Mrs. MURRAY. Mr. President, the Governors' letter urges Congress to give the States time to determine the impact on their Medicaid programs before enacting sweeping changes in how we treat Medicaid beneficiaries and how States pay for coverage for low-income seniors and the disabled.

So under this plan, if States save money by shifting drug costs from Medicaid to Medicare, States have to give a portion of those savings that they get back to the Federal Government every year.

Many States, such as Washington, have stepped up to the plate and have tried to fill the gap in Medicare by providing affordable, comprehensive prescription drug coverage through Medicaid for people who are eligible for both programs.

Over the past 10 years, as drug costs have rapidly increased, this burden has become overwhelming. Many States are now being forced to scale back their coverage in access.

In 2002, Washington State spent an estimated \$212.8 million on drug costs for people who are eligible for both Medicare and Medicaid. That was a huge strain on my State.

Under this plan we are considering, the States will see some relief by shifting Medicaid beneficiaries to Medicare for drug coverage. But, unfortunately, the plan gives with one hand and takes back with the other.

Washington State, under this plan, will be forced to surrender much of the savings it sees back to the Federal Government. That could reduce Washington State's Federal Medicaid dollars by almost \$2 billion from 2006 to 2013. That could devastate the entire program and result in further Medicaid reductions for low-income children and families. It could force the State to again implement reductions in provider payments for doctors, hospitals, and nursing homes.

A \$2 billion give-back, just for my State, will mean more uninsured, lower provider payments, and more children losing any health care safety net they have today.

Let's not forget that States will be handed a massive new administration burden under this plan. Washington State will now have to administer new asset tests to determine who qualifies under Medicare for low-income assistance. These tests are extremely restrictive and will result in many low-income seniors being pushed into higher income categories.

Under the conference agreement, assets will be limited to \$6,000 for a single person and \$9,000 for a married couple.

In order to get any additional financial assistance under this plan, many seniors and the disabled will be forced to impoverish themselves and give up almost everything they have worked so hard to earn. Even if the States want to provide a more humane benefit or assistance, they will not be allowed to do so.

Now, many of us fought to provide relief to States just this year by temporarily increasing the Federal Medicaid match. This was a critically important fight to save Medicaid and prevent massive Medicaid cuts on doctors and hospitals. Our success in achieving a small measure of relief is now being undone by imposing an even greater burden on the States.

Finally, Mr. President, this bill will punish Washington State even further in Medicare payments. For several years, I have been working to address the geographic disparities that punish providers and seniors in my State of Washington. For years, Washington State has received unfair treatment.

Today, Washington State ranks 41st in the Nation in Medicare payments per beneficiary. We are being penalized because we have a tradition of low-cost, efficient health care, and healthy seniors. Medicare should reward that. Instead, its outdated reimbursement formulas are causing doctors to leave my State or close their practices to new Medicare patients.

I have spoken at great length on the Senate floor before about this, and I have introduced legislation to correct that inequity. But under this bill, the situation would be even worse.

Washington State would fall from 41st in the Nation to 45th in the Nation. Even though there will be a slight increase in payments to Washington, because of what happens to other States, we end up falling even further behind. This is a fundamental shift in the Medicare entitlement, in exchange for a very weak benefit.

Philosophically, this plan goes in the wrong direction. We should be strengthening the foundation of Medicare, not experimenting with imposing a new health care system on seniors.

This plan undermines the role of the Federal Government in ensuring that every senior can live with the dignity and respect and stability they deserve. It could force seniors into an overly restrictive, ever-changing health system.

Let's not forget why Medicare was enacted in the first place. It was created because the private insurance market failed seniors and the disabled. Coverage was sporadic, expensive, and unpredictable. Medicare, when it was enacted, changed all of that for our Nation's seniors. Now I am afraid we are flirting with that original failed model. I believe we can do better.

During my time in the Senate, I have been proud to work on prescription drug coverage—from helping to draft the MEND Act in the 106th Congress to working on the Budget Committee over the past 4 years to fund prescription drugs.

I was proud to support the Graham-Miller-Kennedy bill in the 107th Congress that would have provided an affordable, reliable, comprehensive prescription drug benefit as part of Medicare. We had a chance to do much better.

I believe a prescription drug benefit ought to be a seamless part of Medicare. It should be treated just like a doctor's office visit or an outpatient surgical procedure.

By implementing a seamless, affordable benefit as part of Medicare, as we did when we added the Part B benefit, we would guarantee that all seniors have access to the same level of care, regardless of their health status or their age or their income or their assets or where they live. That access would be stable, and it would be predictable.

I know we can do this. Many of us in this Chamber, on both sides of the aisle, have worked to significantly boost our investment in NIH funding. We have fought to reform and modernize the FDA to ensure timely approval of new, lifesaving drugs. I want all of my seniors and disabled constituents to benefit from those kinds of investments.

Under the plan before us today, I cannot be sure they will reap the rewards of this Federal investment.

The PRESIDING OFFICER (Mr. GRASSLEY). The Chair is responding to the request that the Senator be notified when she has 5 minutes left.

Mrs. MURRAY. Thank you, Mr. President.

Mr. President, we should be on the floor today debating a prescription drug benefit package, not a proposal to radically alter Medicare. This should be a fight about providing good, affordable, stable coverage, not about experimenting with Medicare.

I do want to thank my friend and colleague, Senator BAUCUS, for his efforts. I know he worked hard to do the best he could. Senator BAUCUS understands the importance of Medicare for seniors and the disabled, and I know he fought against incredible odds. He was sitting across the table from Members of Congress who tried before to privatize Medicare, and many who still hope to turn Social Security over to Wall Street. He faced an impossible task.

I know he did all he could, and I thank him for his fight.

Mr. President, I do want to note there are some things in this bill that I fought for that are important.

It does prevent additional cuts in payments to doctors who are scheduled to take effect early next year. The scheduled reduction of 4.5 percent, as we all know, is unacceptable. I worked hard to prevent that scheduled reduction of 4 percent in 2003, and I do applaud the conferees for meeting our demands on this issue.

The package also provides additional relief for rural hospitals, home health care agencies, and rural health care providers. This relief is truly a life line

for saving rural health care. I have always supported these provisions, and I will continue to fight for fair and equitable rural payments.

I can promise health care providers and patients in my home State that regardless of the outcome of this legislation, I remain committed to stabilizing Medicare payments.

Now, Mr. President, I know many organizations representing doctors and hospitals think we can come back in 2006 and correct the mechanisms in this bill that undermine Medicare. That is a pretty dangerous gamble. Not only that, but we don't know what the people who put this bill together will demand down the road in exchange for changes—premiums support or vouchers for States; larger gaps in coverage; more copayments; more restrictions on access; more deals on the House floor in the middle of the night?

We do not know what the pricetag will be to undo the damage that this bill will impose. I assure everyone, it will not be easy.

I had looked forward to the day when the Senate would pass a Medicare prescription drug benefit. That day is upon us, but I believe that the price of this benefit is far too high.

In the coming months and years we will see the theory behind this bill put to practice. As more and more people discover what this bill and this President have done to their health care, I am confident we will hear from seniors as we have never heard before.

This is a difficult decision. The \$400 billion in this bill does represent a step forward. The provider payments contained in this bill are needed in my State, and seniors deserve the prescription drug coverage they have been asking for. Passage of this bill and being signed into law is not the end of the story. A tremendous amount of work will be required to fix the deficiencies in this bill. I will be there, as I have been all these years, working the best I can to do the right thing for the people I represent in my State and the people across this country.

I yield the floor.

EXHIBIT 1

DEMOCRATIC GOVERNORS' ASSOCIATION,
Washington, DC, November 21, 2003.
MEMBERS OF THE U.S. SENATE,
U.S. Capitol,
Washington, DC.

DEAR SENATOR: As you know, the near 700-page Medicare reform bill was unveiled yesterday. As a consequence, states have not thoroughly reviewed the language or seen individual cost estimates needed to make an accurate determination of its benefits and/or costs. Late yesterday, the Congressional Budget Office (CBO) released numbers portraying a net savings to states of \$17 billion over ten years. Notwithstanding this projected rosy scenario, neither CBO, nor any other independent entity has completed a state-by-state impact analysis of this legislation. Even CBO is projecting that states will be \$900 million in the red in the first year of the Medicare's program implementation in 2006. States need to ensure that their reading of the legislation confirms that the projected new state costs have not been underestimated by CBO.

With this in mind, we urge you to reject any effort to vote on this legislation before you know its full content and cost impact on your state and the people we both serve. To this end, CBO estimates on Medicare reform impact and expedited state reviews of the direct and indirect cost/savings impact from this legislation must be done and fully disseminated. Any rush to judgment, without this information, may have both short and long-term consequences that could prove to be irrevocably severe.

Early in the deliberations of the Medicare reform conference, governors were advised that at a minimum, the conferees were committed to ensuring that states would face no new costs as a consequence of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This commitment was made for each and every state, for each and every year, of the ten-year budget. For this reason, we are writing to urge you to not vote on this legislation until it is absolutely clear that this assurance has been upheld.

In recent days, there have been reports that the new administrative and other indirect state costs of this program—combined with the bill's exceedingly high "claw-back" of state savings—would more than exceed any Medicare savings for many states. Such an unacceptable outcome would be in addition to another misguided policy, reportedly seeking to mandate states and the territories to permanently pay 75 percent of the current Federal prescription drug cost-shift to states. In 2006, the first year of the bill's enactment, states would have to pay 90 percent of these costs.

Some have already suggested that this is a poorly crafted bill and in the long run it would do more harm than good to the very population it was intended to benefit. Although some states are witnessing a small increase in revenues, most states will continue to experience budget shortfalls for the current fiscal year. Some analysts believe that the overall shortfall will likely be \$25 to \$40 billion. With the continued sluggish growth in state revenues, any increases in state costs imposed by this legislation would be yet another unfunded federal mandate, creating additional pressure on states to cut essential programs and/or raise taxes.

Similarly, any permanent continuation of the Federal government's prescription drug cost-shift to states runs counter to existing National Governors Association (NGA) policy that, "if Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states and territories" and establishes a damaging precedent.

Sincerely,

Gov. GARY LOCKE,
Washington, DGA Chair.
Gov. TOM VILSACK,
Iowa, DGA Vice-Chair.
Gov. BILL RICHARDSON,
New Mexico, DGA Federal Liaison.

The PRESIDING OFFICER. The Chair recognizes the Senator from Wyoming.

Mr. ENZI. Mr. President, as we all know by now, the Medicare conferees have reached agreement on the most significant changes to the Medicare Program in history. I thank the Presiding Officer for the hours he has spent working on this, the agony he has gone through at understanding and reaching agreement with this diverse body of Senators. There are 100 of us. We usually amount to probably 150 opinions on anything. The Chair has had to put all of that together into a

bill that not only the 100 Senators agree with—and not all 100 Senators do—as many of the Senators as possible, and as many of the House as possible, because a bill to go through to the President has to pass both the House and the Senate. When it gets this complicated, it is an extremely talented person who is able to put together the kind of legislation that reaches a compromise that will be able to pass.

This is a copy of the bill. If anybody thinks it is simple, they haven't looked at it. It takes a long time to wander through this. We have been working on it for a few days and now have the finalized copy, the copy that has passed the House. It is the most significant change in the history of Medicare. It may be the most significant change in medical delivery in the history of the world.

I congratulate the Presiding Officer, the Senator from Iowa, Mr. GRASSLEY, for all the hard work he put in on this bill. We will soon be voting on it.

This bill will add a prescription drug benefit to Medicare, it will offer new Medicare coverage options to seniors, and it will expand tax incentives for people who save money to pay for their own health care needs. That is quite a package.

I want to strengthen Medicare. Seniors and disabled people in Wyoming depend upon Medicare to pay for their health care needs. We have relatively few major employers in Wyoming so most of our retired seniors don't have access to health care coverage through their former employers. Medicare is critical to the health and well-being of 66,000 elderly and disabled citizens in my home State. That may not sound like a lot of people, but it is over 13 percent of Wyoming's population.

Adding a prescription drug benefit to Medicare makes sense. Medicare is the only traditional insurance plan in the United States that does not cover outpatient prescription drugs. The reason Medicare does not cover prescription medications is that pharmaceuticals were not a major part of medical care in the 1960s, when Medicare was founded. It is a different story today. Today, prescription drugs are absolutely integral to providing quality health care. All of us rely on them. It makes sense for Medicare to keep up with the times by offering voluntary prescription drug coverage to seniors.

Let me emphasize the voluntary nature of this program some more. We have heard that the AARP is going to regret supporting this Medicare bill just as they regretted supporting the catastrophic coverage bill of the 1980s. I will come back to that a little bit later. The reason seniors revolted against the catastrophic coverage bill back then was that it was mandatory. They didn't have a choice. They had to pay for the coverage even if they didn't want it.

This bill does not make that mistake. This bill is different. If seniors

don't want Medicare drug coverage, they don't have to pay for it. If they have coverage through their former employer, they can keep that. Plus we provide a lot of support in this bill for employers to continue providing their retirees with drug coverage so that seniors won't be forced to buy a Medicare drug plan because they lost their retiree coverage. So this is indeed a voluntary program.

It gives seniors a chance to sign up for Medicare drug coverage or stay in the traditional Medicare and keep what they have. Choice is a great concept. America was built on the idea that people should have the freedom to choose how to live their lives, as long as their choices don't infringe on the freedom of others.

When it comes to health care, choice is also important. Today seniors don't have choices. Medicare is a one-size-fits-all program, take it or leave it. But we all know that most seniors cannot afford to leave it. So right now they are stuck with Medicare, warts and all. The fact that Congress has to pass a law to add a prescription drug benefit is part of the problem with the Medicare system. Medicare is not flexible enough to adjust and adapt to the complex nature of health care today.

As I have noted, prescription drugs play a much greater role in treating disease today than they did when Medicare was created nearly four decades ago. But unlike private health plans, Medicare has not changed with the times. Under this Medicare agreement, seniors will have the option to choose drug coverage through Medicare. They will also have options that go beyond voluntary drug coverage.

The conference agreement would allow a variety of private health plans to offer coverage of Medicare beneficiaries. I am not talking about HMOs. Despite what I have heard here on the Senate floor, this bill does not force seniors and disabled into HMOs. Medicare HMOs exist today, and no one is being forced into them. What this bill does is allow preferred provider organizations, or PPOs, to offer Medicare plans.

Most of us are familiar with PPOs. They are the type of health plans to which more Americans belong than any other type. HMOs give you a list of doctors. If your doctor is not on the list, you can't visit him. The great thing about PPOs is, you can use any doctor you choose. And if the doctor is part of the plan's network, you get a discount on the cost of his or her services. These private PPO plans will compete to serve seniors by offering new choices and benefits, choices that are currently unavailable under Medicare's one-size-fits-all structure.

To be blunt, I believe the legislation could be bolder in stimulating competition. But it represents a good step in the direction of flexibility, innovation, and here is that word again—choice.

Let's be clear on what the Medicare bill would do. It would offer security to

seniors who are without drug coverage. It would provide incentives to employers to encourage them to maintain the coverage they provide to their retirees. At the same time, the bill would create new Medicare options for seniors. It also would create incentives for private health plans to innovate and compete for the businesses of today's seniors and invigorate the Medicare Program for future generations.

Let's also be clear on what the bill won't do. It won't force seniors and the disabled to pay for a Medicare drug benefit if they don't want it. It won't encourage employers to drop drug coverage for their retirees. It won't force seniors and the disabled into HMOs.

I should also point out that the Medicare bill won't pay for every dollar of a senior's prescription drug costs. A drug benefit for needy seniors is important, but it is also important that we preserve Medicare for future generations. Already 30 percent of Medicare funding comes from the general government revenues. Projected expenditures are expected to exceed projected tax and premium revenues after 2015. I will be keeping a careful eye on Medicare spending, especially now that we have passed this drug benefit. If we are going to add anything new to Medicare beyond a basic and sensible drug benefit, we need to pay for it directly.

This drug benefit isn't free, but it is responsible. We set aside \$400 billion of the Federal budget over the next 10 years to pay for this benefit. That is how much the agreement is projected to cost. Actually, it comes in slightly under that. But last year when we were doing the appropriations, we set aside the \$400 billion. Some people say \$400 billion is not enough. They point out that seniors are expected to spend \$1.8 trillion on prescription drugs over the next 10 years.

Well, nothing in life is truly free, and prescription drugs will not be an exception. We need to remember that every new Federal program comes at a price. We need to be aware of just what that price is when we ask for a new program. It is not always the people receiving the benefit that are paying the benefit. The \$400 billion is the equivalent of \$1,600 from every taxpayer over that 10-year period. What would taxpayers say about the need for any program if we put it into that kind of a form for them? There would be increased concern just like there is increased concern when people have to pay their own costs of medical treatment.

That is how the competition comes into the market. I suppose we could have passed a \$1.8 trillion drug benefit. Of course, we would have had to raise taxes by \$1.4 trillion to do it. I cannot speak for the rest of my colleagues, but I just became a grandfather this year and I am not willing to put that kind of a tax burden on my grandson.

Even the critics of this agreement acknowledge that low-income seniors would be eligible for substantial sub-

sidies for their prescription drugs. Even the critics admit that seniors with catastrophic drug expenditures get measurable relief under this bill. There is a generous 95 percent coverage of a seniors' drug cost over \$5,000.

This bill also includes important protections for which I fought on the Senate floor this summer, which protect every senior's right to visit their community pharmacy and receive the high level of service they are accustomed to receiving from them. We have put a huge burden on our pharmacists in this country, the local ones that are right there to answer your questions face to face. There is a provision in the bill that will help to keep that local pharmacist in place and operating. It gives them an equal chance under the bill to be providing prescription drugs for seniors on Medicare. It is important that we keep those small businesses and pharmacists—local people that you can talk to—in place.

This bill doesn't cover every dollar of every prescription for every senior. But that is not a reasonable expectation. What this bill does is provide help and protection for the two groups that need it the most—those who can least afford prescription drugs, and those who otherwise would be bankrupted by a serious illness that requires expensive drug therapies. These are worthy objectives and this agreement accomplishes those goals.

I want to discuss a couple of other aspects of this agreement. First, the bipartisan Medicare agreement would establish health savings accounts, HSAs. These HSAs are tax advantaged savings accounts that all people could use to pay for medical expenses. This is a huge advancement in taking care of the uninsured. Health savings accounts would be open to everybody with a high deductible health insurance plan. The higher the deductible, the less the cost to the insurance plan. The higher the deductible, the more a person is allowed to put into a HSA. Employers would also be able to contribute to the employee's health savings account, and neither the employer's nor the employee's contribution would be taxable. Tax free, you can set up this account.

If you have an HSA, your total yearly contributions to it would be as large as your health insurance plan deductible. Just like an individual retirement account, the interest and investment earnings your health savings account would generate are not taxable. Furthermore, the money you take out of HSAs to pay for medical costs are not taxable, as long as the money is used to pay for health care expenses. Let's see, you don't pay taxes on it when you put it in, you don't pay taxes on the earnings, and you don't pay taxes when you take it out. It is a little incentive to put away money to cover deductibles, or anything to do with health care later on. I hope that every young person in this country will establish a health savings account. No matter what their income level is, no

matter how good their health is, it is an opportunity to put away money for when the health is not as good, and to take care of any deductibles that are necessary at any point in life with an insurance plan. It is an opportunity to be insured from the time you enter the job market, and to put a little away and perhaps have a lot for the years when 50 to 80 percent of the health care costs come up.

One of the best features of health savings accounts is they would be portable. That means that if you change jobs, the health savings account goes with you, you still have it. It is yours. Health savings accounts are a great innovation. Health savings accounts create a tax incentive for everybody—not just seniors—to save for health care expenses, plus it doesn't matter whether your employer offers health insurance or not; you can still save money in a health savings account and receive the tax benefit. This provides some tax fairness for those of you who don't have access to tax advantages of the employer-sponsored health insurance. Let me say that again. This provides some tax fairness to those who don't have access to the tax advantage of employer-sponsored health insurance. Employer-sponsored health insurance is tax free. It doesn't even show up on anything that you have to file. This would give the average person the same opportunity to have tax-free health coverage.

Health savings accounts are an idea whose time has come. Giving people more flexibility and responsibility in their health care spending will result in healthier and wiser consumers. I wholeheartedly support this part of the Medicare agreement. It is long overdue. It needs to be advertised. Young people of this country need to understand that that is their part of Medicare, that they can get into this now and it will save them costs later. It will be a part that will shore up the system.

I also want to speak to the provisions that would address a very sore subject on the frontier, the inequity in Medicare reimbursement between urban and rural areas. I am pleased that the conference agreement ensures reimbursement equity to doctors, hospitals, and other providers of health care in Wyoming and other rural States.

Right now, Medicare underpays rural hospitals, home health alleges, and other providers, as compared to urban counterparts. This limits the ability of these providers to maintain their services and their infrastructures and to recruit qualified personnel.

Some people do not understand the challenges that rural health care providers face in providing quality care to seniors and the disabled. For instance, I read a column in the Washington Post last Friday by a gentleman named Steven Pearlstein. I think it was supposed to be a semi-humorous column—I hope so—although it was in the business section. Well, to those of us in

rural areas, it wasn't even semi-humorous, and it wasn't accurate either. I suppose I could ask that this column be printed in the CONGRESSIONAL RECORD, but I would not want to waste the space. I will, however, cite a paragraph from the column in which this gentleman called politicians from rural States “nothing more than welfare queens in overalls.” At this point, I'll state that I still believe Senators ought to be able to bring laptops onto the floor. But I assure my colleagues I will not be petitioning them to wear overalls on the Senate floor.

Let me read one of the paragraphs that Mr. Pearlstein wrote:

Then there is Medicare bill, which was supposed to be about providing drug benefits to seniors, but wound up being yet another chance to whine about the plight of country doctors and hospitals. Although the cost to providing medical service is actually lower out there in God's country [the God's country is true] that hasn't stopped your guys from squeezing \$25 billion more from the Federal Treasury over the next decade to pad Medicare payments to rural providers.

I don't know if this gentleman has ever been to God's country or not. Maybe he has flown over God's country, Mr. President. I doubt he has ever visited the Niobrara Health and Life Center, a very small hospital in Lusk, WY. Lusk has a population of 1,500. Lusk is the county seat Niobrara County, population 2,500. That is Wyoming's least populated county. Incidentally, it is a little bigger than the State of Delaware. It has one person for every 524 acres of land.

The hospital in Lusk has been closed since May of 2000. Since then, folks in Niobrara have had to travel to Douglas and Torrington for surgery or other hospital care. Douglas and Torrington are in different directions from Lusk. They are both about 55 miles from Lusk. That is a long drive any time, but in winter—and we are having winter there now. I don't know if you saw pictures of the Bronco football game where they were scraping snow off of the field; but yesterday there was a blizzard in Colorado and in Wyoming, and the temperatures were about 16 degrees, and it gets a little tough to get around, if you can at all.

Fifty-five miles is a long drive in winter when the winds are howling and the snow blows across two-lane roads. That is an important hospital for the people of Niobrara County, and they are getting ready to reopen it. They are hoping to be able to afford it. It is also important for the State of Wyoming because there is a State prison for women in Lusk. The State tried to keep the hospital open in the 1990s, but the financial pressures were simply too great.

Hospitals across rural America are struggling, particularly the smallest hospitals, such as the one in Lusk. If it were really true that the “cost of providing medical service was actually lower out there in God's country” then why are the rural hospitals struggling to stay open?

Our Federal Government's own Medicare Payment Advisory Commission published a report in 2001 on Medicare in rural America. That report found that the Medicare “payment system does not recognize factors that have a greater effect on the cost of rural hospitals.” The study also found that there are aspects of Medicare's prospective payment system for inpatient hospital care that tend to work against rural hospitals.

Every hospital has to buy a certain amount of medical equipment from hospital beds to x-ray machines. If rural hospitals get a rural discount on this equipment, it is news to me. In fact, I think there are probably some quantity discounts on which they lose out.

Rural hospitals also have to hire nurses and technicians, just as urban hospitals. It is hard enough to recruit nurses because we have a nationwide shortage. Trying to recruit nurses to come to the Wyoming frontier is even harder. So our rural hospitals have to offer a competitive wage.

Most rural hospitals also have a low patient volume compared to their urban counterparts, and this contributes to a higher cost of rural hospital care. There is a certain amount of staff and everything that has to be on hand ready for patients if they show up.

As the Medicare Payment Advisory Commission rightly points out in its study, hospitals in small and isolated communities “cannot achieve the economies of scale and service scope of their larger counterparts and thus have higher per-case costs.” The current Medicare rates do not directly account for the relationship between cost and volume, potentially placing smaller providers at a financial disadvantage relative to the other facilities.

I am pleased to note that the Lusk hospital is scheduled to reopen in October 2004 after completing some important upgrades and renovations. I am confident the hospital will be able to survive this time because Congress passed a law in 1997 to allow for special payments to hospitals in rural areas that are too sparsely populated to support a full-service facility.

The Medicare conference agreement would increase payments over the 1997 law to critical access hospitals, such as the one in Lusk. Despite Mr. Pearlstein's criticisms, he ignored the fact that urban hospitals have higher Medicare margins than rural hospitals.

The additional support for rural health care providers in this bill will help close the gap between higher Medicare margins of urban hospitals and the lower Medicare margins of the rural hospitals. This additional help will not come a moment too soon for the people of Niobrara County, WY, and other counties in Wyoming and other counties throughout the United States. I hope Mr. Pearlstein will visit Lusk if he ever visits Wyoming. I have been there, and I can tell you that the Medicare payments he considers “padding” are critical to the hospital in

Lusk and to the seniors who depend on it.

It is a long drive to Lusk from Yellowstone National Park or skiing in Jackson Hole, but I think it would be quite educational for him or anyone else who makes the journey.

There are a lot of good aspects about this Medicare agreement. Adding a prescription drug benefit to the program is good. Providing seniors and the disabled with new Medicare options is good. Offering all Americans new ways to save money for their health care expenses is good. Providing fair Medicare payments to rural doctors and hospitals is good. Having health savings accounts is outstanding.

For these reasons, I am going to vote for this bipartisan Medicare agreement, and I am going to work in the future to ensure that Medicare continues to offer a reasonable drug benefit for many of America's seniors, but one that does not place a huge financial burden on future generations.

Earlier the majority leader, Senator FRIST from Tennessee, the only doctor in this body, gave an outstanding speech outlining the reasons that in a bipartisan way he and others have worked on this for 6 years to bring this to fruition. A person from the other side of the aisle who has worked on that for 6 years has been Senator BREAUX from Louisiana. They served on a special task force to come up with a way to make Medicare be solvent for generations to come. This will be the first significant piece of legislation to address what they have talked about for 6 years.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator from Wyoming has 4 minutes 15 seconds remaining.

Mr. ENZI. I thank the Chair.

Mr. President, in the Senator's remarks he did point out there have been a lot of health care advances. Science has played a great part in health from genetically engineered vaccines, to coronary angioplasties, to heart transplants, to the human genome project that is coming up with a lot of new medicines that will take care of us. That project, incidentally, came in 2 years ahead of time, in 2003, and has led to a massive increase in the number of projects that are being done to come up with new drugs that will help us.

This is the way Medicare has advanced. It is pretty inflexible. There has not been much advancement. We have an opportunity to correct that right now. We need to get the flexibility of Medicare to increase the same way that medical advances are increasing, and those are mostly in the area of prescription drugs. So it is time we added a prescription drug benefit.

The bill also takes care of some problems we have with Medicare. I mentioned this task force that Senator BREAUX and Senator FRIST were on. The task force recognized the problem that when Medicare got underway, there were 20.4 million people under Medicare. Today there are 40.8 million

people under Medicare. That is a doubling. By 2030, 77.6 million people will be under Medicare. That is another doubling. That is a huge increase in the number of people who will come under Medicare.

How is it paid for? It is paid for by people who are in the workforce, not the people who are retired—the people in the workforce.

In 1973, there were 7.3 people. That tenth of a person probably didn't feel too well. But 7.3 people were paying for every person under Medicare. In the year 2000, there were 3.9 people paying the bill for those in Medicare. By the year 2030, 2.4 people per person will be paying the bill for those on Medicare. These people have to pick up the costs of all of Medicare for those people. So it is important we have some cost containment, that we put in some reforms to make sure the system is available for those 77 million people in the year 2030.

Prescription drugs are the most important treatment factor now. They were not in 1965. We have come a long way on the issue of prescription drugs. This is where we are headed. These are the number of drugs in clinical development: Cancer, 402 different kinds in clinical development. The percentage of drugs that actually make it is very small. Is there a high cost to develop a drug? Yes. Diabetes, there are 30 different kinds of medicines; rheumatoid arthritis, 24; osteoporosis, 20; obesity, overweight, 29; depression 19; congestive heart failure, 18; Alzheimer's disease, 17; schizophrenia, 16; hypertension, 11; hyperlipidemia, 10; migraine headaches, 20, and so on.

There are a lot of drugs that are being worked on. That is a new treatment. That is a tool that has to be put in the hands of doctors.

Now, we have heard some comments, as well as different versions, about surprise that AARP has backed this bill. It is not a perfect bill. We never pass a perfect bill out of the Senate.

AARP has had some comments on it. I hope my colleagues all pay attention to them. AARP believes that millions of older Americans and their families will be helped by this legislation. AARP also endorses the Medicare bill. On November 17, they stated, "The integrity of Medicare will be protected."

These are the most significant reforms. It provides access to medical prescription drugs. It dramatically expands voluntary, private health plan choices. I hope my colleagues will look at the comments the leader made and read them in full.

I thank the President for the time, and I yield the floor.

The PRESIDING OFFICER. The Chair now recognizes the Senator from New Jersey.

Mr. CORZINE. Mr. President, I rise today to join this historical debate on health care for America's seniors. I also rise so that I can provide a perspective to the people of New Jersey on why I will regrettably be voting against this Medicare conference report.

I particularly find it unfortunate and disappointing because there are 300,000 seniors in New Jersey, out of about 1.2 million, who lack any prescription drug coverage. Those seniors make tough choices between medicine and other of life's expenses, as we have heard talked about in political debate for years.

I truly want to be a positive participant in assuring access to quality drug coverage at an affordable price for all of America's seniors. I think all of us do. That is why I voted affirmatively on a bipartisan Senate bill. I worked very closely with the senior Senator from Iowa to put together what I thought was an outstanding bill, one I would have been proud to support.

Those 300,000 seniors badly need and deserve affordable, quality coverage. But just as badly as they need it, we need to make sure their gain does not come at the expense of harming others. If the left-out seniors were the only ones impacted by this bill, I would vote for this plan we now are debating. I would vote for it because I thought it was going to provide access to those 300,000 folks and that would happen regardless of all the ideological or political arguments that have been made over the last several days.

Sadly, hundreds of thousands of other seniors in my State will be seriously and negatively impacted by this bill. The fact is, this plan harms more New Jersey seniors than it helps. I calculate that, at a minimum, 500,000 seniors will be harmed, breaking the first rule of medicine: "Do no harm."

The negative impact comes at a very high financial cost not only to my State but to the Nation at large. I believe the scarce resources we are using would be better used to make the limited and complex benefit more substantial and to reduce the harm to those who already have benefits that they will lose.

This Senator can only wonder in that context that we feel compelled to lavish \$14 billion of subsidies on HMOs and other insurers to provide them profit incentives to compete with traditional Medicare as opposed to improving the benefits to uninsured seniors who are constructively a part of this bill. We could close that so-called donut hole, that gap.

With all due respect to the Herculean efforts of those on both sides of the aisle who cobbled together this compromise—and I really do want to congratulate and thank those who worked so hard. Ranking Member BAUCUS, and Senator BREAUX, the senior Senator from Louisiana, as well as the senior Senator from Iowa, have done a great job of trying to get to a conclusion on which we could all agree. In my case, the cost/benefit for New Jersey seniors just does not work. It just flat out does not work.

My staff and I have done the numbers. We have worked very hard, to the

best of our ability, to really scrub down these numbers and to come up with a conclusion on whether this works for our folks. Considering we are in a mad dash to absorb and analyze this 1,100-page bill, I will bet there is not a single Senator who has read it. I could be wrong. Maybe there are one or two who just did not have anything to do in the last 24, 36, 48 hours, but I doubt if there is anyone who has read this. The result is that the only certainty about this bill is that in addition to its unintended consequences, even from the well-intended, it is certain to have unfortunate consequences for many American seniors, as well as all of us who might hope to be seniors one of these days.

So my reason for opposing this legislation is that this body should be thoughtful and careful when we are spending \$400 billion for a good cause, but we ought to make sure we are not doing more harm than good. That is objection 1. Objection 2 is if we do not plan to implement this bill in its broad form before 2006, I do not understand why we need to cram all of this analysis into 48 hours or 72 hours over a 3- or 4-day period.

Why before Thanksgiving? What is the hurry when we have a bill this complex, this big, and we only have 3 or 4 days to look at it? I think there are a lot of problems stuck right in here.

So let me repeat what I do know. For roughly \$4,000 of out-of-pocket payments, a senior will get \$5,000 worth of return, plus a catastrophic coverage for everything above \$5,000 of drug spending.

Let me repeat: A \$4,000 payment for \$5,000 worth of coverage will come with a complex concoction of HMOs, PPOs, PDPs, premiums, deductibles, copays, formularies, annual price increases, shifts of providers, and a bevy of choices that are more to the confusion of seniors than they are to the security of seniors. In fact, the complexity of navigating this proposal for an individual senior is almost enough of a reason for me to vote no on the bill to start with.

I have stood in all kinds of townhall meetings with seniors just trying to explain the simple first steps of this bill. I think we are going to be creating a tremendous industry of opportunity out there informing seniors about what is going to be borne from this 1,100 pages, 1,200 pages of work. Somebody is going to have to tell folks how they get through this.

That said, this bill does provide favorable relief to doctors, as I have heard some talk about, serving Medicare patients. It gives some needed aid to hospitals, particularly America's rural hospitals, as the Senator from Wyoming adequately presented. Of course, in a thousand pages plus, there have to be some good things, and there are. We are spending \$400 billion.

A few of the benefits I have talked about are good but, in my view, they

come at too high a price, and that is before one weighs in on the serious push in this bill to get Medicare on a pathway to privatization and the dismantling of the social safety net and coverage of our seniors' health which has been so fundamental to the success of moving so many of our seniors out of poverty into longer, healthier lives.

While this bill fundamentally being debated is in the context of prescription drugs in general, spending \$400 billion, one would think that might have some positive implications for the broader health care system. To that end, I believe this bill falls far short of the mark. Once again, at least from my perspective, it does more harm than good.

Cost containment through Medicare negotiating the cost of drugs with the drug industry could have led to lower prices for everybody in America. You have unbelievably strong buying power out of Medicare—if they were negotiating those prices. We are talking about reimportation? We could do a heck of a lot better if we just had Medicare go out and negotiate those prices. That would help all Americans: Children, generation Xers, juniors, seniors, corporate America. That is not happening.

Other missed opportunities? Cost containment is omitted in this bill. The only containment of costs that I see falls on the shoulders of beneficiaries with escalating copays and premium hikes.

Equally troubling, reforming reimbursement rates for cancer treatment by doctors would have strengthened Medicare, as opposed to limiting oncological drug payments that undermines cancer care. For my State, this is really a troubling and unacceptable aspect. The fact is, we have the third highest incidence of cancer in our State. I think we are putting at risk the treatment of that not only for our seniors but for the whole of the community.

Egregiously—and this is where I strongly disagree with those who would make this case—the diversion of \$6 billion into these health savings accounts in this bill I think is a big mistake. It encourages the healthy and the wealthy out of the employer-based health care system, leaving the older and sicker and more poor in the system that remains or until employers drop coverage altogether. Frankly, I think this appears to be a handout to insurers. Several credible studies, including the Rand Corporation's, suggest a major reduction in employer health care coverage will follow as the likely outcome of this tax cut proposal because of adverse selection.

I don't understand this. This doesn't seem to be relevant to the purpose we are about in a \$400 billion prescription drug benefit for seniors. Once again, I think this legislation in this area does more harm than good. It certainly does with respect to the U.S. Treasury because I think it has the capacity to go

well beyond the \$6 billion in cost over a period of time, particularly as it is more of a savings program than it is one that is going to help on health care.

That is the big picture for me. As you can tell, I don't think it is so good. But let me now illustrate the specifics, at least as I see them, in a cost-benefit analysis for New Jersey's seniors because that is what I care about. It is clear to me this is the analysis that is the most important from my perspective. It is the primary driver for how I came to my conclusion with respect to this bill.

This is not about insurers and HMOs. It is not about what the Democratic caucus would argue. It is not about what political scorekeepers think. It is not even about the pharmaceutical industry, which, by the way, in our country is most heavily concentrated in my State. It generates about 65,000 jobs and produces about \$30 billion worth of business and revenues. It is really important to our State. But simply my analysis is about New Jersey's seniors and their role and participation in this program across this Nation. On that basis, I would like to talk about some of what we see.

First of all, I think from all of the independent analyses we see, approximately 94,000 New Jersey retirees will lose their employer-based prescription drug benefits. There are estimates of 2.1 to 2.7, whether it is CBO or some private estimates. The middle of the range number for New Jersey is about 94,000.

We have, in New Jersey, a substantial number of seniors, what people call dual eligible, who would receive this wraparound of their Medicaid benefits, various low-income folks, 152,000 of those who receive their benefits through Medicaid and, as we all know, will be paying copays and potentially have an accelerated rise in health costs. They certainly will be on formularies that may limit their choices of drugs. Those 152,000 seniors I think will find this difficult.

We also have 220,000 seniors who are currently enrolled in our State pharmaceutical plan. I first want to congratulate the conferees because they did provide for a wrap here around State programs. It is going to be cumbersome and anything but seamless to move from the program that has been in place for 25 years, created by a bipartisan set of Governors and legislators over that period of time, that have provided the State program. We are going to have to change it. We are going to have to have our seniors go into private programs, and then the State is going to have to fill in those gaps, to be able to make sure that our low-income seniors, who have terrific programs, probably the best in the country, are able to maintain the same coverage.

As I say, I think the facilitating language with regard to financial obligations has been very good. I am very

grateful for the work of the conferees with regard to this estimate. But the seamless element, the quality of coverage with regard to this element, this particular program, is going to be very hard to implement. Each of these seniors, the lowest income seniors in our State, is going to end up being faced with formularies and be experiencing changes each year with regard to who has maximum coverage, and it will be a major impact on how they look at it. Plus they are going to end up potentially paying copays and premiums that are slightly more than what they have in current benefits. So there is another 220,000.

Finally, there are about 52,000 seniors in New Jersey's program who pay more for Part 3 premiums due to the premium test—the means testing—that is coming out. Some can argue means testing is good. That is said where you have already very high income seniors.

Now \$80,000 in New Jersey, which is where this means testing begins, is not exactly superrich. We happen to have the most wealthy average population in the country. We also have the most expensive cost of living of any place in the country. We pay more in taxes; we send more to Washington than any place else in the country. This means testing, which is going to affect about 52,000 of our seniors, is not going to Bill Gates-like folks or Warren Buffett; it is going to middle class New Jerseyans and I think is going to have a lot more bite. I would have liked to have seen it set higher. It was cut back. I frankly wonder if this is going to be good for the overall Medicare Program because we are ultimately going to start pulling out a lot of these high-income seniors. As people know, Part B is voluntary, and we could end up again providing another adverse selection element to the overall underlying traditional Medicare Program.

We will come back to some other perspectives with regard to New Jersey. But by my calculations, it is 94,000 retirees with employer-based coverage. They are going to lose that coverage, at least that quality coverage relative to what they will get in a new prescription drug program in Medicare. There are 152,000 dual eligibles who will end up with payments that are different than what they would have had under the old program; 220,000 of our State beneficiaries will end up with a lower quality, less seamless program than what they have today, and 40,000—I talked about this earlier in my remarks—40,000 diagnosed with cancer every year are going to have a much harder time getting drug treatments that they previously had. It is going to cost about \$50 million to the State over the 10-year period in payments with respect to these drugs. Those folks are going to be impacted.

Then there are the 52,000 subject to means testing. That is 558,000. I am not going to be so certain there are not some overlaps here, but we are talking in the neighborhood of about 500,000

folks who are going to be hurt. There are now only 300,000 New Jerseyans who are without drug coverage. I think that speaks for itself. There is a tough tally when you look at those who are harmed and those who are benefitted. That, to me, is an important consideration.

That is an important consideration. Those are not the only considerations. With regard to New Jersey, we have certainly one that already meets the Medicare privatization approach that falls under the premium support program demonstration projects. Actually, it looks as if there will probably be two. I don't think our seniors are going to say they want that in their backyard. They like prescription drugs, but they also like traditional Medicare.

I think it is hard for me to go back to them and argue when they have had a chance—by the way, we have seen a lot of people dropping out of Medicare+Plus Choice because they haven't felt like the program is good. Plus a number of insurers dropped people who signed up for it. They thought it was going to be a good deal and it didn't turn out to be so. That is another one that a lot of folks talked about. There are approximately 1 million New Jersey Medicare beneficiaries who are going to see their Part B deductible rise at a faster rate than their Social Security benefit.

Some people will say that is not a part of this bill, that it is something else. But the fact is, we are building an escalator on Part B. It doesn't compare with what I think is going on with Social Security. At least when I go to townhall meetings, that is a real problem for me to try to deal with and explain to folks. That is the challenge.

Roughly 100,000 seniors will be negatively impacted and a lot of others will feel as if they were somehow not properly protected in it. Again, 300,000 don't now have drug coverage.

That system doesn't work. It is arithmetic. It is very straightforward. It seems to me that there is more harm than benefits. For me, the case is closed.

It would be remiss of me not to say that I have another objection that I believe is built into this package. If I could convince myself that New Jersey seniors were going to be benefitted, I would come around on this issue. But I think this package puts America on a pathway to privatization of Medicare. I suggest that is not the right direction. I think we ought to be enhancing and extending the traditional Medicare Program and have a prescription drug benefit. We ought to be using that \$12 billion to \$14 billion that is going to benefit the managed care industry and the insurance industry to cover up one of those donut holes that we are talking about. We ought to be putting that money to work to enhance traditional Medicare.

While others have spoken eloquently and extensively, maybe even politi-

cally about this, I think it is a very serious consideration for those of us who believe that traditional Medicare should be enhanced.

I looked at three steps that will put it on that pathway.

Fourteen-billion dollars in subsidies and protection against skyrocketing health care costs provided to health insurers in this bill doesn't seem to me to be the right place to put us into a comparative cost-benefit analysis with the private providers who I think have many incentives to cherry-pick the healthiest, the wealthiest, and the most able versus what is going to be left in the traditional Medicare program, which raises costs. I think that is step 1.

Step No. 2, this series of demonstration projects which is hardly a level playing field by comparison—and I think it is actually going to be difficult for us to make a real assessment if it—I have heard actually limits this program under 600,000 folks. I think it is also possible that it will be cherry-picked in the areas as opposed to the difficulty of looking at the wide diversity of populations that we have in the country. I am particularly troubled when I look at what I see with regard to what fits into New Jersey with regard to this program. It could be very difficult.

Then the third step is this 45-percent trigger on general fund expenditures that will cause an overall review of traditional Medicare when the breach occurs. I think all of us realize with the changing demographics and the baby boomers going into retirement, and with 40 million seniors growing to 75 million or 77 million seniors over the next 10 to 15 years, we are going to have that happen. I think that is going to lead to pretty hard choices without the kind of triggers we have here.

I think that it is just one more step, one more nail in the box that is trying to change us and move us away from traditional Government-supported and underwritten Medicare to privatization. In my view, after an inadequate analysis of this 1,100-page bill, I really think that may be the most troubling piece.

I think it is very difficult to be certain about any of the conclusions that any of us are drawing with regard to this bill. The one thing that I do know for certain as it shows up both in the marketplace and in the phone calls that we are receiving is that there are great benefits for the insurance industry and the pharmaceutical industry built into this.

By the way, as I said, the pharmaceutical industry is right smack dab in the middle of my State. I like to see them do well. I like to see them press forward in their research. But I don't think that should come at the serious expense of many of America's seniors. I can say, at least based on what I understand by my analysis, that is not the case with regard to New Jersey seniors.

Frankly, I just do not understand this mad dash to get this done before

Thanksgiving. It obviously must reflect some other agenda than what seems sensible. I think we ought to slow down. We ought to be careful. We ought to be thoughtful. I know there are a lot of people who have spent a lot of time. We have heard about the 6 years of debate and discussion. But to come to a conclusion where we have to make a decision about something that is extraordinarily important to the lives of the people across this country—not only to our seniors but to the families, and the impact it has on the markets that we deal with with regard to prescription drugs—investing \$400 billion is a very important issue. It ought to help our seniors as much as possible. It is a good thing. I think all of us want to be supportive. We should do our best with what we have to invest in this project. You have to think about it in the context of a very limited amount relative to how much seniors are going to spend over the next decade. I hear estimates that it may be as much as \$1.8 trillion. What we are talking about here is about 20 percent of that.

We have to make tough choices. I appreciate the difficulty with which the Senator from Iowa had to work his way through these difficult areas. I think he made a lot of good choices, but there are some in here that are very difficult. I think we ought to be wise and reflect on this 1,100-page report.

I am convinced we can do better, at least in the cost-benefit analysis that I put together for my State.

As a consequence, I have to oppose this report. I hope we can slow it down and make some revisions and bring it to a positive conclusion which is not ideological and which is not political; that is, believing we are searching for the best interests of all of our seniors in America.

I yield the floor.

The PRESIDING OFFICER (Mr. ENZI). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, before the Senator from New Jersey leaves, I want to speak about a couple of words which he mentioned. And I don't say it to take exception with what he said or to quibble with his description of the legislation before us. But if the President of the United States saw Senator GRASSLEY speaking right after some words that the Senator from New Jersey used about legislation, the President would be offended because I found fault with the President using those very same words back on December 10 last year when I had my first meeting with the President on the Medicare issue.

The words that the Senator from New Jersey used about the legislation before the Senate is that it is cobbled up. As everyone in this body knows, for about a year and a half I worked with five Members of this body on what was then called the tripartisan plan. The President started his lecture to me last December, something along this line: We have to have a dramatic change of

Medicare. We have to provide prescription drugs for the seniors. We have to change Medicare for the future. He says: We do not want something like that cobbled-up tripartisan plan.

Obviously, the President cannot know everything that goes on in the Congress of the United States about forming legislation, but if he knew the hours and hours, not only at the staff level but at the Member level, that went into the tripartisan plan that we unfolded here a year ago in July, the President would not use the words "cobbled up." I never heard the President use the words "cobble up" after that because I tried to impress upon him there was a great deal of thought, a great deal of hard work, and most importantly, time, plus bill compromise that the word "tripartisan" implies to bring together where we were at that time.

If he had appreciated it, he would see we have to have the same sort of thought and hard work go into what he was thinking about. I never heard him say that again. I am reminded of that story now that the Senator from New Jersey said this legislation is cobbled together.

To some extent, I suppose every political compromise, for every piece of legislation, one could use those words to describe it. I know the Senator from New Jersey participates in a lot of very difficult legislation in the committees he serves on and knows what it takes to put a bill together. However, I look at this piece of legislation, the compromise it takes, the hard work it takes, all the long hours it takes, as not a perfect piece of legislation but surely not a cobbled-together piece of legislation.

From that point of view I will respond not to the Senator from New Jersey any further but to speak about some of the aspects of this legislation as we get ready to vote on it tomorrow.

Mr. CORZINE. Will the Senator from Iowa yield for just a question and a comment?

Mr. GRASSLEY. I would be glad to yield for a short question or short comment and reserve my right to the floor.

Mr. CORZINE. I appreciate the comment with regard to cobbling. It is great to be put in the same company of criticism with regard to the use of the term. I do not want to leave the impression that I don't think there was great thought and effort in putting together this extraordinary piece of legislation. It is actually a tremendous tribute to the Senator from Iowa for the ability to put together all the various interests in common and come up with something that is pretty doggone close for all Members to be able to consider.

My concern is that it is very hard to know from this Senator's point of view all the details. I wish I could say I was absolutely certain that I had analyzed this exactly the right way for those seniors in my State. But this is an incredibly complex issue, not only for the

seniors themselves to be facing but also for those who are trying to decide how we are investing \$400 billion.

I congratulate the Senator for his efforts. Unfortunately, as I look at it, I come out with a different perspective, but I don't think it is for lack of good intentions, hard work, and great compromise on the Senator's part.

Mr. GRASSLEY. I surely appreciate the good nature in which the Senator from New Jersey just stated his feelings about this legislation. I wanted to give equal treatment to the President, as I did the Senator from New Jersey and vice versa.

One of the aspects of this legislation that is misunderstood is the issue of health savings accounts, which is a new name for what people hear Congressmen talk about as medical savings accounts, only different in name, particularly, as it relates to people in my State, the benefit to farmers and small business people.

This bipartisan agreement includes these provisions establishing health savings accounts. I will refer to them as HSAs.

HSAs are tax-advantaged savings accounts that can be used to pay for medical expenses incurred by individuals, their spouse, or dependents. HSAs are similar to medical savings accounts. However, medical savings account eligibility has been restricted to employees of small businesses and the self-employed. HSAs are open to everyone with a high deductible health insurance plan. The only limitation on the health plan is that the annual deductible must be at least \$1,000 for individual coverage, and \$2,000 for family coverage. Contributions to the HSA by an employer are not included in the individual's taxable income. Contributions to an individual are tax deductible.

Total yearly contributions to an HSA can be as large as the individual's health insurance plan deductible, between \$1,000 and \$5,000 for self-coverage, and \$2,000 and \$10,000 for family coverage.

The interest in investment earnings generated by this account is also not taxable while in the health savings account. Amounts distributed are not taxable as long as they are used to pay for qualified medical expenses such as prescriptions, over-the-counter drugs, and long-term care services, as well as the purchase of continued health care coverage for the unemployed individual. That is legislation we passed a long time ago called COBRA.

Amounts distributed which are not used to pay for qualified medical expenses will be taxable, plus an additional 10-percent tax being applied in order to prevent the use of HSAs for nonmedical purposes. These accounts are portable, so an individual is not dependent on a particular employer to enjoy the advantages of having an HSA, low-income individual retirement account. The HSA is owned by the individual, not by the employer, and if the

individual changes jobs, the HSA goes with the individual.

In addition, individuals over age 55 may contribute extra contributions to their accounts and still enjoy the same tax advantage.

In 2004, an additional \$500 can be added to the HSA. By the year 2009, an additional \$1,000 can be added to the HSA.

In regard to this legislation before the Senate beyond the health savings accounts, I point out what a great prescription drug benefit structure we have. First and foremost, it is important to point out that this is a voluntary program. If you currently have drug coverage and you like it, you can keep it or, if you do not have drug coverage and do not want it, you do not have to take it. If you are covered by Medicare fee for service today, and you are satisfied with it, you can stay right where you are.

This drug benefit also offered through Medicare will be a comprehensive benefit that will provide real relief for our seniors. Seniors that now pay full retail price could see a 25-percent reduction in their prescription spending. Additionally, these seniors' overall out-of-pocket drug spending could fall by as much as 77 percent. This is real relief for real people, not some hypothetical.

To provide relief to all seniors, the drug benefit is based upon income level. It is quite simple. Those who need more help because they are low income will receive more help under this program.

We divide this up according to the levels of poverty under the official poverty indexes of the Federal Government.

For those individuals and couples who are above 150 percent of the Federal poverty level, they can expect to see a monthly premium of \$35, an annual deductible amounting to \$250, a 75-25 percent cost-sharing up to a payment of \$2,250, and a true out-of-pocket catastrophic cap at \$3,600.

Additional benefits, including help with both the premium and initial cost-sharing, are targeted to seniors with income levels below 150 percent of the Federal poverty level. These subsidies will be available at increasing levels for those between 135 and 150 percent of the poverty index, and those between 100 and 135 percent. And then there is still another category of greater help for those below 100 percent of poverty.

I will explain how this differs for each of these categories. First, for individuals who are 135 to 150 percent of poverty, this group would have a \$50 deductible, sliding-scale premium assistance, and 15 percent cost-sharing up to the benefit limit of \$2,250, and \$2 or \$5 cost-sharing above the catastrophic level—\$2 meaning for generic, \$5 for brand-name drugs.

For individuals who are below 135 percent of the poverty index, they would have no deductibles, no pre-

miums, \$2 and \$5 cost-sharing up to the catastrophic limit, and no cost-sharing after the catastrophic level has been reached.

Now, we go to the neediest of our seniors, the dual eligibles, those who are presently low income and getting help not only from Medicare but from the State Medicaid Program. They currently have their drug costs paid for by the Medicare Program that differs a little bit from State to State based upon the laws of those States.

Our conference report calls for Medicare to pick up the cost of their prescription drugs. Most of this population will have a \$1 and \$3 cost-sharing up to the cost-sharing limit, and then, after that, no cost-sharing on the catastrophic. Now, that \$1 and \$3, again, is generic for the \$1, and \$3 for the brand-name drugs.

By providing coverage to all seniors based on income levels, you can see that the number of individuals with no prescription drug coverage will fall from 24 percent in the year 2002 to 2 percent in the year 2009.

Now let's make it clear. About over half of individuals today have some prescription drug coverage—some very good, some not so good—and then 25 percent, maybe 30 percent have nothing. Now, we expect this to go down under this program to just 2 percent of our population, after 3 years of phase in.

Mr. President, 98 percent of the seniors receiving prescription drug coverage in 2009 will receive it from privately insured plans. Moreover, 33 percent of the beneficiaries will get their prescription drug coverage from integrated private plans, three times the rate in 2002.

Additionally, seniors will see immediate benefits with discount drug cards. These are going to be available in the middle of next year, and through all of the year 2005. Then, after the year 2005, the new program, in its entirety, kicks in. So the discount drug card is for an interim period of time while it takes the Department of HHS a period of time to set up what we are going to pass tomorrow. These discount drug cards will pass on between 15 and 25 percent of savings on seniors' current drug prices.

It is clear to see that the conference agreement has come a long way since we passed this bill in this body the first time in June. Many of my colleagues wanted a lower deductible. We have a lower deductible. Other colleagues were more concerned with getting the dual eligibles' drug costs out of the Medicaid Program and covering everybody by Medicare. We have done that as well.

So this is a good, solid drug benefit that will provide real relief to all seniors. Not only is this a good bill, with a good benefit, this bill provides an incentive for employers not to drop their retiree coverage.

Because there has been so much misinformation about corporations drop-

ping employees, and since we have gone to such great strides in the conference report to overcome that problem and reduce that possibility, I want to spend some time on that and make clear that what we did in this respect—I think it is fair for me to say that the conference report, the compromise between the House bill and the Senate bill, is very much better than either the Senate bill, when it passed in June, or the House bill, when it passed the other body in June. So I would make these comments about whether or not employers are going to drop coverage of their retirees.

Now, we have heard a lot from opponents of this historic bipartisan effort alleging that this bill will cause employers to drop their retiree health coverage. But one thing these opponents do not do is tell the people the whole story.

So as Paul Harvey says, the rest of the story and the reality is that employers have been dropping retiree coverage for years.

As you can see from this chart, there has been a gradual decline in the number of corporations providing coverage for their retirees. Since 1991, the number of larger employers offering health coverage to their retirees has dropped by nearly 20 percent, from 80 percent down to 61 percent.

This chart shows what we have been seeing in our States and hearing from our constituents. So employers have been dropping coverage for their retirees, and this has already been going on for more than a decade.

We know these days employers are finding it harder and harder to continue voluntarily providing health insurance coverage for their retirees.

That is why we in the Medicare conference worked diligently—put resources behind it—to help employers continue providing coverage for retirees, not just to be nice to the retirees but to be nice to the taxpayers because it is a heck of a lot cheaper to keep these retirees in their corporate plans than have them go on our plan.

That is our goal. Let me make it very clear; we have done a very good job of accomplishing that goal.

So let me tell you the three important ways we have done it.

First, the bill provides a 28-percent subsidy for the prescription drug costs for retirees so they will continue providing this coverage. That is about \$750 per retiree, but that is just on average because every corporation has a different plan.

Second, we exclude this retiree subsidy from the Federal corporate tax. This dramatically increases the value of this subsidy for retiree coverage and helps the employer continue offering this coverage.

Third, the bill provides additional flexibility for employers to structure plans that complement Medicare's new drug benefit.

Overall, the conferees agreed to put \$89 billion in this bill to protect retiree health coverage.

This funding makes it more likely—obviously not less likely—that employers will continue their retiree benefits. I think I ought to emphasize what \$89 billion happens to be. That is 20 percent of all the money we are putting in this bill for prescription drugs for seniors. Now the Congressional Budget Office estimates that 17 percent of the retirees will not receive supplemental drug coverage from their employers beyond what is offered by Medicare in this bill. We have a different estimate from the Employee Benefits Research Institute that is outside of our government. It is a nationally respected organization that studies retiree benefits. They estimate that that number is going to be much smaller: 2 to 9 percent of the retirees might not receive supplemental coverage from their employer in the future if Congress passes the Medicare benefit.

According to the Employee Benefits Research Institute, if Congress creates a Medicare drug benefit of any kind, some employers will want their retirees to take advantage of that new benefit. This is an important part of the rest of the story. The only way to prevent employers from putting their retirees in the Medicare drug program is if we don't pass legislation such as this, if we say we don't give a darn about the 25 to 30 percent of the people who don't now have prescription drugs and we don't care if they ever have it. That is not the attitude of Congress. That is why this legislation is before us, because we do care about people who can't afford or don't have available a plan for prescription drugs.

For those people, particularly on this side of the aisle, who have been complaining about not doing enough or that passing this bill might cause some corporations to change their health benefits and prescription drugs for their seniors, do they think we should do nothing? No, they don't think so. They are crying because we aren't doing enough. I tell you honestly, we could put \$400 billion, all of this bill, into just those 30 percent of the people in this country who retire from corporations that have a pretty good prescription drug program, probably better than most people have, and I couldn't guarantee anybody in this country that some corporation, big or little, wouldn't dump their programs, just dump them, as they have been doing for 20 years.

Let me be clear, these retirees will not be left without drug coverage. Retirees are not going to lose drug coverage. Why? Because of this bipartisan bill before us. These retirees will still be better off than today, because today when their employer drops coverage, they are left with nothing—no coverage whatsoever. Because of this bill, these retirees will be getting drug coverage from Medicare, and their former employer will likely pay the monthly premium for them. They will still be better off than they would be today where there is no Medicare drug benefit to back them up.

It is also important to recognize that keeping employers in the game lowers the Federal cost of the drug benefit. That is why we are concerned about the taxpayer as well as the corporate retiree. Obviously, if it is dumped, it is going to cost the plan more than if they stay on the corporate plan. So providing this 28 percent subsidy actually lowers the cost of the Medicare benefit. This generous 28 percent subsidy for retiree coverage is good policy. And because it is good policy, it is good politics. This bipartisan bill protects retiree benefits. That has been our goal, and we have accomplished it.

Mr. GRASSLEY. Mr. President, Medicare contractor reform will not succeed if contractors are subject to unlimited civil liability in carrying out the payments, provider services, and beneficiary services functions expected of them. The conference agreement would therefore continue the past policy of limiting the liability of certifying and disbursing officers, and the Medicare administrative contractors for whom those officers serve, with respect to certain payments.

In addition, the language contained in section 911 of the conference agreement clarifies that Medicare administrative contractors are not liable for inadvertent billing errors but, as in the past, are liable for all damages resulting from reckless disregard or intent to defraud the United States. Importantly, the reckless disregard standard is the same as the standard the standard under the False Claims Act. This standard balances the practical need to shelter Medicare administrative contractors from frivolous civil litigation by disgruntled providers or beneficiaries with the Medicare program's interest in protecting itself from contractor fraud.

The False Claims Act, 31 U.S.C. §§3729–3733, applies to Medicare fiscal intermediaries and carriers under current law. This legislation makes it clear that the False Claims Act continues, as in the past, to remain available as a remedy for fraud against Medicare by certifying officers, disbursing officers, and Medicare administrative contractors alike and that, among other things, the remedy subjects Medicare contractors to administrative, as well as trust fund, damages.

ORDERS FOR MONDAY, NOVEMBER 24, 2003

Mr. GRASSLEY. Mr. President, for the leader, I would like to give what is referred to daily as the closing script, if I may.

I ask unanimous consent that when the Senate completes its business today, it adjourn until 9 a.m., Monday, November 24. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of 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 consider-

ation of the conference report to accompany H.R. 1, the Medicare modernization bill, provided that the time until 12:30 p.m. be equally divided between the chairman of the Finance Committee or his designee and the minority leader or his designee. I further ask unanimous consent that the cloture vote on the conference report begin at 12:30 p.m. Finally, I ask that the last 10 minutes prior to the vote be allocated to the Democratic leader for 5 minutes, to be followed by the majority leader for 5 minutes.

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

PROGRAM

Mr. GRASSLEY. Mr. President, tomorrow morning we will resume debate on the Medicare modernization conference report. Under the previous order, there will be approximately 3½ hours of debate prior to the cloture vote on the conference report which is locked in to occur at 12:30 p.m. The cloture vote on the conference report will be the first vote of the day. It is my hope and expectation that cloture will be successful. This issue deserves an up-or-down vote. I urge my colleagues on the other side of the aisle to allow this process to move forward.

MORNING BUSINESS

THE FLORIDA CITRUS INDUSTRY

Mr. NELSON of Florida. Mr. President, this week, leaders from thirty-four countries around the Western Hemisphere gathered in Miami for the Free Trade Area of the Americas (FTAA) Ministerial and Americas Business Forum for the purposes of expanding free trade within the Western Hemisphere.

The negotiations at this and future Ministerial meetings will greatly impact my State of Florida.

This event drew large headlines in the papers across the hemisphere as leaders converged upon Miami and anti-globalization protesters gathered outside to voice opposition. In this context, I feel it appropriate to commend Miami-Dade County, the City of Miami, and all the local and Federal law enforcement officers who helped keep the peace during a tense week of negotiations, and everyone who made it a success.

But in light of these talks, I want to share my own concerns regarding the FTAA negotiations, and the path ahead.

These talks did generate positive movement forward, towards greater economic integration in the hemisphere. Trade Ministers agreed to a baseline of minimum standards for a full and comprehensive agreement that takes into account differing levels of development among nations. This framework is a step forward that gives nations flexibility.

A carefully negotiated Free Trade Area of the Americas could generate new economic opportunities for Florida, our country, and the entire Western Hemisphere.

Yet, the FTAA poses opportunities and challenges for Florida as we work to make Miami the premier U.S. candidate city for the location of the permanent FTAA Secretariat, while at the same time protecting the viability of a key part of our way of life in Florida—the domestic citrus industry.

We must be cautious about the scope of the final FTAA and consider how it affects our domestic industries. I urge U.S. negotiators to take some important concerns into account as an agreement is shaped in the months ahead. The different parties, alliances, and groups involved in the negotiations have gone back and forth on which goods and products to include in a final agreement, and the flexibility provided for in the final Miami Declaration reflects this fact.

Citrus is one product that must not be included in these negotiations. I again call upon the Administration, as I have done in the past, to give citrus special consideration; given the unique nature of the citrus fruit and juice trade.

The administration should state unambiguously that it will not agree to any reduction of the current tariff on imported orange juice in the context of the FTAA or any other trade negotiation, until Brazil ceases its monopolistic, anticompetitive trade practices. Let me explain why this is so important to the State of Florida.

This tariff is a lifeline for Florida's citrus industry and the State's economy because it helps to promote competition—and it enables us to compete in the global marketplace.

It is very clear that any reduction in the tariff would destroy Florida's citrus industry and devastate the State's economy. The citrus industry is the State's second largest, contributing over \$9 billion to our economy. And the citrus industry accounts for nearly 90,000 direct and indirect jobs throughout Florida and the country.

A collapse of this industry would not only cost tens of thousands of jobs, it would also cost the State and county governments of Florida up to \$1 billion in lost tax revenues.

This would mean less money for other vital public services, such as police and firefighters.

This spring, I arranged for Andrew LaVigne, Executive Vice President and CEO of Florida Citrus Mutual to testify before the Senate Foreign Relations Committee and share these arguments, for the benefit of my colleagues in the U.S. Senate so that they could be made a permanent part of the record, because they are so strong.

Orange juice consumption is concentrated chiefly in two places: the United States and the European Union. Unlike other agricultural products, production is also limited chiefly to

two places: the United States and Brazil. Florida's growers provide the vast majority of U.S. citrus that is used for orange juice.

Florida's citrus industry is efficient, competitive, and environmentally responsible; it is also one of only a handful of U.S. agricultural commodities that receives no federal or state subsidies. Let me say it another way: American taxpayers do not subsidize the citrus industry, unlike many other sectors that reaped benefits in last year's farm bill.

Florida's citrus industry is composed of 12,000 growers, many of them small family-owned operations, in addition to the many tens of thousands of others around the state and country who contribute to this \$9 billion industry. But, this is more than just an economic engine to Florida. It is an American way of life.

Brazil's citrus industry, in contrast, is dominated by four large producers who form large export cartels to maximize their advantage and squeeze small producers. The industry also benefits from advantages brought by years of past subsidization and dumping, lax environmental laws, weak and largely unenforced labor laws, and price manipulation. And, Brazilian orange juice already has access to U.S. markets. Their government's pronouncements to the contrary are counterproductive to advancing greater hemispheric economic cooperation.

Brazil's citrus industry also continues to rely heavily on child labor and the low wages associated with using children.

In Florida, we do not allow children to work in our orange groves.

Until Brazil wholeheartedly enforces its labor laws, putting an end to child labor and paying workers a decent living wage, there will not be a level playing field for competition.

Florida's citrus industry can compete with Brazil, or anyone else, as long as there is a fair playing field. WTO negotiations should deal with these problems. But in the meantime, the tariff on frozen concentrated orange juice imports acts to balance the anti-competitive practices of Brazil. It also acts to prevent the large Brazilian producers from overwhelming the U.S. market and driving Florida's 12,000 growers out of business.

During the Trade Promotion Authority debate in 2001, Senator GRAHAM and I offered an amendment that would have prevented tariffs from being reduced on commodities imported from other countries in violation of trade laws, such as Brazilian orange juice.

Although this amendment was defeated, we were successful in including language that required the Administration to study and report to the Congress on the economic effects that a tariff removal would have on import-sensitive commodities like frozen concentrated orange juice and citrus. I look forward to reviewing the results of these studies as the debate progresses.

Without this tariff, the Florida citrus industry could collapse, and Brazil would have a monopoly over the global market. Already, Brazil produces 53 percent of the world's orange juice and has a virtual monopoly over the European market.

Removal of this tariff would not enhance free trade—it would, rather, give Brazil a total world monopoly and make that country the world's dominant citrus and citrus juice producer and enable them to control market supply, access and prices with no competition.

This would not only devastate Florida's citrus industry, it would also be bad for all consumers. Absent competition from Florida's growers, the large Brazilian cartels would have all consumers at their mercy.

I have worked to bring these issues to the attention of the Administration and to ensure that one of Florida's primary industries is not traded away at the negotiating table, and I will continue to do so. In fact, I plan to travel to Brazil in the coming weeks and have asked to meet with President Lula da Silva so that I can carry the message of the Florida citrus growers: free trade can only benefit American consumers if it offers free and fair competition and is not monopolistic—so Brazil must reform its monopolistic citrus industry.

It is past time for this administration to acknowledge the inequalities between the U.S. and Brazilian citrus industries, and recognizing these inequalities, to treat citrus accordingly.

I would like to conclude by again urging the administration not to agree to any reduction of the current tariff on imported orange juice, because if they do, an American industry and American consumers will pay a steep price. These issues are too important to the people of Florida to be ignored, and we will all be watching closely in the months ahead.

I ask unanimous consent to have printed in the record conclusions in the testimony from Executive Vice President and CEO of Florida Citrus Mutual, from a hearing before the House Agriculture Committee on June 18, 2003, and Squire Smith, President of Florida Citrus Mutual, before the House Agriculture Committee, Subcommittee on Livestock and Horticulture on November 5, 2003, and an Op-Ed that appeared in the Miami Herald on November 19, 2003.

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

CONCLUSION

The U.S. market is by far the most significant market we have. Unlike dairy and crop commodities, which are consumed throughout the world, orange juice is consumed primarily in the highly developed market economies of the United States and Europe. With Brazilian juice firmly entrenched in Europe at rock bottom prices, it only makes sense for Florida producers to concentrate on sales at home. Our growth in exports of specialty products, such as NFC, must necessarily be incremental and secondary to the

domestic market for FCOJ. While the Florida industry will continue to seek out new export markets, both for fresh and processed products, it is myopic to think that we are likely to be as large a factor in foreign markets as Brazil. We simply do not have the domestic subsidies we would need to compete with the Brazilians and Europeans in Europe. Furthermore, we cannot be there to develop those new foreign markets slowly over the many years it will take them to achieve higher disposable incomes, if the Florida industry is forced out of existence by the elimination of the tariff. We want to serve the U.S. market and we can do so without the huge government payments that other agricultural sectors receive. However, the U.S. orange juice tariff is necessary to offset the unfair or artificial advantages that lower the price of Brazilian juice.

Florida Citrus Mutual understands that free trade in many industries, including many agricultural industries, leads to increased competition, eventual price benefits to consumers, and overall global economic growth. Unfortunately, free trade cannot deliver these rewards to such a concentrated and polarized global industry, especially one in which the developing country's industry is, in fact, already the most highly developed in the world. Florida Citrus Mutual appreciated the opportunity to explain to the Committee the unique global structure of the orange juice industry and the negative economic effects that would occur as a result of U.S. tariff reduction or elimination.

DOMESTIC POLICIES AFFECTING THE SPECIALTY CROP INDUSTRY CONCLUSION

The U.S. Government's approach to domestic policy that impacts the fruit and vegetable industry, including the citrus industry, is to a large extent driven by the U.S. trade policy as it affects the industry. Our ability to properly address issues of pest and disease interdiction and eradication, labor law reform, agricultural research and export market growth depend almost entirely upon the balancing impact of the tariff, which assures that the industry can continue to exist in an unsubsidized domestic environment alongside otherwise artificially manipulated global competition.

[From the Miami Herald, Nov. 19, 2003]

TARIFFS WOULD CONTROL OVERSUPPLY (By Mark Ritchie)

Last September in Cancun, the Bush administration's promises of free trade's benefits ran headlong into the reality of the last ten years under the World Trade Organization and the U.S.-Canada-Mexico arrangement known as NAFTA—the North American Free Trade Agreement.

Governments from Latin America, Africa and Asia decried the loss of millions of farm jobs, and denounced a system that promotes the continued export of agricultural commodities below their cost of production price (dumping) by U.S. and European agribusiness corporations. That's why the WTO talks in Cancun collapsed.

Fortunately, a close look at the underlying conflicts at the WTO reveals the potential for a new approach that negotiators trying to create a Free Trade Area of the Americas should use as a blueprint. It would create a win-win solution to the chronic low prices that plague farmers in the United States, Brazil and elsewhere.

International trade negotiations used to be about finding solutions that were aimed at benefiting societies as a whole. In 1947, just a few miles from Miami, governments met in Havana to discuss the creation of the Inter-

national Trade Organization (ITO). The stated goal for the organization was full employment and the need to global monopolies and predatory trade practices. At that time, the nations gathered knew well the ravages of war and the role that brutal trade conflicts played in creating the economic Depression of the 1930s, the breeding ground for fascism.

BALANCING NEEDS

At the talks in Havana, the U.S. Department of Agriculture brought forward a special set of agricultural trade rules that would help balance the needs of producers and consumers with an emphasis on protecting food security over the long term. In essence, U.S. negotiators, with the Great Depression still very much on their minds, developed rules that helped nations balance supply and demand.

The ITO never got off the ground, but these agricultural rules were included in the original general Agreement on Tariffs and Trade, precursor to the WTO. The rules allowed nations to use quantitative import controls as long as they were imposing supply controls. This spurred countries to address domestic oversupply, helping to bring global supply and demand into balance. This plan was key to the "golden era" for U.S. and global agriculture in the 1950s and 60s.

The WTO Agreement on Agriculture undid this important work, but now the ministers gathering in Miami have an opportunity to make improvements by returning to the work done by the pioneers back in Havana in 1947. They have to tackle global over-supply in ways that can help producers in Florida and Brazil earn a profit by restoring the balance between supply and demand that has been damaged by the "race to the bottom" results of free trade.

Negotiators must address monopoly-style business practices that dominate global trade in highly competitive products when global prices fall too far.

TARIFFS BENEFICIAL

The solution to low commodity prices in general, be it orange juice or coffee, is not that complicated. Every business knows that when supply and demand are out of balance, there is going to be trouble. In agriculture, when there is not enough supply, some people go hungry. When there is too much supply, prices drop, farmers suffer and many go out of business.

We need modern trade agreements that enable countries to restore the balancing mechanisms for supply and demand. To take that step, the Bush administration needs to unlock the "free trade" straitjacket of eliminating tariffs at all costs, and start focusing on agricultural market fundamentals.

ADDITIONAL STATEMENTS

DANIEL AND JO ANN PLATT

• Mr. BOND. Mr. President, today I rise to honor two outstanding Missourians, Daniel and Jo Ann Platt. The occasion is a special one, as they celebrate their 50th wedding anniversary.

Only a year after Jo Ann, a native of Indiana, and Dan, a New Yorker, were married on December 5, 1953, they came to the Midwest from Manhattan, where Dan—an anesthesiologist—had been asked to become chief of the Anesthesia Department at Knickerbocker Hospital and the New York Eye and Ear Infirmary.

Instead, Dan practiced at Alton Memorial Hospital, a place where the

Platts believed that he could engage in a personal, patient-centered style of medicine that was impossible in a larger, more urban hospital setting. And there, he opened the first recovery room in the St. Louis metropolitan area, and established one of the first coronary care units and intensive care units in the St. Louis area, along with Barnes Hospital. Upon Dan's retirement in 2002, Alton Memorial Hospital dedicated its surgical and emergency building in his name, to commemorate his 48 years of service to the community, complete with a bust and a plaque paying tribute to Dan as "the consummate physician."

As Dan worked long hours at the hospital, Jo Ann was busy, as well. Over the years, she has served the community in many capacities, including as a member of the board of trustees of St. Louis Country Day School, on the vestry of The Church of Saint Michael and Saint George, on the board of governors of the Saint Louis Woman's Club, on the board of the St. Louis Charitable Foundation, and as a board member for both the Jennie D. Hayner Library Association and the Alton Museum of History.

Yet the bulk of Jo Ann's time was spent in supporting Dan's practice of medicine—which she considered a ministry—and being a devoted and fun-loving mother to their three children: Drew, now a commercial realtor and developer in Evansville, IN; Brett, who runs his own currency hedge fund in London, England, and recently became engaged to Mariela Ferro; and Carol, an attorney, political analyst and commentator, who lives in San Marino, CA, with her husband Jack Liebau, a portfolio manager who recently opened his own investment management firm. Carol, after surviving Harvard Law School as an overt Republican, worked faithfully on my staff in Washington for 2 years before realizing that her colleagues simply could not listen fast enough. All three children remember lives filled with the love, support and encouragement of their parents—and many, many good times.

Truly, Dan and Jo Ann's life together has been full of accomplishments and blessings—most notably, the heartfelt love and respect of their children and children-in-law. We wish them every happiness in the years to come, together with our warmest congratulations and best wishes.●

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. NICKLES (for himself, Ms. LANDRIEU, Mr. CRAIG, Mr. BINGAMAN, Mr. INHOFE, and Mr. SMITH):

S. 1934. A bill to establish an Office of Intercountry Adoptions within the Department of State, and to reform United States laws governing intercountry adoptions; to the Committee on the Judiciary.

By Mr. CORZINE:

S. 1935. A bill to amend the Public Health Service Act to require employers to offer health care coverage for all employees, to amend the Social Security Act to guarantee comprehensive health care coverage for all children born after 2001, and for other purposes; to the Committee on Finance.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. NICKLES (for himself, Ms. LANDRIEU, Mr. CRAIG, Mr. BINGAMAN, Mr. INHOFE, and Mr. SMITH):

S. 1934. A bill to establish an Office of Intercountry Adoptions within the Department of State, and to reform United States laws governing intercountry adoptions; to the Committee on the Judiciary.

Mr. NICKLES. Mr. President, today on National Adoption Day, I rise to introduce the Intercountry Adoption Reform Act along with my colleagues Senators LANDRIEU, CRAIG, BINGAMAN, INHOFE and SMITH. The primary focus of this bill is to streamline, simplify and improve the foreign adoption process for families, adoption agencies and more importantly for the foreign adopted children of American citizens.

In the last decade, there has been a significant growth in intercountry adoption. In 1990, Americans adopted more than 7,000 children from abroad. In 2002, Americans adopted almost 20,000 children from abroad. Families are increasingly seeking to create or enlarge their families through intercountry adoptions. There are many children worldwide who are without permanent homes. It is the intent of this bill to make much-needed reforms to the intercountry adoption process used by U.S. citizens and therefore help more homeless children worldwide find a permanent home here in the United States.

There are two main goals of this legislation. First, and more importantly, this bill acknowledges and affirms that foreign adopted children of American citizens are to be treated in all respects the same as children born abroad to an American citizen. Under existing law, foreign adopted children are treated as immigrants to the United States. They have to apply for, and be granted immigrant visas to enter the United States. Once they enter the United States, citizenship is acquired automatically. Had these children been born abroad to American citizens, they would have traveled back to the United States with a U.S. passport and entered as citizens. This bill provides for equal treatment for foreign adopted children.

Furthermore, these children are not immigrating to the United States in the traditional sense of the word. They are not choosing to come to our country, but rather American citizens are choosing to bring them here as part of their families. Once a full and final adoption has occurred, then the adopted child is a full-fledged member of the family and under adoption law is con-

sidered as if "natural born." As a child of an American citizen, the foreign adopted child should be treated as such, not as an immigrant.

The second goal is to consolidate the existing functions of the Federal Government relating to foreign adoption into one centralized office located within the Department of State. Currently, these functions are performed by offices within the Department of Homeland Security and the Department of State. Consolidation of these functions into one office will result in focused attention on the needs of families seeking to adopt overseas and on the children they are hoping to make part of their families.

Today, when a family seeks to adopt overseas, it has to first be approved to adopt by the Department of Homeland Security. Then, after a child has been chosen, the Department of Homeland Security has to determine if the child is adoptable under Federal adoption law. After this determination is made, the Department of State has to determine whether the child qualifies for a visa as an immediate relative of an American citizen. This bill seeks to minimize the paperwork involved and streamline the process by having these functions all performed in one, centralized office, the Office of Intercountry Adoptions, staffed by expert personnel trained in adoption practices.

The focus of this office will be on foreign adoptions and only on foreign adoptions. Officials in the Department of Homeland Security and the Department of State that currently perform the functions being transferred to this new office have many other duties, such as screening for terrorists or dealing with illegal immigrants. Adoption is frequently a low priority on the desk of such officers. By consolidating these functions into one office, with its sole focus being foreign adoption, these issues can be handled more promptly and given the priority they deserve.

Another aspect of the Office of Inter-country Adoptions that I consider extremely important is the proactive role that we intend for it to take in assisting other countries in establishing fraud-free, transparent adoption practices and interceding on behalf of American citizens when foreign adoption issues occur. By establishing an Ambassador at Large for Inter-country Adoption, this legislation will provide a point of contact for foreign governments when issues involving foreign adoptions arise.

In the last few years there have been many examples of instances where our government has had to intercede on behalf of Americans seeking to adopt a foreign child. For example, Romania has been closed to foreign adoption for more than 2 years now. When Romania issued its moratorium on foreign adoption, hundreds of American families who were in the process of adopting Romanian orphans were unable to complete their adoptions. Fortunately, the Department of State was able to work

successfully with the Romanian government to have these adoptions processed and persuaded Romania to grant exceptions to the moratorium for these American families and their adopted. Unfortunately, the moratorium is still in place leaving many orphans stuck in orphanages across Romania.

There also have been major adoption issues involving Cambodia, Vietnam, and Guatemala in the last 2 years. These issues are still being addressed by various officials within the Department of State and the Department of Homeland Security. It will be greatly beneficial to have a point person within the Federal Government to work on these issues, facilitate resolutions, and intercede on behalf of American families.

There also are some very significant procedural changes in the foreign adoption process included in this bill. Under the Child Citizenship Act of 2000, a foreign child adopted by a U.S. citizen acquires automatic citizenship upon entry into the United States to reside permanently. This bill proposes to change the point of acquisition of citizenship from entry into the United States to the time when a full and final adoption decree is entered by a foreign government or a court in the United States. Prior to citizenship attaching, the child must be determined to be an "adoption child" under U.S. law as defined in this bill. This provision is made retroactive to January 1, 1950, the year Americans began to adopt from abroad. This date also addresses the issue of children adopted during this time period whose parents failed to naturalize them under previous law.

Additionally, the Secretary of State shall issue a U.S. passport and a Consular Report of Birth for a child who satisfies the requirements of the Child Citizenship Act as amended by this Act. No visa will be required for such a child; instead it will be admitted to the United States upon presentation of a valid U.S. passport. No affidavit of support under 213A of the Immigration and Nationality Act will be required nor will the child be required to undergo a medical exam. These changes are again made to more closely equate the process of bringing a foreign adopted child home to the process of documenting and bringing home a biological child born abroad to a U.S. citizen.

When a U.S. citizen gives birth abroad, the parents simply go to the U.S. Embassy, present the child's birth certificate, their marriage license and proof of U.S. citizenship. Upon receiving this documentation, the embassy provides the parents with a U.S. passport for the child and a Consular Report of Birth that serves as proof of their child's citizenship as well as the child's birth certificate. This process takes little to no time to complete.

The process for foreign adopted children, however, is anything but quick and easy. Currently, an adoptive family may have to travel from the country where it adopts a child to another

country in order to get the child's immigrant visa. Only certain embassies are able to grant such visas. On the other hand, most embassies are equipped to provide passports and Consular Reports of Birth. This will eliminate the need and expense associated with families having to travel with their newly adopted children to another U.S. Embassy in a different location prior to bringing the children home.

This bill also provides that the adoptive parents do not have to prove twice that they are financially capable of providing for their child and eliminates the immigration requirement of having the child undergo a medical exam. Before a family is approved to adopt a foreign child, the Federal Government has to be satisfied that the family is financially able to care for the child. This is part of the approval process. They should not have to repeat this process once they have fully and finally adopted a child.

In addition, prior to a family choosing to adopt a child, they should acquire and be provided as much medical information as is available on the health of the child so that it can make an informed decision on its ability to care for the child. Once that information has been provided and the child has been adopted, the child is now a member of the family. No biological child is denied entry because of medical reasons, nor should an adopted child be denied.

Another section of this bill provides for a new type of visa for children traveling to the United States for the purpose of being adopted by an American citizen who has been approved to adopt. Currently children who are not adopted overseas prior to their entry into the United States are allowed entry using an immigrant visa. As I have stated earlier, these children are not immigrants. They are being brought to the United States, at the request of a U.S. citizen, to become a member of that family. This new visa is a non-immigrant visa which authorizes admission of the child for the purposes of adoption. The authorized admission under this section terminates on the date the adoption is finalized, or 2 years after the date of admission if the adoption has not been finalized. Until the child is adopted, the child will receive temporary treatment as a legal permanent resident.

This bill also redefines the criteria used to determine a child's eligibility for adoption. This is a critical piece of this legislation. The existing statutory language has not been revised since it was first written over 50 years ago. When it was written it was intended to deal primarily with war orphans and it does not permit voluntary relinquishment of children who have two living parents. The provision in this bill has been written to more fully comport with the language as agreed to in the Inter-country Adoption Act of 2000 which does permit the adoption of chil-

dren whose parents have irrevocably relinquished them.

The bill also includes many safeguards such as: requirements that the Secretary of State is satisfied that the proper care will be furnished the child; that the purpose of the adoption is to form a bona fide parent-child relationship; that the biological parent-child relationships have been terminated; that the Secretary of State, in consultation with the Secretary of Homeland Security, is satisfied that the child is not a security risk; and that whose adoption and emigration to the United States has been approved by the competent authority of the country of the child's place of birth or residence.

Now that I have covered some of the significant aspects of this bill, let me tell you what this bill does not do. It does not create more bureaucracy or additional regulation. It does not increase fees for adoption. It does not slow down the adoption process. It does not add more red tape or additional paperwork. In fact, it does just the opposite.

It consolidates existing Federal processes for foreign adoptions into what is intended to be a "one stop shop"—the Office of Inter-country Adoptions. It eliminates paperwork involved in getting an immigrant visa and provides citizenship documentation up front for the child, saving the adoptive family from having to deal with this upon its return home. Instead the fully and finally adopted child enters the United States on a U.S. passport as a U.S. citizen and child of a U.S. citizen.

This bill is intended to ease the paperwork burden on adoptive parents who have already gone through extensive paperwork and documentation production to accomplish their adoption. It is intended to recognize that children adopted by American citizens are the children of American citizens and entitled to all the same rights, duties and responsibilities of biological children of U.S. citizens born abroad.

I introduce this bill with the hope that its passage will significantly improve the foreign adoption process so that more children worldwide can find loving, permanent homes. It is my prayer that someday, adoption will not be needed. That all children will be born into stable, loving homes to parents who want them and are able to care for them. However, until that day comes the foreign adoption process can be improved and should be improved. Foreign adopted children should be treated as children of U.S. citizens, not as immigrants, and should be accorded all the same rights as biological children of U.S. citizens. To that end, I introduce this bill.

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. 1934

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 "Inter-country Adoption Reform Act of 2003" or the "ICARE Act".

SEC. 2. FINDINGS; PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) That a child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love, and understanding.

(2) That intercountry adoption may offer the advantage of a permanent family to a child for whom a suitable family cannot be found in his or her country of origin.

(3) There has been a significant growth in intercountry adoptions. In 1990, Americans adopted 7,093 children from abroad. In 2001, they adopted 19,237 children from abroad.

(4) Americans increasingly seek to create or enlarge their families through intercountry adoptions.

(5) There are many children worldwide that are without permanent homes.

(6) In the interest of United States citizens and homeless children, reforms are needed in the intercountry adoption process used by United States citizens.

(7) In addition, Congress recognizes that foreign born adopted children do not make the decision whether to immigrate to the United States. They are being chosen by Americans to become part of their immediate families.

(8) As such these children should not be classified as immigrants in the traditional sense. Once fully and finally adopted, they should be treated as children of United States citizens.

(9) Since a child who is fully and finally adopted is entitled to the same rights, duties, and responsibilities as a biological child, the law should reflect such equality.

(10) Therefore, foreign born adopted children of United States citizens should be accorded the same procedural treatment as biological children born abroad to a United States citizen.

(11) If a United States citizen can confer citizenship to a biological child born abroad, then the same citizen is entitled to confer such citizenship to their legally and fully adopted foreign born children immediately upon final adoption.

(12) If a United States citizen cannot confer citizenship to a biological child born abroad, then such citizen cannot confer citizenship to their legally and fully adopted foreign born child, except through the naturalization process.

(b) PURPOSES.—The purposes of this Act are—

(1) to ensure that foreign born children adopted by United States citizens will be treated identically to a biological child born abroad to the same citizen parent;

(2) to improve the intercountry adoption process to make it more citizen friendly and child oriented; and

(3) to foster best practices.

SEC. 3. DEFINITIONS.

In this Act:

(1) ADOPTABLE CHILD.—The term "adoptable child" has the same meaning given such term in section 101(c)(3) of the Immigration and Nationality Act (8 U.S.C. 1101(c)(3)), as added by section 204(a) of this Act.

(2) AMBASSADOR AT LARGE.—The term "Ambassador at Large" means the Ambassador at Large for Inter-country Adoptions appointed to head the Office pursuant to section 101(b).

(3) FULL AND FINAL ADOPTION.—The term “full and final adoption” means an adoption—

(A) that is completed according to the laws of the child’s country of origin or the State law of the parent’s residence;

(B) under which a person is granted full and legal custody of the adopted child;

(C) that has the force and effect of severing the child’s legal ties to the child’s biological parents;

(D) under which the adoptive parents meet the requirements of section 205; and

(E) under which the child has been adjudicated to be an adoptable child in accordance with section 206.

(4) OFFICE.—The term “Office” means the Office of Intercountry Adoptions established under section 101(a).

(5) READILY APPROVABLE.—A petition or certification is considered “readily approvable” if the documentary support provided demonstrates that the petitioner satisfies the eligibility requirements and no additional information or investigation is necessary.

TITLE I—ADMINISTRATION OF INTERCOUNTRY ADOPTIONS

Subtitle A—In General

SEC. 101. OFFICE OF INTERCOUNTRY ADOPTIONS.

(a) ESTABLISHMENT.—There is established within the Department of State, an Office of Intercountry Adoptions which shall be headed by the Ambassador at Large for Inter-country Adoptions who shall be appointed pursuant to subsection (b).

(b) AMBASSADOR AT LARGE.—

(1) APPOINTMENT.—The Ambassador at Large shall be appointed by the President, by and with the advice and consent of the Senate, from among individuals who have background, experience, and training in intercountry adoptions.

(2) AUTHORITY.—The Ambassador at Large shall report directly to the Secretary of State, in consultation with the Assistant Secretary for Consular Affairs.

(3) DUTIES OF THE AMBASSADOR AT LARGE.—In carrying out the functions of the Office, the Ambassador at Large shall have the following responsibilities:

(A) IN GENERAL.—The primary responsibilities of the Ambassador at Large shall be—

(i) to ensure that intercountry adoptions take place in the best interests of the child; and

(ii) to assist the Secretary of State in fulfilling the responsibilities designated to the central authority under title I of the Inter-country Adoption Act of 2000 (42 U.S.C. 14911 et seq.).

(B) ADVISORY ROLE.—The Ambassador at Large shall be a principal advisor to the President and the Secretary of State regarding matters affecting intercountry adoption and the general welfare of children abroad and shall make recommendations regarding—

(i) the policies of the United States with respect to the establishment of a system of cooperation among the parties to The Hague Convention;

(ii) the policies to prevent abandonment, strengthen families, and to advance the placement of children in permanent families; and

(iii) policies that promote the well-being of children.

(C) DIPLOMATIC REPRESENTATION.—Subject to the direction of the President and the Secretary of State, the Ambassador at Large may represent the United States in matters and cases relevant to international adoption in—

(i) fulfillment of the responsibilities designated to the central authority under title

I of the Intercountry Adoption Act of 2000 (42 U.S.C. 14911 et seq.);

(ii) contacts with foreign governments, intergovernmental organizations, and specialized agencies of the United Nations and other international organizations of which the United States is a member; and

(iii) multilateral conferences and meetings relevant to international adoption.

(D) INTERNATIONAL POLICY DEVELOPMENT.—To advise and support the Secretary of State and other relevant Bureaus in the development of sound policy regarding child protection and intercountry adoption.

(E) REPORTING RESPONSIBILITIES.—The Ambassador at Large shall have the following reporting responsibilities:

(i) IN GENERAL.—The Ambassador at Large shall assist the Secretary of State and other relevant Bureaus in preparing those portions of the Human Rights Reports that relate to the abduction, sale, and trafficking of children.

(ii) ANNUAL REPORT ON INTERCOUNTRY ADOPTION.—On September 1 of each year, the Secretary of State, with the assistance of the Ambassador at Large, shall prepare and transmit to Congress an annual report on intercountry adoption. Each annual report shall include—

(I) a description of the status of child protection and adoption in each foreign country, including—

(aa) trends toward improvement in the welfare and protection of children and families;

(bb) trends in family reunification, domestic adoption, and intercountry adoption;

(cc) movement toward ratification and implementation of The Hague Convention; and

(dd) census information on the number of children in orphanages, foster homes, and other types of nonpermanent residential care;

(II) the number of intercountry adoptions by United States citizens, regardless of whether the adoption occurred under The Hague Convention, including the country from which each child emigrated, the State in which each child resides, and the country in which the adoption was finalized;

(III) the number of intercountry adoptions involving emigration from the United States, regardless of whether the adoption occurred under The Hague Convention, including the country where each child now resides and the State from which each child emigrated;

(IV) the number of Hague Convention placements for adoption in the United States that were disrupted, including the country from which the child emigrated, the age of the child, the date of the placement for adoption, the reasons for the disruption, the resolution of the disruption, the agencies that handled the placement for adoption, and the plans for the child, and in addition, any information regarding disruption or dissolution of adoptions of children from other countries received pursuant to section 422(b)(4) of the Social Security Act;

(V) the average time required for completion of an adoption, set forth by the country from which the child emigrated;

(VI) the current list of agencies accredited and persons approved under the Inter-country Adoption Act of 2000 (42 U.S.C. 14901 et seq.) to provide adoption services;

(VII) the names of the agencies and persons temporarily or permanently debarred under the Inter-country Adoption Act of 2000 (42 U.S.C. 14901 et seq.), and the reasons for the debarment;

(VIII) the range of adoption fees charged in connection with Hague Convention adoptions involving adoptions by United States citizens and the median of such fees set forth by the country of origin;

(IX) the range of fees charged for accreditation of agencies and the approval of persons in the United States engaged in providing adoption services under The Hague Convention; and

(X) recommendations of ways the United States might act to improve the welfare and protection of children and families in each foreign country.

(c) FUNCTIONS OF OFFICE.—The Office shall have the following 6 functions:

(1) APPROVAL OF A FAMILY TO ADOPT.—To approve or disapprove the eligibility of United States citizens to adopt foreign born children.

(2) CHILD ADJUDICATION.—To adjudicate the status of a child born abroad as an adoptable child.

(3) FAMILY SERVICES.—To provide assistance to United States citizens engaged in the intercountry adoption process in resolving problems with respect to that process and to track intercountry adoption cases so as to ensure that all such adoptions are processed in a timely manner.

(4) INTERNATIONAL POLICY DEVELOPMENT.—To advise and support the Ambassador at Large and other relevant Bureaus in the development of sound policy regarding child protection and intercountry adoption.

(5) CENTRAL AUTHORITY.—To assist the Secretary of State in carrying out duties of the central authority as defined in section 3 of the Inter-country Adoption Act of 2000 (42 U.S.C. 14902).

(6) ADMINISTRATION.—To perform administrative functions related to the functions performed under paragraphs (1) through (5), including legal functions and congressional liaison and public affairs functions.

(d) ORGANIZATION.—

(1) IN GENERAL.—All functions of the Office shall be performed by officers housed in a centralized office located in Washington, D.C. Within the Washington, D.C., office, there shall be 6 divisions corresponding to the 6 functions of the Office. All 6 divisions and their respective directors shall report directly to the Ambassador at Large.

(2) APPROVAL TO ADOPT.—The division responsible for approving parents to adopt shall be divided into regions of the United States as follows:

(A) Northwest.

(B) Northeast.

(C) Southwest.

(D) Southeast.

(E) Midwest.

(F) West.

(3) CHILD ADJUDICATION.—To the extent practicable, the division responsible for the adjudication of foreign born children as adoptable shall be divided by world regions which correspond to those currently used by other divisions within the Department of State.

(4) USE OF INTERNATIONAL FIELD OFFICERS.—Nothing in this section shall be construed to prohibit the use of international field officers posted abroad, as necessary, to fulfill the requirements of this Act.

(e) QUALIFICATIONS AND TRAINING.—In addition to meeting the employment requirements of the Department of State, officers employed in any of the 6 divisions of the Office shall undergo extensive and specialized training in the laws and processes of intercountry adoption as well as understanding the cultural, medical, emotional, and social issues surrounding intercountry adoption and adoptive families. The Ambassador at Large shall, whenever possible, recruit and hire individuals with background and experience in intercountry adoptions.

(f) USE OF ELECTRONIC DATABASES AND FILING.—To the extent possible, the Office shall make use of centralized, electronic databases and electronic form filing.

SEC. 102. RECOGNITION OF CONVENTION ADOPTIONS IN THE UNITED STATES.

Section 505(a)(1) of the Intercountry Adoption Act of 2000 (42 U.S.C. 14901 note) is amended by inserting “301, 302,” after “205.”

SEC. 103. TECHNICAL AND CONFORMING AMENDMENT.

Section 104 of the Intercountry Adoption Act of 2000 (42 U.S.C. 14914) is repealed.

Subtitle B—Transition Provisions**SEC. 111. TRANSFER OF FUNCTIONS.**

(a) **IN GENERAL.**—All functions under the immigration laws of the United States with respect to the adoption of foreign born children by United States citizens and their admission to the United States that have been vested by statute in, or exercised by, the Commissioner of Immigration and Naturalization, the Immigration and Naturalization Service (or any officer, employee, or component thereof), of the Department of Homeland Security (or any officer, employee, or component thereof) immediately prior to the effective date of this title, are transferred to the Office on such effective date for exercise by the Ambassador at Large in accordance with applicable laws and title II of this Act.

(b) **EXERCISE OF AUTHORITIES.**—Except as otherwise provided by law, the Ambassador at Large may, for purposes of performing any function transferred to the Ambassador at Large under subsection (a), exercise all authorities under any other provision of law that were available with respect to the performance of that function to the official responsible for the performance of the function immediately before the effective date of the transfer of the function pursuant to this title.

SEC. 112. TRANSFER OF RESOURCES.

Subject to section 1531 of title 31, United States Code, upon the effective date of this title, there are transferred to the Ambassador at Large for appropriate allocation in accordance with section 115, the assets, liabilities, contracts, property, records, and unexpended balance of appropriations, authorizations, allocations, and other funds employed, held, used, arising from, available to, or to be made available to the Immigration and Naturalization Service or the Department of Homeland Security in connection with the functions transferred pursuant to this title.

SEC. 113. INCIDENTAL TRANSFERS.

The Ambassador at Large may make such additional incidental dispositions of personnel, assets, liabilities, grants, contracts, property, records, and unexpended balances of appropriations, authorizations, allocations, and other funds held, used, arising from, available to, or to be made available in connection with such functions, as may be necessary to carry out this title. The Ambassador at Large shall provide for such further measures and dispositions as may be necessary to effectuate the purposes of this title.

SEC. 114. SAVINGS PROVISIONS.

(a) **LEGAL DOCUMENTS.**—All orders, determinations, rules, regulations, permits, grants, loans, contracts, agreements, including collective bargaining agreements, certificates, licenses, and privileges—

(1) that have been issued, made, granted, or allowed to become effective by the President, the Ambassador at Large, the former Commissioner of the Immigration and Naturalization Service, their delegates, or any other Government official, or by a court of competent jurisdiction, in the performance of any function that is transferred pursuant to this title; and

(2) that are in effect on the effective date of such transfer (or become effective after

such date pursuant to their terms as in effect on such effective date);

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, any other authorized official, a court of competent jurisdiction, or operation of law, except that any collective bargaining agreement shall remain in effect until the date of termination specified in the agreement.

(b) PROCEEDINGS.—

(1) **PENDING.**—The transfer of functions under section 111 shall not affect any proceeding or any application for any benefit, service, license, permit, certificate, or financial assistance pending on the effective date of this title before an office whose functions are transferred pursuant to this title, but such proceedings and applications shall be continued.

(2) **ORDERS.**—Orders shall be issued in such proceedings, appeals shall be taken therefrom, and payments shall be made pursuant to such orders, as if this Act had not been enacted, and orders issued in any such proceeding shall continue in effect until modified, terminated, superseded, or revoked by a duly authorized official, by a court of competent jurisdiction, or by operation of law.

(3) **DISCONTINUANCE OR MODIFICATION.**—Nothing in this section shall be considered to prohibit the discontinuance or modification of any such proceeding under the same terms and conditions and to the same extent that such proceeding could have been discontinued or modified if this section had not been enacted.

(c) **SUITS.**—This title shall not affect suits commenced before the effective date of this title, and in all such suits, proceeding shall be had, appeals taken, and judgments rendered in the same manner and with the same effect as if this title had not been enacted.

(d) **NONABATEMENT OF ACTIONS.**—No suit, action, or other proceeding commenced by or against the Department of State, the Immigration and Naturalization Service, or the Department of Homeland Security, or by or against any individual in the official capacity of such individual as an officer or employee in connection with a function transferred pursuant to this section, shall abate by reason of the enactment of this Act.

(e) **CONTINUANCE OF SUIT WITH SUBSTITUTION OF PARTIES.**—If any Government officer in the official capacity of such officer is party to a suit with respect to a function of the officer, and pursuant to this title such function is transferred to any other officer or office, then such suit shall be continued with the other officer or the head of such other office, as applicable, substituted or added as a party.

(f) **ADMINISTRATIVE PROCEDURE AND JUDICIAL REVIEW.**—Except as otherwise provided by this title, any statutory requirements relating to notice, hearings, action upon the record, or administrative or judicial review that apply to any function transferred pursuant to any provision of this title shall apply to the exercise of such function by the head of the office, and other officers of the office, to which such function is transferred pursuant to such provision.

Subtitle C—Effective Date**SEC. 121. EFFECTIVE DATE.**

This title shall take effect 180 days after the date of enactment of this Act.

TITLE II—REFORM OF UNITED STATES LAWS GOVERNING INTERCOUNTRY ADOPTIONS**SEC. 201. AUTOMATIC ACQUISITION OF CITIZENSHIP FOR ADOPTED CHILDREN BORN OUTSIDE THE UNITED STATES.**

(a) **AMENDMENTS OF AUTOMATIC CITIZENSHIP PROVISIONS.**—Section 320 of the Immigration

and Nationality Act (8 U.S.C. 1431) is amended—

(1) by amending the section heading to read as follows: “CHILDREN BORN OUTSIDE THE UNITED STATES; CONDITIONS UNDER WHICH CITIZENSHIP AUTOMATICALLY ACQUIRED”; and

(2) in subsection (a), by striking paragraphs (1) through (3) and inserting the following:

“(1) Upon the date the adoption becomes full and final, at least 1 parent of the child is a citizen of the United States, whether by birth or naturalization, who has been physically present in the United States or its outlying possessions for a period or periods totaling not less than 5 years, at least 2 of which were after attaining the age of 14 years. Any periods of honorable service in the Armed Forces of the United States, or periods of employment with the United States Government or with an international organization as that term is defined in section 1 of the International Organizations Immunities Act (22 U.S.C. 288) by such citizen parent, or any periods during which such citizen parent is physically present abroad as the dependent unmarried son or daughter and a member of the household of a person—

“(A) honorably serving with the Armed Forces of the United States; or

“(B) employed by the United States Government or an international organization as defined in section 1 of the International Organizations Immunities Act (22 U.S.C. 288);

may be included in order to satisfy the physical presence requirement of this paragraph.

“(2) The child is an adoptable child described in section 101(c)(3).

“(3) The child is the beneficiary of a full and final adoption decree entered by a foreign government or a court in the United States.

“(4) For purposes of this subsection, the term “full and final adoption” means an adoption—

“(A) that is completed under the laws of the child’s country of origin or the State law of the parent’s residence;

“(B) under which a person is granted full and legal custody of the adopted child;

“(C) that has the force and effect of severing the child’s legal ties to the child’s biological parents;

“(D) under which the adoptive parents meet the requirements of section 205 of the Intercountry Adoption Reform Act; and

“(E) under which the child has been adjudicated to be an adoptable child in accordance with section 206 of the Intercountry Adoption Reform Act.”

(b) **EFFECTIVE DATE.**—This section shall take effect as if enacted on January 1, 1950.

SEC. 202. REVISED PROCEDURES.

(a) **IN GENERAL.**—Notwithstanding any other provision of law, the following requirements shall apply with respect to the adoption of foreign born children by United States citizens:

(1) Upon completion of a full and final adoption, the Secretary of State shall issue a United States passport and a Consular Report of Birth for a child who satisfies the requirements of section 320 of the Immigration and Nationality Act (8 U.S.C. 1431), as amended by section 201 of this Act, upon application by a United States citizen parent.

(2) An adopted child described in paragraph (1) shall not require the issuance of a visa for travel and admission to the United States but shall be admitted to the United States upon presentation of a valid, unexpired United States passport.

(3) No affidavit of support under section 213A of the Immigration and Nationality Act (8 U.S.C. 1183a) shall be required in the case of any adoptable child.

(4) The Secretary of State shall not require an adopted child described in paragraph (1) to undergo a medical exam.

(b) REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary of State shall prescribe such regulations as may be necessary to carry out this section.

SEC. 203. NONIMMIGRANT VISAS FOR CHILDREN TRAVELING TO THE UNITED STATES TO BE ADOPTED BY A UNITED STATES CITIZEN.

(a) IN GENERAL.—Section 101(a)(15) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)) is amended—

(1) by striking “or” at the end of subparagraph (U);

(2) by striking the period at the end of subparagraph (V) and inserting “; or”; and

(3) by adding at the end the following:

“(W) an adoptable child who is coming into the United States for adoption by a United States citizen and a spouse jointly or by an unmarried United States citizen at least 25 years of age, who has been approved to adopt by the Ambassador at Large, acting through the Office of Intercountry Adoptions established under section 101(a) of the Inter-country Adoption Reform Act.”.

(b) TERMINATION OF PERIOD OF AUTHORIZED ADMISSION.—Section 214 of the Immigration and Nationality Act (8 U.S.C. 1184) is amended by adding at the end the following:

“(q) In the case of a nonimmigrant described in section 101(a)(15)(W), the period of authorized admission shall terminate on the earlier of—

“(1) the date on which the adoption of the nonimmigrant is completed by the courts of the State where the parents reside; or

“(2) the date that is 2 years after the date of admission of the nonimmigrant into the United States.”.

(c) TEMPORARY TREATMENT AS LEGAL PERMANENT RESIDENT.—Notwithstanding any other law, all benefits and protections that apply to a legal permanent resident shall apply to a nonimmigrant described in section 101(a)(15)(W) of the Immigration and Nationality Act, as added by subsection (a), pending a full and final adoption.

(d) EXCEPTION FROM IMMUNIZATION REQUIREMENT FOR CERTAIN ADOPTED CHILDREN.—Section 212(a)(1)(C) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(C)) is amended—

(1) in the heading by striking “10 YEARS” and inserting “18 YEARS”; and

(2) in clause (i), by striking “10 years” and inserting “18 years”.

(e) REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary of State shall prescribe such regulations as may be necessary to carry out this section.

SEC. 204. DEFINITION OF “ADOPTABLE CHILD”.

(a) IN GENERAL.—Section 101(c) of the Immigration and Nationality Act (8 U.S.C. 1101(c)) is amended by adding at the end the following:

“(3) The term “adoptable child” means an unmarried person under the age of 18—

“(A) whose biological parents (or parent, in the case of a child who has one sole or surviving parent) or other persons or institutions that retain legal custody of the child—

“(i) have freely given their written irrevocable consent to the termination of their legal relationship with the child, and to the child’s emigration and adoption;

“(ii) are unable to provide proper care for the child, as determined by the appropriate governmental authority of the child’s residence; or

“(iii) have voluntarily relinquished the child to governmental authorities pursuant to the law of the child’s residence;

“(B) with respect to whom the Secretary of State is satisfied that the proper care will be

furnished the child if admitted to the United States;

“(C) with respect to whom the Secretary of State is satisfied that the purpose of the adoption is to form a bona fide parent-child relationship and that the parent-child relationship of the child and the biological parents has been terminated (and in carrying out both obligations under this subparagraph the Secretary of State, in consultation with the Secretary of Homeland Security, may consider whether there is a petition pending to confer immigrant status on one or both of the biological parents);

“(D) with respect to whom the Secretary of State, in consultation with the Secretary of Homeland Security, is satisfied that the person is not a security risk; and

“(E) whose adoption and emigration to the United States has been approved by the competent authority of the country of the child’s place of birth or residence.”.

(b) CONFORMING AMENDMENT.—Section 204(d) of the Immigration and Nationality Act (8 U.S.C. 1154(d)) is amended by inserting “and an adoptable child as defined in section 101(c)(3)” before “unless a valid home-study”.

SEC. 205. APPROVAL TO ADOPT.

(a) IN GENERAL.—Prior to the issuance of a visa under section 101(a)(15)(W) of the Immigration and Nationality Act, as added by section 203(a) of this Act, or the issuance of a full and final adoption decree, the United States citizen adoptive parent shall have approved by the Office a petition to adopt. Such petition shall be subject to the same terms and conditions as are applicable to petitions for classification under section 204.3 of title 8 of the Code of Federal Regulations, as in effect on the day before the date of enactment of this Act.

(b) EXPIRATION OF APPROVAL.—Approval to adopt under this Act is valid for 24 months from the date of approval.

(c) EXPEDITED REAPPROVAL PROCESS OF FAMILIES PREVIOUSLY APPROVED TO ADOPT.—The Ambassador at Large shall prescribe such regulations as may be necessary to provide for an expedited and streamlined process for families who have been previously approved to adopt and whose approval has expired, so long as not more than 3 years have lapsed since the original application.

(d) DENIAL OF PETITION.—

(1) NOTICE OF INTENT.—If the officer adjudicating the petition to adopt finds that it is not readily approvable, the officer shall notify the petitioner, in writing, of the officer’s intent to deny the petition. Such notice shall include the specific reasons why the petition is not readily approvable.

(2) PETITIONERS RIGHT TO RESPOND.—Upon receiving a notice of intent to deny, the petitioner has 30 days to respond to such notice.

(3) DECISION.—Within 30 days of receipt of the petitioner’s response the Office must reach a final decision regarding the eligibility of the petitioner to adopt. Notice of a formal decision must be delivered in writing.

(4) RIGHT TO AN APPEAL.—Unfavorable decisions may be appealed to the appropriate appellate jurisdiction of the Department of State, and if necessary, Federal court.

(5) REGULATIONS REGARDING APPEALS.—Not later than 6 months after the date of enactment of this Act, the Ambassador at Large shall promulgate formal regulations regarding the process for appealing the denial of a petition.

SEC. 206. ADJUDICATION OF CHILD STATUS.

(a) IN GENERAL.—Prior to the issuance of a full and final adoption decree or a visa under section 101(a)(15)(W) of the Immigration and Nationality Act, as added by section 203(a) of this Act—

(1) the Office shall obtain from the competent authority of the country of the child’s

residence a certification, together with documentary support, that the child sought to be adopted meets the description of an adoptable child; and

(2) within 30 days of receipt of the certification referred to in paragraph (1), the Office shall make a final determination on whether the certification and the documentary support are sufficient to meet the requirements of this section.

(b) PROCESS FOR DETERMINATION.—

(1) IN GENERAL.—The Ambassador at Large shall work with the competent authorities of the child’s country of residence to establish a uniform, transparent, and efficient process for the exchange and approval of the certification and documentary support required under subsection (a).

(2) NOTICE OF INTENT.—If the Office finds that the certification submitted by the competent authority of the child’s country of origin is not readily approvable, the Office shall—

(A) notify the competent authority and the prospective adoptive parents, in writing, of the specific reasons why the certification is not sufficient; and

(B) provide the competent authority and the prospective adoptive parents the opportunity to address the stated insufficiencies.

TITLE III—FUNDING

SEC. 301. FUNDS.

The Secretary of State shall provide the Ambassador at Large with such funds as may be necessary for—

(1) the hiring of staff for the Office;

(2) investigations conducted by the Office; and

(3) travel and other expenses necessary to carry out this Act.

Ms. LANDRIEU. Mr. President, two years ago, I had the distinct pleasure of spending an hour with the President of China, Jiang Jiamin. As you know, President Jiamin is tremendously busy and has numerous requests for personal meetings, but he agreed to meet with this particular U.S. delegation because of the importance of the subject we were there to discuss, international adoption. During this meeting, he shared with us that the Chinese believe every child born is born with a red string attached to their heart, the other end of which is tied to the ankle of their soul mate. It is because of this string, they believe, that soul mates eventually find each other and spend the rest of their lives together. It is his belief, that perhaps the same is true of children who are adopted. That when they are born, their hearts have a string that is tied to the ankle of their forever family, and it is because of that heartstring that they eventually find one another.

I will treasure the memory of this meeting forever. Not only because it was an extreme honor to meet with such a learned and distinguished leader, but because it reminds me of how profound adoption is. 19,237 children were adopted by American citizens last year. 18,477 children the year before that, 16,363 in 1999 and 15,744 children in 1998. That is almost 100,000 children in four years. I think it is easy for us to understand the impact that these adoptions have had on the adoptive families and the orphan children, but what I would like to focus on this morning is the impact that this has for

the diplomatic relations between the United States and countries throughout the world.

In sheer numbers alone, the impact is evident. In real terms, these children are "mini-ambassadors" to 200,000 American citizen parents, 400,000 grandparents, conservatively 800,000 aunts and uncles, and 300,000 siblings. According to a recent report by the U.S. Census Bureau, 1.6 million people in the United States were adopted, fifteen percent of them from abroad. Because of this magnificent process, communities all over the U.S. are deepening this understanding and affinity for the people of the world. September 11 reminded us of the importance of continuing to build bridges with the nations of the world. International adoption is one very effective and lasting way to build these bridges.

Over this past year, I have also had the privilege of meeting with the Presidents of Kazakhstan, Romania and Russia and high-ranking government officials from Cambodia, Vietnam, Guatemala, Africa, and the Ukraine. Each time the message is the same. They want to do what they can to make the Hague more than just a piece of paper with 59 signatures on it. They are looking to the U.S. to lead the way toward a system of international adoption and child welfare that is based on best practices. A system comprised of meaningful protections for the adoptive parents, the birth parents, and perhaps most importantly the children; a system that universally recognizes that a government institution is not and cannot be an adequate replacement for a family and works toward the shared mission of finding every child in this world a loving and nurturing, permanent family.

I am proud to be here today, along with my colleague, the Senior Senator from Oklahoma, to introduce legislation that will take us in that direction. What it proposes to do is simple, but what it might help us to achieve is limitless. Simply put, this bill hopes to streamline the existing international adoption process, consolidate its federal functions into one agency and to empower that agency with the staff and resources it needs to represent the United States, the largest beneficiary from international adoption. With this office in place, the United States can begin to lead the world community in forging an international system of adoption that protects the interests of all those involved.

Under current law the federal responsibility for international adoption lies with the Department of State and the U.S. Citizenship and Immigration Services. This dual jurisdiction gives rise to several problems including: lack of coordination, lack of accountability, duplication of efforts and unnecessary paperwork and fees for prospective adoptive families. It also impedes the State Departments ability to fulfill its responsibilities as the central authority under the Hague Treaty on Cooperation in International Adoption.

Now, you may be asking yourself, as I have many times, what does adoption have to do with immigration? You see, under current law children adopted by United States citizens abroad are treated as immigrants, forced to apply for an immigrant visa to enter the United States. This process is not only impractical, since these children obtain automatic citizenship upon entry into the United States, it is inequitable. Children born to U.S. citizens abroad are conferred automatic citizenship upon their birth and are therefore permitted to travel to the United States on a U.S. passport. Children adopted by United States citizens should be afforded this same protection. This bill affords them that protection.

This bill also proposes that we update the current law definitions of an "adoptable child" to reflect the types of children in need of homes throughout the world. The current law definition of "orphan" reflects the reality for which it was created; to help U.S. citizens adopt children orphaned by the wars in Korea and Vietnam. As such, it is an extremely narrow definition that in many cases prohibits a family from bringing their newly adopted child to the United States.

In creating an Ambassador at Large for international adoption, this bill hopes to provide the leadership and high level diplomatic representation so desperately needed in international adoption. Under his or her leadership, the Office of International Adoptions will be able to take the proactive measures necessary to limit corruption and ensure that adoptions are performed in the most efficient, transparent manner possible. The Hague Treaty already gives the State Department this responsibility; this bill is designed to help them fulfill it.

Let me tell you why we need to act now to pass this legislation. Because of the lack of consistent leadership by the United States in this area, many countries around the world are in "crisis mode" and have been forced to take unilateral actions to solve perceived problems in the system. For two years, there has been a moratorium on international adoption in Romania. The second anniversary of the INS issued suspension in Cambodia is fast approaching. The governments of Guatemala and Vietnam have taken actions to limit the number of international adoptions. In each and every one of these cases, the foreign governments have expressed frustration with the lack of action on the part of the U.S. to limit corruption or close potential loopholes in the system. The end result, hundreds and thousands of children are left in orphanages. This cannot be.

I have spent the past two years talking to foreign governments, agencies, and most importantly, adoptive parents and they tell me that this legislation is needed. I urge my colleagues to join me in supporting this legislation

and I look forward to seeing it passed as soon as possible.

Mr. INHOFE. Mr. President, I rise today, National Adoption Day, to join my colleagues in introducing this bill to give children everywhere around the world a greater chance to find a loving, permanent home.

This bill, the Intercountry Adoption Reform Act (ICARE), will automatically make a child who is adopted from another country a citizen the minute the adoption is finalized.

This legislation has a personal impact for me. My granddaughter was adopted from Ethiopia a few years ago. Even though she is a vital part of our family, she was not a citizen when she arrived. We now have to do work to make the law recognize her in the same light we do—as a legal member of our family and a lawful citizen of this country—entitled to the same rights and privileges as all my other biological grandchildren.

ICARE will ensure that foreign-born children, such as my granddaughter, will be treated the same as biological children born abroad to the same parent who is an American citizen. It will help streamline international adoptions and implement best practices for all adoptions.

Situations such as one that happened in my State of Oklahoma would not have happened under this legislation. Anna Lynn Fincher was born in the Philippines and adopted by a U.S. military couple in the Philippines. Even though they adopted Anna Lynn in the Philippines, they never brought her to the United States. Sadly, both of Anna Lynn's American parents died while in the Philippines—before Anna Lynn was able to set foot on American soil and become a U.S. citizen. As a result, she had to be granted Humanitarian Parole, which is granted to people in extreme circumstances, so that she could come to the United States and be adopted by her adoptive sister.

Under ICARE, Anna Lynn would have become a citizen as soon as her adoption was finalized—eliminating the need for Humanitarian Parole and another adoption.

Providing children, such as my granddaughter and Anna Lynn, with a permanent, stable family is the most precious gift we can give a child. I am proud to lend my support to this important legislation that will help give these young people a home.

By Mr. CORZINE:

S. 1935. A bill to amend the Public Health Service Act to require employers to offer health care coverage for all employees, to amend the Social Security Act to guarantee comprehensive health care coverage for all children born after 2001, and for other purposes; to the Committee on Finance.

Mr. CORZINE. Mr. President, I rise today to introduce legislation on an issue that is of utmost importance to me, to the State of New Jersey, and to our Nation: providing universal access to health insurance.

This is an issue I talked about incessantly during my campaign, because I strongly believe it is a national outrage that we are the only industrial society on earth that does not insure the health of all its people.

I begin with a basic premise. Health care is a basic right, and neither the government nor the private sector is doing enough to secure that right for everyone.

Unfortunately, as I have traveled across the State of New Jersey, I have talked to many men and women who lay awake nights trying to figure out how to care for loved ones. I've met people who work two jobs to support their family, and end up taking their kids to the emergency room when they're sick because they are unable to afford preventive care and timely treatment for their children.

In 2002, more than 43 million Americans—or a staggering 17 percent of the total nonelderly population—were uninsured. In my State of New Jersey, 1.1 million citizens lack health insurance.

The number of uninsured grew steadily throughout the 1990's until 1999, when modest increases in employer coverage due to the robust economy, coupled with expansion and improved enrollment in the State Children's Health Insurance Program (CHIP), led to the first decline in the number of uninsured in over a decade. Unfortunately, the number of uninsured is on the rise again, as State budget deficits have forced deep cuts in public health programs and as unemployment has risen.

Unemployment, however, is not the leading cause of being uninsured. In fact, more than eighty percent of the uninsured—four out of five Americans—are in working families. Seventy-two percent live in households with a full-time worker, and 11 percent live with a part-time worker. Low-wage workers are at greater risk of being uninsured, as are unskilled laborers, service workers, and those employed in small businesses.

The consequences of our Nation's significant uninsured population are devastating for our health and our economy.

The uninsured are significantly more likely to delay or forego needed care and are less likely to receive preventive care.

Delaying or not receiving treatment can lead to more serious illness and avoidable health problems, which in turn results in unnecessary and costly hospitalizations. For example, the uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes. In addition, the uninsured with various forms of cancer are more likely to be diagnosed with late stage cancer.

Indeed, my own State of New Jersey struggles to deal with the costs of charity care provided to the uninsured. In 2002, New Jersey hospitals provided

\$624 million in charity care to the uninsured and underinsured, but were only reimbursed for \$381 million of these costs.

In sum, health insurance coverage matters. It matters to families who don't receive adequate care, and it matters to communities. We ignore the issue of the uninsured at our peril and at a great cost to the quality of life—and to the very life—of our citizens. That is why today I am introducing legislation that will provide universal access to health care for all Americans. My legislation, the Universal Secure Access to (USA) Health Care Act has several components:

First, we must cover all children. Despite the success of the CHIP program, over nine million children are still uninsured. These children are less likely to have immunizations and receive less preventive care, which often results in health problems later in life and also leads to poor school performance. The millions of uninsured children cannot control whether they have health care coverage, and it is a measure of the failure of our politics that we do not take care of our children.

My proposal, modeled on legislation introduced by Senator ROCKEFELLER, would create a MediKids program that would provide universal health insurance for children up to age 23 through a new federal program modeled after Medicare, but with benefits tailored toward the needs of children.

Maintaining the health of our children is critical to the future of our country. Indeed, it is clear that providing health care coverage to children impacts more than just their health—it impacts their ability to learn, their ability to thrive, and their ability to become productive members of society. MediKids simplifies the confusing array of health insurance assistance programs for children today and guarantees them coverage until adulthood.

The next step is to demand that the private sector do its part. Under my bill, large employers would be required to provide health coverage for all their workers. A minimum wage in America should include with it minimum benefits, among them health insurance. But unfortunately, the current system puts the responsible employer who provides health insurance at a disadvantage relative to the employers who do not. When employers fail to cover employees, society pays their share of the bill at the emergency room. In fact, the universal health care delivered in the emergency rooms of our community hospitals is the most expensive and short-sighted approach to address the problem of the uninsured Americans.

Under my bill, small businesses, the self-employed and unemployed would be able to buy coverage in the Federal Employee Health Benefit Program. If it is good enough for Senators, it is good enough for America. Those who are between the ages of 55 and 64 would be able to buy-in to the Medicare program. My legislation would provide tax

credits to the self-employed to assist them in purchasing health insurance and would allow them to buy into the FEHBP program. But although I am passionate about universal access to health care, I realize we can't get there yet. Not because the popular will is not there, but because the political will isn't.

Therefore I believe we can and should be doing all that we can to make incremental progress. So I support incremental changes, starting with the most vulnerable populations, and building on Medicaid and CHIP, success public programs. That is why I am a strong supporter of the Family Care proposal, which would cover the parents of children already enrolled in the CHIP program.

I was also pleased to be an original cosponsor of Senator BINGAMAN's bipartisan legislation, the Start Healthy, Stay Healthy Act, which would expand coverage for children and pregnant women. It is based on the common sense principle that children deserve to start life healthy and stay healthy.

Health professionals agree that one of the best ways to ensure the birth of a healthy baby is to ensure adequate prenatal care. Yet as a Nation, we do far too little to provide this type of care. This is evident by the stark statistics on the subject: the United States ranks 27th in infant mortality and 21st in material mortality—the worst among developed nations. The statistics in New Jersey are equally stark: New Jersey ranks an abysmal 44th among the States in the percentage of mothers receiving adequate prenatal care, 34th in low birth weights, and 12th in infant mortality rates.

Specifically, this important legislation would allow States to cover prenatal care services for women up to 185 percent of the Federal poverty level through the Children's Health Insurance (CHIP) Program. It would also allow States to extend coverage to children under the CHIP program through age 20, and would increase CHIP funding by \$2.65 billion over four years.

I often say that we are not a Nation of equal outcomes, but we should be a Nation of equal beginnings.

Until we give all Americans access to health care, however, we cannot live up to that promise.

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. 1935

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

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the "Universal Secure Access to Health Care Act of 2003".

(b) FINDINGS.—

(1) In 2002, 43,600,000 Americans, nearly 17.2 percent of the total nonelderly population, were uninsured.

(2) The number of uninsured has grown by nearly 10,000,000 over the past decade.

(3) While 61 percent of Americans receive health insurance coverage through their employers, millions of Americans lack access to such coverage either because their employer does not offer such coverage or the employer cannot afford to pay for such coverage.

(4) Today, fewer Americans have health insurance through their employment to cover themselves and their dependents than 10 years ago.

(5) Eighty-two percent of the individuals that are uninsured in the United States are in working families.

(6) Low-wage workers have more difficulty obtaining affordable health care coverage since such workers are less likely than high-wage workers to have such coverage offered as a benefit by an employer, and prohibitive premiums for individually purchased coverage often prevents such workers from purchasing such coverage independently.

(7) The consequences of our nation's significant uninsured population are devastating.

(8) The uninsured are significantly more likely to delay or forego needed health care.

(9) The uninsured are less likely to receive preventive health care.

(10) Delaying or foregoing health care treatment when such treatment is needed can produce unnecessarily dire and expensive results. More severe health care conditions may arise and more expensive health care treatments, such as costly hospitalizations, may be necessary even though such conditions or treatments could have been avoided by the initial provision of adequate and timely health care. The uninsured, for example, are more likely to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes, than the insured. The uninsured with various forms of cancer are also more likely to be diagnosed with late stage cancer than the insured.

SEC. 2. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXVIII—UNIVERSAL HEALTH INSURANCE COVERAGE

"Subtitle A—Employer Mandated Health Insurance Coverage

"SEC. 2801. EMPLOYER MANDATED HEALTH INSURANCE COVERAGE.

"(a) IN GENERAL.—Each employer shall offer to enroll each of its employees and their families in a standard health benefit plan.

"(b) STANDARD HEALTH BENEFIT PLAN.—For purposes of this title, the term 'standard health benefit plan' means a plan that provides benefits for health care items and services that are actuarially equivalent or greater in value than the benefits offered as of January 1, 2000, under the Blue Cross/Blue Shield Standard Option Plan provided under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

"(c) PART-TIME EMPLOYEES.—Subsection (a) shall apply to part-time employees.

"SEC. 2802. TYPE OF COVERAGE.

"(a) IN GENERAL.—Each standard health benefit plan offered by an employer under section 2801(a) shall conform to the requirements of this section.

"(b) PROHIBITION AGAINST DISCRIMINATION.—A standard health benefit plan offered by an employer under section 2801(a) shall not establish rules for eligibility of any individual to enroll under the plan or exclude or otherwise limit any individual from coverage under the plan based on—

"(1) medical history;

"(2) health status;

"(3) a preexisting medical condition, disease, or disorder; or

"(4) genetic information.

"(c) OPEN ENROLLMENT.—A standard health benefit plan offered by an employer under section 2801(a) shall offer an annual open enrollment period during which an individual may change enrollment from such plan to another standard health benefit plan offered by such employer.

"(d) MEDICALLY NECESSARY SERVICES.—A standard health benefit plan offered by an employer under section 2801(a) shall, if such plan provides coverage for a certain health care item or service, provide coverage for such item or service if a doctor determines that such item or service is medically necessary.

"(e) DATE OF INITIAL COVERAGE.—In the case of an employee enrolled in a standard health benefit plan provided by an employer under section 2801(a), the coverage under such plan shall commence not later than 5 days after the day on which the employee first performs an hour of service as an employee of that employer. No waiting period beyond this initial 5-day period may be imposed regarding such coverage.

"SEC. 2803. PREMIUMS.

"(a) IN GENERAL.—Each employer shall—

"(1) contribute to the cost of any standard health benefit plan that an employee has enrolled in in accordance with this section; and

"(2) withhold from wages of an employee, the employee share of the premium assessed for coverage under the standard health benefit plan.

"(b) CONTRIBUTION.—

"(1) EMPLOYER SHARE.—

"(A) FULL-TIME EMPLOYEES.—Each employer who has enrolled an employee in a standard health benefit plan shall contribute not less than 72 percent of the monthly premium for such employee.

"(B) PART-TIME EMPLOYEES.—

"(i) PRO-RATED PORTION PAID.—Each employer who has enrolled a part-time employee in a standard health benefit plan shall pay a portion of the monthly premium for such employee that is pro-rated to correspond with the number of hours of work that such employee has provided during the past month.

"(ii) EXCEPTION.—No employer contribution is required under this section with respect to an employee who works less than 10 hours per week.

"(2) EMPLOYEE SHARE.—

"(A) IN GENERAL.—Each employee enrolled in a standard health benefit plan under section 2801(a) shall pay the remaining portion of the monthly premium after payment by the employer as required under subsection (a).

"(B) PART-TIME EMPLOYEES.—An employee who is enrolled in a standard health benefit plan under section 2801(a) and works for such employer for not more than 30 hours and not less than 10 hours per week shall be eligible for a subsidy to aid such employee in paying his or her portion of the monthly premium.

"(3) LOW-INCOME EMPLOYEES.—An employee who is enrolled in a standard health benefit plan under section 2801(a) whose family income does not exceed 250 percent of the poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)) as applicable to a family of the size involved, shall be eligible to receive a subsidy from the State as described in subtitle B to aid in payment of premiums.

"SEC. 2804. ENFORCEMENT.

"(a) STATE INELIGIBILITY FOR PUBLIC HEALTH SERVICE ACT FUNDS.—An employer

that is a State or political subdivision of a State or an agency or instrumentality of a State or political subdivision that does not comply with the requirements of this title shall not be eligible to receive a grant, contract, cooperative agreement, loan, or loan guarantee under this Act.

"(b) CIVIL PENALTY FOR PRIVATE EMPLOYERS.—

"(1) IN GENERAL.—Any nongovernmental employer that does not comply with this title shall be subject to a civil penalty of not more than 10 percent of the total amount of the employer's expenditures for wages for employees in that year.

"(2) ASSESSMENT PROCEDURE.—A civil money penalty under this section shall be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court. The Secretary shall not assess such a penalty on an employer until the employer has been given notice and an opportunity to present its views on such charge.

"(3) AMOUNT OF PENALTY.—In determining the amount of the penalty, or the amount agreed to in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification of a violation of this title.

"SEC. 2805. DEFINITIONS.

"In this title:

"(1) EMPLOYER.—The term 'employer' means, with respect to a calendar year and plan year, an employer that employed an average of at least 50 full-time employees on business days during the preceding calendar year and employs not less than 50 employees on the first day of the plan year.

"(2) PART-TIME EMPLOYEE.—The term 'part-time employee' means any individual employed by an employer who works less than 40 hours a week.

"(3) WAITING PERIOD.—The term 'waiting period' means, with respect to a plan and an individual who is a potential beneficiary or participant in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. noncompliance by the Secretary.

"SEC. 2806. EFFECTIVE DATE.

"This title shall take effect 2 years after the date of enactment of the Universal Secure Access to Health Care Act of 2003.

"Subtitle B—Individual and Employer Subsidies

"SEC. 2811. SUBSIDY PROGRAM.

"(a) IN GENERAL.—The Secretary shall establish a Federal program to award grants to States for State premium assistance programs.

"(b) FEDERAL PROGRAM.—

"(1) IN GENERAL.—The Secretary shall establish a Federal program that shall set all standards for administration of State programs, receive applications from States for the establishment of such programs, and receive reports from States regarding the developments of such programs.

"(2) REGULATIONS.—The Secretary shall promulgate regulations specifying requirements for State programs under this subtitle, including—

"(A) standards for determining eligibility for premium assistance;

"(B) standards for States operating programs under this subtitle which ensure that such programs are operated in a uniform manner with respect to application procedures, data processing systems, and such other administrative activities as the Secretary determines to be necessary; and

"(C) standards for accepting reports regarding developments of such programs.

“(3) CONTENT.—The regulations described in paragraph (2) shall require that a State program—

“(A) enable an individual to file an application for assistance with an agency designated by the State at any time, in person, by mail, or online;

“(B) provide for the use of an application form developed by the Secretary;

“(C) make applications accessible at locations where individuals are most likely to obtain the applications;

“(D) require individuals to submit revised applications to reflect changes in estimated family incomes, including changes in employment status of family members, during the year, and the State shall revise the amount of any premium assistance based on such a revised application; and

“(E) provide for verification of the information supplied in applications under this subtitle, including examining return information disclosed to the State.

“(4) APPLICATION.—The Secretary shall develop an application form for assistance to be used by a State which shall—

“(A) be simple in form and understandable to the average individual;

“(B) require the provision of information necessary to make a determination as to whether an individual is eligible for assistance, including a declaration of estimated income by the individual based, at the election of the individual—

“(I) on multiplying by a factor of 4 the individual's family income for the 3-month period immediately preceding the month in which the application is made; or

“(II) on estimated income for the entire year for which the application is submitted; and

“(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

“(c) STATE ADMINISTRATION.—

“(1) IN GENERAL.—A State shall have in effect a program for furnishing premium assistance in accordance with this subtitle.

“(2) DESIGNATION OF STATE AGENCY.—A State may designate any appropriate State agency to administer the program under this subtitle.

“(3) EFFECTIVENESS OF ELIGIBILITY.—A determination by a State that an individual is eligible for premium assistance shall be effective for the calendar year for which such determination is made unless a revised application indicates that an individual is no longer eligible for assistance.

“SEC. 2812. SUBSIDIES FOR LOW-INCOME WORKERS.

“(a) IN GENERAL.—A low-income worker shall be eligible for premium assistance if such worker is eligible under subsection (b).

“(b) ELIGIBILITY.—A low-income worker is eligible for premium assistance under subsection (a) if the State determines that such worker has a family income which does not exceed 250 percent of the poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)) as applicable to a family of the size involved.

“(c) AMOUNT OF ASSISTANCE.—The amount of premium assistance for a month for a low-income worker determined to be eligible under subsection (b) shall be determined by the Secretary.

“(d) PAYMENTS.—The amount of the premium assistance available to a low-income worker shall be paid by the State in which the individual resides directly to the standard health plan in which the individual is enrolled. Payments under the preceding sentence shall commence in the first month during which the individual is enrolled in a

standard health benefit plan and determined to be eligible for premium assistance under this subtitle.

“SEC. 2813. SUBSIDIES FOR SMALL BUSINESS EMPLOYERS.

“(a) IN GENERAL.—A small business employer that offers to enroll its employees and their families in a standard health benefit plan shall be eligible for premium assistance if the State determines that such employer qualifies for such assistance under subsection (b).

“(b) ELIGIBILITY.—A small business employer is eligible for premium assistance if such employer employs an average of not more than 75 full-time employees on business days during the preceding calendar year and employs not more than 75 employees on the first day of the plan year.

“(c) AMOUNT OF ASSISTANCE.—The amount of premium assistance for a small business employer for a month shall be determined by the Secretary.

“(d) PAYMENTS.—The amount of the premium assistance available to a small business employer shall be paid by the State in which the business is located directly to the standard health benefit plan in which the employee of such business is enrolled. Payments under the preceding sentence shall commence in the first month during which the employee is enrolled in a standard health benefit plan and the employer is determined to be eligible for premium assistance under this subtitle.

“Subtitle C—Election of Coverage

“SEC. 2815. ELECTION OF COVERAGE.

“(a) IN GENERAL.—A small business employer as described in subsection (b) may elect to enroll its employees in—

“(1) a plan provided under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code; or

“(2) the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), if such employees are not less than 50 years of age.

“(b) SMALL BUSINESS EMPLOYER.—In this section, the term ‘small business employer’ means an employer that employs an average of not more than 75 full-time employees on business days during the preceding calendar year and employs not more than 75 employees on the first day of the plan year.

“Subtitle D—Community Rating

“SEC. 2821. COMMUNITY RATING.

“(a) IN GENERAL.—Each State shall establish community rating areas in which standard health benefit plans shall offer a standard premium in accordance with this subtitle for enrollment for all eligible individuals.

“(b) COMMUNITY RATING AREAS.—

“(1) IN GENERAL.—In accordance with this subtitle, each State shall, subject to approval of the Secretary, provide for the division of the State into 1 or more community rating areas.

“(2) REVISION OF AREAS.—Each State may, subject to approval of the Secretary, redraw the boundaries of such community rating areas as described in paragraph (1) if such revision is reasonable or necessary.

“(3) MULTIPLE AREAS.—With respect to a community rating area—

“(A) no metropolitan statistical area in a State may be incorporated into more than 1 such area in the State;

“(B) the number of individuals residing within such an area may not be less than 250,000; and

“(C) no area incorporated in a community rating area may be incorporated into another such area.

“(4) NONDISCRIMINATION.—In establishing boundaries for community rating areas, a State shall not directly or through contractual arrangements—

“(A) deny or limit access to or the availability of health care services, or otherwise discriminate in connection with the provision of health care services; or

“(B) limit, segregate, or classify an individual in any way which would deprive or tend to deprive such individual of health care services, or otherwise adversely affect his or her access to health care services; on the basis of race, national origin, sex, religion, language, income, age, sexual orientation, disability, health status, or anticipated need for health services.

“(5) COORDINATING MULTIPLE COMMUNITY RATING AREAS.—Nothing in this section shall be construed as preventing a State from coordinating the activities of 1 or more community rating areas in the State.

“(6) INTERSTATE COMMUNITY RATING AREAS.—Community rating areas with respect to interstate areas shall be established in accordance with rules established by the Secretary.

“(7) COORDINATION IN MULTI-STATE AREAS.—One or more States may coordinate their operations in contiguous community rating areas. Such coordination may include, the adoption of joint operating rules, contracting with standard health benefit plans, enforcement activities, and establishment of fee schedules for health providers.

“(c) OPEN ENROLLMENT.—Each State, based on rules and procedures established by the Secretary, shall specify a uniform annual open enrollment period for each community rating area during which all eligible individuals are permitted the opportunity to change enrollment among the standard health benefit plans offered to such individuals in such area under this Act. The initial annual open enrollment period shall be for a period of 90 days.

“(d) STANDARD PREMIUM.—Each standard health benefit plan shall establish within each community rating area in which the plan is to be offered a standard premium for enrollment of eligible individuals who seek enrollment in such plan.

“(e) UNIFORM PREMIUMS WITHIN COMMUNITY RATING AREAS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), the standard premium for each group health plan to which this section applies shall be the same, but shall not include the costs of premium processing and enrollment.

“(2) APPLICATION TO ENROLLEES.—

“(A) IN GENERAL.—The premium charged for coverage in a group health plan which covers eligible employees and eligible individuals shall be the product of—

“(i) the standard premium (established under paragraph (1));

“(ii) in the case of enrollment other than individual enrollment, the family adjustment factor specified under subparagraph (B); and

“(iii) the age adjustment factor (specified under subparagraph (C)).

“(B) FAMILY ADJUSTMENT FACTOR.—

“(i) IN GENERAL.—The Secretary shall specify family adjustment factors that reflect the relative actuarial costs of benefit packages based on family classes of enrollment (as compared with such costs for individual enrollment).

“(ii) CLASSES OF ENROLLMENT.—For purposes of this subtitle, there are 4 classes of enrollment:

“(I) Coverage only of an individual (referred to in this subtitle as the ‘individual’ enrollment or class of enrollment).

“(II) Coverage of a married couple without children (referred to in this subtitle as the ‘couple-only’ enrollment or class of enrollment).

“(III) Coverage of an individual and one or more children (referred to in this subtitle as

the 'single parent' enrollment or class of enrollment).

"(IV) Coverage of a married couple and one or more children (referred to in this subtitle as the 'dual parent' enrollment or class of enrollment).

"(iii) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this subtitle:

"(I) FAMILY.—The terms 'family enrollment' and 'family class of enrollment' refer to enrollment in a class of enrollment described in any subclause of clause (ii) (other than subclause (I)).

"(II) COUPLE.—The term 'couple class of enrollment' refers to enrollment in a class of enrollment described in subclause (II) or (IV) of clause (ii).

"(iv) SPOUSE; MARRIED; COUPLE.—

"(I) IN GENERAL.—In this subtitle, the terms 'spouse' and 'married' mean, with respect to an individual, another individual who is the spouse of, or is married to, the individual, as determined under applicable State law.

"(II) COUPLE.—The term 'couple' means an individual and the individual's spouse.

"(C) AGE ADJUSTMENT FACTOR.—The Secretary shall specify uniform age categories and maximum rating increments for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. For individuals who have attained age 18 but not age 65, the highest age adjustment factor may not exceed 3 times the lowest age adjustment factor."

SEC. 3. TAX DEDUCTION FOR SELF-EMPLOYED.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

"(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, the taxpayer's spouse, and taxpayer's dependents."

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2004.

SEC. 4. ACCESS TO MEDICARE BENEFITS FOR INDIVIDUALS 62-TO-65 YEARS OF AGE.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended—

(1) by redesignating section 1859 and part D as section 1858 and part E, respectively; and

(2) by inserting after such section the following new part:

"PART D—PURCHASE OF MEDICARE BENEFITS BY CERTAIN INDIVIDUALS AGE 62-TO-65 YEARS OF AGE

"SEC. 1859. PROGRAM BENEFITS; ELIGIBILITY.

"(a) ENTITLEMENT TO MEDICARE BENEFITS FOR ENROLLED INDIVIDUALS.—

"(1) IN GENERAL.—An individual enrolled under this part is entitled to the same benefits under this title as an individual entitled to benefits under part A and enrolled under part B.

"(2) DEFINITIONS.—For purposes of this part:

"(A) FEDERAL OR STATE COBRA CONTINUATION PROVISION.—The term 'Federal or State COBRA continuation provision' has the meaning given the term 'COBRA continuation provision' in section 2791(d)(4) of the Public Health Service Act and includes a comparable State program, as determined by the Secretary.

"(B) FEDERAL HEALTH INSURANCE PROGRAM DEFINED.—The term 'Federal health insurance program' means any of the following:

"(i) MEDICARE.—Part A or part B of this title (other than by reason of this part).

"(ii) MEDICAID.—A State plan under title XIX.

"(iii) FEHBP.—The Federal employees health benefit program under chapter 89 of title 5, United States Code.

"(iv) TRICARE.—The TRICARE program (as defined in section 1072(7) of title 10, United States Code).

"(v) ACTIVE DUTY MILITARY.—Health benefits under title 10, United States Code, to an individual as a member of the uniformed services of the United States.

"(C) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term in section 2791(a)(1) of the Public Health Service Act.

"(b) ELIGIBILITY OF INDIVIDUALS AGE 62-TO-65 YEARS OF AGE.—

"(1) IN GENERAL.—Subject to paragraph (2), an individual who meets the following requirements with respect to a month is eligible to enroll under this part with respect to such month:

"(A) AGE.—As of the last day of the month, the individual has attained 62 years of age, but has not attained 65 years of age.

"(B) MEDICARE ELIGIBILITY (BUT FOR AGE).—The individual would be eligible for benefits under part A or part B for the month if the individual were 65 years of age.

"(C) NOT ELIGIBLE FOR COVERAGE UNDER GROUP HEALTH PLANS OR FEDERAL HEALTH INSURANCE PROGRAMS.—The individual is not eligible for benefits or coverage under a Federal health insurance program (as defined in subsection (a)(2)(B)) or under a group health plan (other than such eligibility merely through a Federal or State COBRA continuation provision) as of the last day of the month involved.

"(2) LIMITATION ON ELIGIBILITY IF TERMINATED ENROLLMENT.—If an individual described in paragraph (1) enrolls under this part and coverage of the individual is terminated under section 1859A(d) (other than because of age), the individual is not again eligible to enroll under this subsection unless the following requirements are met:

"(A) NEW COVERAGE UNDER GROUP HEALTH PLAN OR FEDERAL HEALTH INSURANCE PROGRAM.—After the date of termination of coverage under such section, the individual obtains coverage under a group health plan or under a Federal health insurance program.

"(B) SUBSEQUENT LOSS OF NEW COVERAGE.—The individual subsequently loses eligibility for the coverage described in subparagraph (A) and exhausts any eligibility the individual may subsequently have for coverage under a Federal or State COBRA continuation provision.

"(3) CHANGE IN HEALTH PLAN ELIGIBILITY DOES NOT AFFECT COVERAGE.—In the case of an individual who is eligible for and enrolls under this part under this subsection, the individual's continued entitlement to benefits under this part shall not be affected by the individual's subsequent eligibility for benefits or coverage described in paragraph (1)(C), or entitlement to such benefits or coverage.

"SEC. 1859A. ENROLLMENT PROCESS; COVERAGE.

"(a) IN GENERAL.—An individual may enroll in the program established under this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed by the Secretary consistent with the provisions of this section. Such regulations shall provide a process under which—

"(1) individuals eligible to enroll as of a month are permitted to pre-enroll during a prior month within an enrollment period described in subsection (b); and

"(2) each individual seeking to enroll under section 1859(b) is notified, before enrolling, of the deferred monthly premium amount the individual will be liable for under section 1859C(b) upon attaining 65

years of age as determined under section 1859B(c)(3).

"(b) ENROLLMENT PERIODS.—

"(1) INDIVIDUALS 62-TO-65 YEARS OF AGE.—In the case of individuals eligible to enroll under this part under section 1859(b)—

"(A) INITIAL ENROLLMENT PERIOD.—If the individual is eligible to enroll under such section for July 2002, the enrollment period shall begin on May 1, 2002, and shall end on August 31, 2002. Any such enrollment before July 1, 2002, is conditioned upon compliance with the conditions of eligibility for July 2002.

"(B) SUBSEQUENT PERIODS.—If the individual is eligible to enroll under such section for a month after July 2002, the enrollment period shall begin on the first day of the second month before the month in which the individual first is eligible to so enroll and shall end 4 months later. Any such enrollment before the first day of the third month of such enrollment period is conditioned upon compliance with the conditions of eligibility for such third month.

"(2) AUTHORITY TO CORRECT FOR GOVERNMENT ERRORS.—The provisions of section 1837(h) apply with respect to enrollment under this part in the same manner as they apply to enrollment under part B.

"(c) DATE COVERAGE BEGINS.—

"(1) IN GENERAL.—The period during which an individual is entitled to benefits under this part shall begin as follows, but in no case earlier than July 1, 2002:

"(A) In the case of an individual who enrolls (including pre-enrolls) before the month in which the individual satisfies eligibility for enrollment under section 1859, the first day of such month of eligibility.

"(B) In the case of an individual who enrolls during or after the month in which the individual first satisfies eligibility for enrollment under such section, the first day of the following month.

"(2) AUTHORITY TO PROVIDE FOR PARTIAL MONTHS OF COVERAGE.—Under regulations, the Secretary may, in the Secretary's discretion, provide for coverage periods that include portions of a month in order to avoid lapses of coverage.

"(3) LIMITATION ON PAYMENTS.—No payments may be made under this title with respect to the expenses of an individual enrolled under this part unless such expenses were incurred by such individual during a period which, with respect to the individual, is a coverage period under this section.

"(d) TERMINATION OF COVERAGE.—

"(1) IN GENERAL.—An individual's coverage period under this part shall continue until the individual's enrollment has been terminated at the earliest of the following:

"(A) GENERAL PROVISIONS.—

"(i) NOTICE.—The individual files notice (in a form and manner prescribed by the Secretary) that the individual no longer wishes to participate in the insurance program under this part.

"(ii) NONPAYMENT OF PREMIUMS.—The individual fails to make payment of premiums required for enrollment under this part.

"(iii) MEDICARE ELIGIBILITY.—The individual becomes entitled to benefits under part A or enrolled under part B (other than by reason of this part).

"(B) TERMINATION BASED ON AGE.—The individual attains 65 years of age.

"(2) EFFECTIVE DATE OF TERMINATION.—

"(A) NOTICE.—The termination of a coverage period under paragraph (1)(A)(i) shall take effect at the close of the month following for which the notice is filed.

"(B) NONPAYMENT OF PREMIUM.—The termination of a coverage period under paragraph (1)(A)(ii) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in

which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 60 days; except that it may be extended for an additional 30 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 60-day period.

“(C) AGE OR MEDICARE ELIGIBILITY.—The termination of a coverage period under paragraph (1)(A)(iii) or (1)(B) shall take effect as of the first day of the month in which the individual attains 65 years of age or becomes entitled to benefits under part A or enrolled for benefits under part B (other than by reason of this part).

“SEC. 1859B. PREMIUMS.

“(a) AMOUNT OF MONTHLY PREMIUMS.—

“(1) BASE MONTHLY PREMIUMS.—The Secretary shall, during September of each year (beginning with 2001), determine the following premium rates which shall apply with respect to coverage provided under this title for any month in the succeeding year:

“(A) BASE MONTHLY PREMIUM FOR INDIVIDUALS 62 YEARS OF AGE OR OLDER.—A base monthly premium for individuals 62 years of age or older is equal to $\frac{1}{2}$ of the base annual premium rate computed under subsection (b) for each premium area.

“(B) DEFERRED MONTHLY PREMIUMS FOR INDIVIDUALS 62 YEARS OF AGE OR OLDER.—The Secretary shall, during September of each year (beginning with 2001), determine under subsection (c) the amount of deferred monthly premiums that shall apply with respect to individuals who first obtain coverage under this part under section 1859(b) in the succeeding year.

“(3) ESTABLISHMENT OF PREMIUM AREAS.—For purposes of this part, the term ‘premium area’ means such an area as the Secretary shall specify to carry out this part. The Secretary from time to time may change the boundaries of such premium areas. The Secretary shall seek to minimize the number of such areas specified under this paragraph.

“(b) BASE ANNUAL PREMIUM FOR INDIVIDUALS 62 YEARS OF AGE OR OLDER.—

“(1) NATIONAL, PER CAPITA AVERAGE.—The Secretary shall estimate the average, annual per capita amount that would be payable under this title with respect to individuals residing in the United States who meet the requirement of section 1859(b)(1)(A) as if all such individuals were eligible for (and enrolled) under this title during the entire year (and assuming that section 1862(b)(2)(A)(i) did not apply).

“(2) GEOGRAPHIC ADJUSTMENT.—The Secretary shall reduce, as determined appropriate, the amount determined under paragraph (1) for a premium area (specified under subsection (a)(3)) that has costs below the national average, in order to assure participation in all areas throughout the United States.

“(3) BASE ANNUAL PREMIUM.—The base annual premium under this subsection for months in a year for individuals 62 years of age or older residing in a premium area is equal to the average, annual per capita amount estimated under paragraph (1) for the year, adjusted for such area under paragraph (2).

“(c) DEFERRED PREMIUM RATE FOR INDIVIDUALS 62 YEARS OF AGE OR OLDER.—The deferred premium rate for individuals with a group of individuals who obtain coverage under section 1859(b) in a year shall be computed by the Secretary as follows:

“(1) ESTIMATION OF NATIONAL, PER CAPITA ANNUAL AVERAGE EXPENDITURES FOR ENROLLMENT GROUP.—The Secretary shall estimate the average, per capita annual amount that will be paid under this part for individuals in such group during the period of enrollment

under section 1859(b). In making such estimate for coverage beginning in a year before 2006, the Secretary may base such estimate on the average, per capita amount that would be payable if the program had been in operation over a previous period of at least 4 years.

“(2) DIFFERENCE BETWEEN ESTIMATED EXPENDITURES AND ESTIMATED PREMIUMS.—Based on the characteristics of individuals in such group, the Secretary shall estimate during the period of coverage of the group under this part under section 1859(b) the amount by which—

“(A) the amount estimated under paragraph (1); exceeds

“(B) the average, annual per capita amount of premiums that will be payable for months during the year under section 1859C(a) for individuals in such group (including premiums that would be payable if there were no terminations in enrollment under clause (i) or (ii) of section 1859A(d)(1)(A)).

“(3) ACTUARIAL COMPUTATION OF DEFERRED MONTHLY PREMIUM RATES.—The Secretary shall determine deferred monthly premium rates for individuals in such group in a manner so that—

“(A) the estimated actuarial value of such premiums payable under section 1859C(b), is equal to

“(B) the estimated actuarial present value of the differences described in paragraph (2). Such rate shall be computed for each individual in the group in a manner so that the rate is based on the number of months between the first month of coverage based on enrollment under section 1859(b) and the month in which the individual attains 65 years of age.

“(4) DETERMINANTS OF ACTUARIAL PRESENT VALUES.—The actuarial present values described in paragraph (3) shall reflect—

“(A) the estimated probabilities of survival at ages 62 through 84 for individuals enrolled during the year; and

“(B) the estimated effective average interest rates that would be earned on investments held in the trust funds under this title during the period in question.

“SEC. 1859C. PAYMENT OF PREMIUMS.

“(a) PAYMENT OF BASE MONTHLY PREMIUM.—

“(1) IN GENERAL.—The Secretary shall provide for payment and collection of the base monthly premium, determined under section 1859B(a)(1) for the age (and age cohort, if applicable) of the individual involved and the premium area in which the individual principally resides, in the same manner as for payment of monthly premiums under section 1840, except that, for purposes of applying this section, any reference in such section to the Federal Supplementary Medical Insurance Trust Fund is deemed a reference to the Trust Fund established under section 1859D.

“(2) PERIOD OF PAYMENT.—In the case of an individual who participates in the program established by this title, the base monthly premium shall be payable for the period commencing with the first month of the individual's coverage period and ending with the month in which the individual's coverage under this title terminates.

“(b) PAYMENT OF DEFERRED PREMIUM FOR INDIVIDUALS COVERED AFTER ATTAINING AGE 62.—

“(1) RATE OF PAYMENT.—

“(A) IN GENERAL.—In the case of an individual who is covered under this part for a month pursuant to an enrollment under section 1859(b), subject to subparagraph (B), the individual is liable for payment of a deferred premium in each month during the period described in paragraph (2) in an amount equal to the full deferred monthly premium

rate determined for the individual under section 1859B(c).

“(B) SPECIAL RULES FOR THOSE WHO DISENROLL EARLY.—

“(i) IN GENERAL.—If such an individual's enrollment under such section is terminated under clause (i) or (ii) of section 1859A(d)(1)(A), subject to clause (ii), the amount of the deferred premium otherwise established under this paragraph shall be pro-rated to reflect the number of months of coverage under this part under such enrollment compared to the maximum number of months of coverage that the individual would have had if the enrollment were not so terminated.

“(ii) ROUNDING TO 12-MONTH MINIMUM COVERAGE PERIODS.—In applying clause (i), the number of months of coverage (if not a multiple of 12) shall be rounded to the next highest multiple of 12 months, except that in no case shall this clause result in a number of months of coverage exceeding the maximum number of months of coverage that the individual would have had if the enrollment were not so terminated.

“(2) PERIOD OF PAYMENT.—The period described in this paragraph for an individual is the period beginning with the first month in which the individual has attained 65 years of age and ending with the month before the month in which the individual attains 85 years of age.

“(3) COLLECTION.—In the case of an individual who is liable for a premium under this subsection, the amount of the premium shall be collected in the same manner as the premium for enrollment under such part is collected under section 1840, except that any reference in such section to the Federal Supplementary Medical Insurance Trust Fund is deemed to be a reference to the Medicare Early Access Trust Fund established under section 1859D.

“(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1840 (other than subsection (h)) shall apply to premiums collected under this section in the same manner as they apply to premiums collected under part B, except that any reference in such section to the Federal Supplementary Medical Insurance Trust Fund is deemed a reference to the Trust Fund established under section 1859D.

“SEC. 1859D. MEDICARE EARLY ACCESS TRUST FUND.

“(a) ESTABLISHMENT OF TRUST FUND.—

“(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ‘Medicare Early Access Trust Fund’ (in this section referred to as the ‘Trust Fund’). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and such amounts as may be deposited in, or appropriated to, such fund as provided in this title.

“(2) PREMIUMS.—Premiums collected under section 1859B shall be transferred to the Trust Fund.

“(b) INCORPORATION OF PROVISIONS.—

“(1) IN GENERAL.—Subject to paragraph (2), subsections (b) through (i) of section 1841 shall apply with respect to the Trust Fund and this title in the same manner as they apply with respect to the Federal Supplementary Medical Insurance Trust Fund and part B, respectively.

“(2) MISCELLANEOUS REFERENCES.—In applying provisions of section 1841 under paragraph (1)—

“(A) any reference in such section to ‘this part’ is construed to refer to this part D;

“(B) any reference in section 1841(h) to section 1840(d) and in section 1841(i) to sections 1840(b)(1) and 1842(g) are deemed references to comparable authority exercised under this part; and

“(C) payments may be made under section 1841(g) to the trust funds under sections 1817 and 1841 as reimbursement to such funds for payments they made for benefits provided under this part.

“SEC. 1859E. OVERSIGHT AND ACCOUNTABILITY.

“(a) THROUGH ANNUAL REPORTS OF TRUSTEES.—The Board of Trustees of the Medicare Early Access Trust Fund under section 1859D(b)(1) shall report on an annual basis to Congress concerning the status of the Trust Fund and the need for adjustments in the program under this part to maintain financial solvency of the program under this part.

“(b) PERIODIC GAO REPORTS.—The Comptroller General of the United States shall periodically submit to Congress reports on the adequacy of the financing of coverage provided under this part. The Comptroller General shall include in such report such recommendations for adjustments in such financing and coverage as the Comptroller General deems appropriate in order to maintain financial solvency of the program under this part.

“SEC. 1859F. ADMINISTRATION AND MISCELLANEOUS.

“(a) TREATMENT FOR PURPOSES OF THIS TITLE.—Except as otherwise provided in this part—

“(1) an individual enrolled under this part shall be treated for purposes of this title as though the individual was entitled to benefits under part A and enrolled under part B; and

“(2) benefits described in section 1859 shall be payable under this title to such an individual in the same manner as if such individual was so entitled and enrolled.

“(b) NOT TREATED AS MEDICARE PROGRAM FOR PURPOSES OF MEDICAID PROGRAM.—For purposes of applying title XIX (including the provision of medicare cost-sharing assistance under such title), an individual who is enrolled under this part shall not be treated as being entitled to benefits under this title.

“(c) NOT TREATED AS MEDICARE PROGRAM FOR PURPOSES OF COBRA CONTINUATION PROVISIONS.—In applying a COBRA continuation provision (as defined in section 2791(d)(4) of the Public Health Service Act), any reference to an entitlement to benefits under this title shall not be construed to include entitlement to benefits under this title pursuant to the operation of this part.”.

(b) CONFORMING AMENDMENTS TO SOCIAL SECURITY ACT PROVISIONS.—

(1) Section 201(i)(1) of the Social Security Act (42 U.S.C. 401(i)(1)) is amended by striking “or the Federal Supplementary Medical Insurance Trust Fund” and inserting “the Federal Supplementary Medical Insurance Trust Fund, and the Medicare Early Access Trust Fund”.

(2) Section 201(g)(1)(A) of such Act (42 U.S.C. 401(g)(1)(A)) is amended by striking “and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII” and inserting “, the Federal Supplementary Medical Insurance Trust Fund, and the Medicare Early Access Trust Fund established by title XVIII”.

(3) Section 1820(i) of such Act (42 U.S.C. 1395i-4(i)) is amended by striking “part D” and inserting “part E”.

(4) Part C of title XVIII of such Act is amended—

(A) in section 1851(a)(2)(B) (42 U.S.C. 1395w-21(a)(2)(B)), by striking “1859(b)(3)” and inserting “1858(b)(3)”;

(B) in section 1851(a)(2)(C) (42 U.S.C. 1395w-21(a)(2)(C)), by striking “1859(b)(2)” and inserting “1858(b)(2)”;

(C) in section 1852(a)(1) (42 U.S.C. 1395w-22(a)(1)), by striking “1859(b)(3)” and inserting “1858(b)(3)”;

(D) in section 1852(a)(3)(B)(ii) (42 U.S.C. 1395w-22(a)(3)(B)(ii)), by striking “1859(b)(2)(B)” and inserting “1858(b)(2)(B)”;

(E) in section 1853(a)(1)(A) (42 U.S.C. 1395w-23(a)(1)(A)), by striking “1859(e)(4)” and inserting “1858(e)(4)”;

(F) in section 1853(a)(3)(D) (42 U.S.C. 1395w-23(a)(3)(D)), by striking “1859(e)(4)” and inserting “1858(e)(4)”.

(5) Section 1853(c) of such Act (42 U.S.C. 1395w-23(c)) is amended—

(A) in paragraph (1), by striking “and (7)” and inserting “, (7), and (8)”, and

(B) by adding at the end the following:

“(8) ADJUSTMENT FOR EARLY ACCESS.—In applying this subsection with respect to individuals entitled to benefits under part D, the Secretary shall provide for an appropriate adjustment in the Medicare+Choice capitation rate as may be appropriate to reflect differences between the population served under such part and the population under parts A and B.”.

(c) OTHER CONFORMING AMENDMENTS.—

(1) Section 138(b)(4) of the Internal Revenue Code of 1986 is amended by striking “1859(b)(3)” and inserting “1858(b)(3)”.

(2)(A) Section 602(D)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended by inserting “(not including an individual who is so entitled pursuant to enrollment under section 1859A)” after “Social Security Act”.

(B) Section 2202(2)(D)(ii) of the Public Health Service Act (42 U.S.C. 300bb-2(2)(D)(ii)) is amended by inserting “(not including an individual who is so entitled pursuant to enrollment under section 1859A)” after “Social Security Act”.

(C) Section 4980B(f)(2)(B)(i)(V) of the Internal Revenue Code of 1986 is amended by inserting “(not including an individual who is so entitled pursuant to enrollment under section 1859A)” after “Social Security Act”.

SEC. 5. ACCESS TO MEDICARE BENEFITS FOR DISPLACED WORKERS 55-TO-62 YEARS OF AGE.

(a) ELIGIBILITY.—Section 1859 of the Social Security Act, as inserted by section 4(a)(2), is amended by adding at the end the following new subsection:

“(c) DISPLACED WORKERS AND SPOUSES.—

“(1) DISPLACED WORKERS.—Subject to paragraph (3), an individual who meets the following requirements with respect to a month is eligible to enroll under this part with respect to such month:

“(A) AGE.—As of the last day of the month, the individual has attained 55 years of age, but has not attained 62 years of age.

“(B) MEDICARE ELIGIBILITY (BUT FOR AGE).—The individual would be eligible for benefits under part A or B for the month if the individual were 65 years of age.

“(C) LOSS OF EMPLOYMENT-BASED COVERAGE.—

“(i) ELIGIBLE FOR UNEMPLOYMENT COMPENSATION.—The individual meets the requirements relating to period of covered employment and conditions of separation from employment to be eligible for unemployment compensation (as defined in section 85(b) of the Internal Revenue Code of 1986), based on a separation from employment occurring on or after January 1, 2001. The previous sentence shall not be construed as requiring the individual to be receiving such unemployment compensation.

“(ii) LOSS OF EMPLOYMENT-BASED COVERAGE.—Immediately before the time of such separation from employment, the individual was covered under a group health plan on the basis of such employment, and, because of such loss, is no longer eligible for coverage under such plan (including such eligibility based on the application of a Federal or State COBRA continuation provision) as of the last day of the month involved.

“(iii) PREVIOUS CREDITABLE COVERAGE FOR AT LEAST 1 YEAR.—As of the date on which the individual loses coverage described in

clause (ii), the aggregate of the periods of creditable coverage (as determined under section 2701(c) of the Public Health Service Act) is 12 months or longer.

“(D) EXHAUSTION OF AVAILABLE COBRA CONTINUATION BENEFITS.—

“(i) IN GENERAL.—In the case of an individual described in clause (ii) for a month described in clause (iii)—

“(I) the individual (or spouse) elected coverage described in clause (ii); and

“(II) the individual (or spouse) has continued such coverage for all months described in clause (iii) in which the individual (or spouse) is eligible for such coverage.

“(ii) INDIVIDUALS TO WHOM COBRA CONTINUATION COVERAGE MADE AVAILABLE.—An individual described in this clause is an individual—

“(I) who was offered coverage under a Federal or State COBRA continuation provision at the time of loss of coverage eligibility described in subparagraph (C)(ii); or

“(II) whose spouse was offered such coverage in a manner that permitted coverage of the individual at such time.

“(iii) MONTHS OF POSSIBLE COBRA CONTINUATION COVERAGE.—A month described in this clause is a month for which an individual described in clause (ii) could have had coverage described in such clause as of the last day of the month if the individual (or the spouse of the individual, as the case may be) had elected such coverage on a timely basis.

“(E) NOT ELIGIBLE FOR COVERAGE UNDER FEDERAL HEALTH INSURANCE PROGRAM OR GROUP HEALTH PLANS.—The individual is not eligible for benefits or coverage under a Federal health insurance program or under a group health plan (whether on the basis of the individual's employment or employment of the individual's spouse) as of the last day of the month involved.

“(2) SPOUSE OF DISPLACED WORKER.—Subject to paragraph (3), an individual who meets the following requirements with respect to a month is eligible to enroll under this part with respect to such month:

“(A) AGE.—As of the last day of the month, the individual has not attained 62 years of age.

“(B) MARRIED TO DISPLACED WORKER.—The individual is the spouse of an individual at the time the individual enrolls under this part under paragraph (1) and loses coverage described in paragraph (1)(C)(ii) because the individual's spouse lost such coverage.

“(C) MEDICARE ELIGIBILITY (BUT FOR AGE); EXHAUSTION OF ANY COBRA CONTINUATION COVERAGE; AND NOT ELIGIBLE FOR COVERAGE UNDER FEDERAL HEALTH INSURANCE PROGRAM OR GROUP HEALTH PLAN.—The individual meets the requirements of subparagraphs (B), (D), and (E) of paragraph (1).

“(3) CHANGE IN HEALTH PLAN ELIGIBILITY AFFECTS CONTINUED ELIGIBILITY.—For provision that terminates enrollment under this section in the case of an individual who becomes eligible for coverage under a group health plan or under a Federal health insurance program, see section 1859A(d)(1)(C).

“(4) REENROLLMENT PERMITTED.—Nothing in this subsection shall be construed as preventing an individual who, after enrolling under this subsection, terminates such enrollment from subsequently reenrolling under this subsection if the individual is eligible to enroll under this subsection at that time.”.

(b) ENROLLMENT.—Section 1859A of such Act, as so inserted, is amended—

(1) in subsection (a), by striking “and” at the end of paragraph (1), by striking the period at the end of paragraph (2) and inserting “; and”, and by adding at the end the following new paragraph:

“(3) individuals whose coverage under this part would terminate because of subsection

(d)(1)(B)(ii) are provided notice and an opportunity to continue enrollment in accordance with section 1859E(c)(1).";

(2) in subsection (b), by inserting after Notwithstanding any other provision of law, (1) the following:

"(2) **DISPLACED WORKERS AND SPOUSES.**—In the case of individuals eligible to enroll under this part under section 1859(c), the following rules apply:

"(A) **INITIAL ENROLLMENT PERIOD.**—If the individual is first eligible to enroll under such section for July 2005, the enrollment period shall begin on May 1, 2002, and shall end on August 31, 2002. Any such enrollment before July 1, 2002, is conditioned upon compliance with the conditions of eligibility for July 2002.

"(B) **SUBSEQUENT PERIODS.**—If the individual is eligible to enroll under such section for a month after July 2002, the enrollment period based on such eligibility shall begin on the first day of the second month before the month in which the individual first is eligible to so enroll (or reenroll) and shall end 4 months later.";

(3) in subsection (d)(1), by amending subparagraph (B) to read as follows:

"(B) **TERMINATION BASED ON AGE.**—

"(i) **AT AGE 65.**—Subject to clause (ii), the individual attains 65 years of age.

"(ii) **AT AGE 62 FOR DISPLACED WORKERS AND SPOUSES.**—In the case of an individual enrolled under this part pursuant to section 1859(c), subject to subsection (a)(1), the individual attains 62 years of age.";

(4) in subsection (d)(1), by adding at the end the following new subparagraph:

"(C) **OBTAINING ACCESS TO EMPLOYMENT-BASED COVERAGE OR FEDERAL HEALTH INSURANCE PROGRAM FOR INDIVIDUALS UNDER 62 YEARS OF AGE.**—In the case of an individual who has not attained 62 years of age, the individual is covered (or eligible for coverage) as a participant or beneficiary under a group health plan or under a Federal health insurance program.";

(5) in subsection (d)(2), by amending subparagraph (C) to read as follows:

"(C) **AGE OR MEDICARE ELIGIBILITY.**—

"(i) **IN GENERAL.**—The termination of a coverage period under paragraph (1)(A)(iii) or (1)(B)(i) shall take effect as of the first day of the month in which the individual attains 65 years of age or becomes entitled to benefits under part A or enrolled for benefits under part B.

"(ii) **DISPLACED WORKERS.**—The termination of a coverage period under paragraph (1)(B)(ii) shall take effect as of the first day of the month in which the individual attains 62 years of age, unless the individual has enrolled under this part pursuant to section 1859(b) and section 1859E(c)(1)."; and

(6) in subsection (d)(2), by adding at the end the following new subparagraph:

"(D) **ACCESS TO COVERAGE.**—The termination of a coverage period under paragraph (1)(C) shall take effect on the date on which the individual is eligible to begin a period of creditable coverage (as defined in section 2701(c) of the Public Health Service Act) under a group health plan or under a Federal health insurance program.";

(c) **PREMIUMS.**—Section 1859B of such Act, as so inserted, is amended—

(1) in subsection (a)(1), by adding at the end the following:

"(B) **BASE MONTHLY PREMIUM FOR INDIVIDUALS UNDER 62 YEARS OF AGE.**—A base monthly premium for individuals under 62 years of age, equal to 1/2 of the base annual premium rate computed under subsection (d)(3) for each premium area and age cohort."; and

(2) by adding at the end the following new subsection:

"(d) **BASE MONTHLY PREMIUM FOR INDIVIDUALS UNDER 62 YEARS OF AGE.**—

"(1) **NATIONAL, PER CAPITA AVERAGE FOR AGE GROUPS.**—

"(A) **ESTIMATE OF AMOUNT.**—The Secretary shall estimate the average, annual per capita amount that would be payable under this title with respect to individuals residing in the United States who meet the requirement of section 1859(c)(1)(A) within each of the age cohorts established under subparagraph (B) as if all such individuals within such cohort were eligible for (and enrolled) under this title during the entire year (and assuming that section 1862(b)(2)(A)(i) did not apply).

"(B) **AGE COHORTS.**—For purposes of subparagraph (A), the Secretary shall establish separate age cohorts in 5-year age increments for individuals who have not attained 60 years of age and a separate cohort for individuals who have attained 60 years of age.

"(2) **GEOGRAPHIC ADJUSTMENT.**—The Secretary shall adjust the amount determined under paragraph (1)(A) for each premium area (specified under subsection (a)(3)) in the same manner and to the same extent as the Secretary provides for adjustments under subsection (b)(2).

"(3) **BASE ANNUAL PREMIUM.**—The base annual premium under this subsection for months in a year for individuals in an age cohort under paragraph (1)(B) in a premium area is equal to 165 percent of the average, annual per capita amount estimated under paragraph (1) for the age cohort and year, adjusted for such area under paragraph (2).

"(4) **PRO-RATION OF PREMIUMS TO REFLECT COVERAGE DURING A PART OF A MONTH.**—If the Secretary provides for coverage of portions of a month under section 1859A(c)(2), the Secretary shall pro-rate the premiums attributable to such coverage under this section to reflect the portion of the month so covered.";

(d) **ADMINISTRATIVE PROVISIONS.**—Section 1859F of such Act, as so inserted, is amended by adding at the end the following:

"(d) **ADDITIONAL ADMINISTRATIVE PROVISIONS.**—

"(1) **PROCESS FOR CONTINUED ENROLLMENT OF DISPLACED WORKERS WHO ATTAIN 62 YEARS OF AGE.**—The Secretary shall provide a process for the continuation of enrollment of individuals whose enrollment under section 1859(c) would be terminated upon attaining 62 years of age. Under such process such individuals shall be provided appropriate and timely notice before the date of such termination and of the requirement to enroll under this part pursuant to section 1859(b) in order to continue entitlement to benefits under this title after attaining 62 years of age.

"(2) **ARRANGEMENTS WITH STATES FOR DETERMINATIONS RELATING TO UNEMPLOYMENT COMPENSATION ELIGIBILITY.**—The Secretary may provide for appropriate arrangements with States for the determination of whether individuals in the State meet or would meet the requirements of section 1859(c)(1)(C)(i).";

(e) **CONFORMING AMENDMENT TO HEADING TO PART.**—The heading of part D of title XVIII of the Social Security Act, as so inserted, is amended by striking "62" and inserting "55".

SEC. 6. PROVISIONS TO MAKE FEHBP COVERAGE AVAILABLE FOR THE SELF-EMPLOYED.

Chapter 89 of title 5, United States Code, is amended by adding at the end the following:

"§ 8915. Expanded access to coverage for the self-employed

"(a) The Office of Personnel Management (referred to in this section as the 'Office') shall administer a health insurance program for eligible individuals who are non-Federal employees in accordance with this section.

"(b) The term 'eligible individual' means a self-employed individual as defined in section 401(c)(1) of the Internal Revenue Code of 1986.

"(c) The Office shall prescribe regulations to apply the provisions of this chapter to the greatest extent practicable to eligible individuals covered under this section.

"(c) In no event shall the enactment of this section result in—

"(1) any increase in the level of individual or Government contributions required under this chapter, including copayments or deductibles;

"(2) any decrease in the types of benefits offered under this chapter; or

"(3) any other change that would adversely affect the coverage afforded under this chapter to employees and annuitants and members of family under this chapter.

"(d) The Office shall develop methods to facilitate enrollment under this section, including the use of the Internet.

"(e) The Office may enter into contracts for the performance of appropriate administrative functions under this chapter.

"(f) Each contract entered into under section 8902 shall require a carrier to offer to eligible individuals under this chapter, throughout each term for which the contract remains effective, the same benefits (subject to the same maximums, limitations, exclusions, and other similar terms or conditions) as would be offered under such contract or applicable health benefits plan to employees, annuitants, and members of family.

"(g) (1) The Office may waive the requirements of this section, if the Office determines, based on a petition submitted by a carrier that—

"(A) the carrier is unable to offer the applicable health benefits plan because of a limitation in the capacity of the plan to deliver services or assure financial solvency;

"(B) the applicable health benefits plan is not sponsored by a carrier licensed under applicable State law; or

"(C) bona fide enrollment restrictions make the application of this chapter inappropriate, including restrictions common to plans which are limited to individuals having a past or current employment relationship with a particular agency or other authority of the Government.

"(2) The Office may require a petition under this subsection to include—

"(A) a description of the efforts the carrier proposes to take in order to offer the applicable health benefits plan under this chapter; and

"(B) the proposed date for offering such a health benefits plan.

"(3) A waiver under this section may be for any period determined by the Office. The Office may grant subsequent waivers under this section.

"(h) The Office shall provide for the implementation of procedures to provide for an annual open enrollment period during which eligible individuals may enroll with a plan or contract for coverage under this section.

"(i) Except as the Office may by regulation prescribe, any reference to this chapter (or any requirement of this chapter), made in any provision of law, shall not be considered to include this section (or any requirement of this section).

"(j) This section shall take effect on the date of enactment of this section and shall apply to contracts that take effect with respect to calendar year 2002 and each calendar year thereafter.";

SEC. 7. MEDIKIDS HEALTH INSURANCE.

(a) **BENEFITS FOR ALL CHILDREN BORN AFTER 2002.**—

(1) **IN GENERAL.**—The Social Security Act is amended by adding at the end the following:

"TITLE XXII—MEDIKIDS PROGRAM

"SEC. 2201. ELIGIBILITY.

"(a) **ELIGIBILITY OF INDIVIDUALS BORN AFTER DECEMBER 31, 2002; ALL CHILDREN**

UNDER 23 YEARS OF AGE IN SIXTH YEAR.—An individual who meets the following requirements with respect to a month is eligible to enroll under this title with respect to such month:

“(1) AGE.—

“(A) FIRST YEAR.—During the first year in which this title is effective, the individual has not attained 6 years of age.

“(B) SECOND YEAR.—During the second year in which this title is effective, the individual has not attained 11 years of age.

“(C) THIRD YEAR.—During the third year in which this title is effective, the individual has not attained 16 years of age.

“(D) FOURTH YEAR.—During the fourth year in which this title is effective, the individual has not attained 21 years of age.

“(E) FIFTH AND SUBSEQUENT YEARS.—During the fifth year in which this title is effective and each subsequent year, the individual has not attained 23 years of age.

“(2) CITIZENSHIP.—The individual is a citizen or national of the United States or is permanently residing in the United States under color of law.

“(b) ENROLLMENT PROCESS.—An individual may enroll in the program established under this title only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed by the Secretary consistent with the provisions of this section. Such regulations shall provide a process under which—

“(1) individuals who are born in the United States after December 31, 2002, are deemed to be enrolled at the time of birth and a parent or guardian of such an individual is permitted to pre-enroll in the month prior to the expected month of birth;

“(2) individuals who are born outside the United States after such date and who become eligible to enroll by virtue of immigration into (or an adjustment of immigration status in) the United States are deemed enrolled at the time of entry or adjustment of status;

“(3) eligible individuals may otherwise be enrolled at such other times and manner as the Secretary shall specify, including the use of outstationed eligibility sites as described in section 1902(a)(55)(A) and the use of presumptive eligibility provisions like those described in section 1920A; and

“(4) at the time of automatic enrollment of a child, the Secretary provides for issuance to a parent or custodian of the individual a card evidencing coverage under this title and for a description of such coverage.

The provisions of section 1837(h) apply with respect to enrollment under this title in the same manner as they apply to enrollment under part B of title XVIII.

“(c) DATE COVERAGE BEGINS.—

“(1) IN GENERAL.—The period during which an individual is entitled to benefits under this title shall begin as follows, but in no case earlier than January 1, 2003:

“(A) In the case of an individual who is enrolled under paragraph (1) or (2) of subsection (b), the date of birth or date of obtaining appropriate citizenship or immigration status, as the case may be.

“(B) In the case of an another individual who enrolls (including pre-enrolls) before the month in which the individual satisfies eligibility for enrollment under subsection (a), the first day of such month of eligibility.

“(C) In the case of an another individual who enrolls during or after the month in which the individual first satisfies eligibility for enrollment under such subsection, the first day of the following month.

“(2) AUTHORITY TO PROVIDE FOR PARTIAL MONTHS OF COVERAGE.—Under regulations, the Secretary may, in the Secretary's discretion, provide for coverage periods that in-

clude portions of a month in order to avoid lapses of coverage.

“(3) LIMITATION ON PAYMENTS.—No payments may be made under this title with respect to the expenses of an individual enrolled under this title unless such expenses were incurred by such individual during a period which, with respect to the individual, is a coverage period under this section.

“(d) EXPIRATION OF ELIGIBILITY.—An individual's coverage period under this part shall continue until the individual's enrollment has been terminated because the individual no longer meets the requirements of subsection (a) (whether because of age or change in immigration status).

“(e) ENTITLEMENT TO MEDIKIDS BENEFITS FOR ENROLLED INDIVIDUALS.—An individual enrolled under this section is entitled to the benefits described in section 2202.

“(f) LOW-INCOME INFORMATION.—At the time of enrollment of a child under this title, the Secretary shall make an inquiry as to whether or not the family income of the family that includes the child is less than 150 percent of the poverty line for a family of the size involved. If the family income is below such level, the Secretary shall encode in the identification card issued in connection with eligibility under this title a code indicating such fact. The Secretary also shall provide for a toll-free telephone line at which providers can verify whether or not such a child is in a family the income of which is below such level.

“(g) CONSTRUCTION.—Nothing in this title shall be construed as requiring (or preventing) an individual who is enrolled under this section from seeking medical assistance under a State Medicaid plan under title XIX or child health assistance under a State child health plan under title XXI.

“SEC. 2202. BENEFITS.

“(a) SECRETARIAL SPECIFICATION OF BENEFIT PACKAGE.—

“(1) IN GENERAL.—The Secretary shall specify the benefits to be made available under this title consistent with the provisions of this section and in a manner designed to meet the health needs of enrollees.

“(2) UPDATING.—The Secretary shall update the specification of benefits over time to ensure the inclusion of age-appropriate benefits to reflect the enrollee population.

“(3) ANNUAL UPDATING.—The Secretary shall establish procedures for the annual review and updating of such benefits to account for changes in medical practice, new information from medical research, and other relevant developments in health science.

“(4) INPUT.—The Secretary shall seek the input of the pediatric community in specifying and updating such benefits.

“(5) LIMITATION ON UPDATING.—In no case shall updating of benefits under this subsection result in a failure to provide benefits required under subsection (b).

“(b) INCLUSION OF CERTAIN BENEFITS.—

“(1) MEDICARE CORE BENEFITS.—Such benefits shall include (to the extent consistent with other provisions of this section) at least the same benefits (including coverage, access, availability, duration, and beneficiary rights) that are available under parts A and B of title XVIII.

“(2) ALL REQUIRED MEDICAID BENEFITS.—Such benefits shall also include all items and services for which medical assistance is required to be provided under section 1902(a)(10)(A) to individuals described in such section, including early and periodic screening, diagnostic services, and treatment services.

“(3) INCLUSION OF PRESCRIPTION DRUGS.—Such benefits also shall include (as specified by the Secretary) prescription drugs and biologicals.

“(4) COST-SHARING.—

“(A) IN GENERAL.—Subject to subparagraph (B), such benefits also shall include the cost-sharing (in the form of deductibles, coinsurance, and copayments) applicable under title XVIII with respect to comparable items and services, except that no cost-sharing shall be imposed with respect to early and periodic screening and diagnostic services included under paragraph (2).

“(B) NO COST-SHARING FOR LOWEST INCOME CHILDREN.—Such benefits shall not include any cost-sharing for children in families the income of which (as determined for purposes of section 1905(pp)) does not exceed 150 percent of the official income poverty line (referred to in such section) applicable to a family of the size involved.

“(C) REFUNDABLE CREDIT FOR COST-SHARING FOR OTHER LOW-INCOME CHILDREN.—For a refundable credit for cost-sharing in the case of children in certain families, see section 35 of the Internal Revenue Code of 1986.

“(c) PAYMENT SCHEDULE.—The Secretary, with the assistance of the Medicare Payment Advisory Commission, shall develop and implement a payment schedule for benefits covered under this title. To the extent feasible, such payment schedule shall be consistent with comparable payment schedules and reimbursement methodologies applied under parts A and B of title XVIII.

“(d) INPUT.—The Secretary shall specify such benefits and payment schedules only after obtaining input from appropriate child health providers and experts.

“(e) ENROLLMENT IN HEALTH PLANS.—The Secretary shall provide for the offering of benefits under this title through enrollment in a health benefit plan that meets the same (or similar) requirements as the requirements that apply to Medicare+Choice plans under part C of title XVIII. In the case of individuals enrolled under this title in such a plan, the Medicare+Choice capitation rate described in section 1853(c) shall be adjusted in an appropriate manner to reflect differences between the population served under this title and the population under title XVIII.

“SEC. 2203. PREMIUMS.

“(a) AMOUNT OF MONTHLY PREMIUMS.—

“(1) IN GENERAL.—The Secretary shall, during September of each year (beginning with 2002), establish a monthly MediKids premium. Subject to paragraph (2), the monthly MediKids premium for a year is equal to 1/2 of the annual premium rate computed under subsection (b).

“(2) ELIMINATION OF MONTHLY PREMIUM FOR DEMONSTRATION OF EQUIVALENT COVERAGE (INCLUDING COVERAGE UNDER LOW-INCOME PROGRAMS).—The amount of the monthly premium imposed under this section for an individual for a month shall be zero in the case of an individual who demonstrates to the satisfaction of the Secretary that the individual has basic health insurance coverage for that month. For purposes of the previous sentence enrollment in a Medicaid plan under title XIX, a State child health insurance plan under title XXI, or under the Medicare program under title XVIII is deemed to constitute basic health insurance coverage described in such sentence.

“(b) ANNUAL PREMIUM.—

“(1) NATIONAL, PER CAPITA AVERAGE.—The Secretary shall estimate the average, annual per capita amount that would be payable under this title with respect to individuals residing in the United States who meet the requirement of section 2201(a)(1) as if all such individuals were eligible for (and enrolled) under this title during the entire year (and assuming that section 1862(b)(2)(A)(i) did not apply).

“(2) ANNUAL PREMIUM.—Subject to subsection (d), the annual premium under this

subsection for months in a year is equal to 25 percent of the average, annual per capita amount estimated under paragraph (1) for the year.

“(c) PAYMENT OF MONTHLY PREMIUM.—

“(1) PERIOD OF PAYMENT.—In the case of an individual who participates in the program established by this title, subject to subsection (d), the monthly premium shall be payable for the period commencing with the first month of the individual's coverage period and ending with the month in which the individual's coverage under this title terminates.

“(2) COLLECTION THROUGH TAX RETURN.—For provisions providing for the payment of monthly premiums under this subsection, see section 59B of the Internal Revenue Code of 1986.

“(3) PROTECTIONS AGAINST FRAUD AND ABUSE.—The Secretary shall develop, in coordination with States and other health insurance issuers, administrative systems to ensure that claims which are submitted to more than one payor are coordinated and duplicate payments are not made.

“(d) REDUCTION IN PREMIUM FOR CERTAIN LOW-INCOME FAMILIES.—For provisions reducing the premium under this section for certain low-income families, see section 59B(c) of the Internal Revenue Code of 1986.

“SEC. 2204. MEDIKIDS TRUST FUND.

“(a) ESTABLISHMENT OF TRUST FUND.—

“(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ‘MediKids Trust Fund’ (in this section referred to as the ‘Trust Fund’). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and such amounts as may be deposited in, or appropriated to, such fund as provided in this title.

“(2) PREMIUMS.—Premiums collected under section 2203 shall be transferred to the Trust Fund.

“(b) INCORPORATION OF PROVISIONS.—

“(1) IN GENERAL.—Subject to paragraph (2), subsections (b) through (i) of section 1841 shall apply with respect to the Trust Fund and this title in the same manner as they apply with respect to the Federal Supplementary Medical Insurance Trust Fund and part B, respectively.

“(2) MISCELLANEOUS REFERENCES.—In applying provisions of section 1841 under paragraph (1)—

“(A) any reference in such section to ‘this part’ is construed to refer to title XXII;

“(B) any reference in section 1841(h) to section 1840(d) and in section 1841(i) to sections 1840(b)(1) and 1842(g) are deemed references to comparable authority exercised under this title;

“(C) payments may be made under section 1841(g) to the Trust Funds under sections 1817 and 1841 as reimbursement to such funds for payments they made for benefits provided under this title; and

“(D) the Board of Trustees of the MediKids Trust Fund shall be the same as the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.

“SEC. 2205. OVERSIGHT AND ACCOUNTABILITY.

“(a) THROUGH ANNUAL REPORTS OF TRUSTEES.—The Board of Trustees of the MediKids Trust Fund under section 2204(b)(1) shall report on an annual basis to Congress concerning the status of the Trust Fund and the need for adjustments in the program under this title to maintain financial solvency of the program under this title.

“(b) PERIODIC GAO REPORTS.—The Comptroller General of the United States shall periodically submit to Congress reports on the adequacy of the financing of coverage provided under this title. The Comptroller Gen-

eral shall include in such report such recommendations for adjustments in such financing and coverage as the Comptroller General deems appropriate in order to maintain financial solvency of the program under this title.

“SEC. 2206. INCLUSION OF CARE COORDINATION SERVICES.

“(a) IN GENERAL.—

“(1) PROGRAM AUTHORITY.—The Secretary, beginning in 2003, may implement a care coordination services program in accordance with the provisions of this section under which, in appropriate circumstances, eligible individuals may elect to have health care services covered under this title managed and coordinated by a designated care coordinator.

“(2) ADMINISTRATION BY CONTRACT.—The Secretary may administer the program under this section through a contract with an appropriate program administrator.

“(3) COVERAGE.—Care coordination services furnished in accordance with this section shall be treated under this title as if they were included in the definition of medical and other health services under section 1861(s) and benefits shall be available under this title with respect to such services without the application of any deductible or coinsurance.

“(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

“(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The Secretary shall specify criteria to be used in making a determination as to whether an individual may appropriately be enrolled in the care coordination services program under this section, which shall include at least a finding by the Secretary that for cohorts of individuals with characteristics identified by the Secretary, professional management and coordination of care can reasonably be expected to improve processes or outcomes of health care and to reduce aggregate costs to the programs under this title.

“(2) PROCEDURES TO FACILITATE ENROLLMENT.—The Secretary shall develop and implement procedures designed to facilitate enrollment of eligible individuals in the program under this section.

“(c) ENROLLMENT OF INDIVIDUALS.—

“(1) SECRETARY'S DETERMINATION OF ELIGIBILITY.—The Secretary shall determine the eligibility for services under this section of individuals who are enrolled in the program under this section and who make application for such services in such form and manner as the Secretary may prescribe.

“(2) ENROLLMENT PERIOD.—

“(A) EFFECTIVE DATE AND DURATION.—Enrollment of an individual in the program under this section shall be effective as of the first day of the month following the month in which the Secretary approves the individual's application under paragraph (1), shall remain in effect for one month (or such longer period as the Secretary may specify), and shall be automatically renewed for additional periods, unless terminated in accordance with such procedures as the Secretary shall establish by regulation. Such procedures shall permit an individual to disenroll for cause at any time and without cause at re-enrollment intervals.

“(B) LIMITATION ON REENROLLMENT.—The Secretary may establish limits on an individual's eligibility to reenroll in the program under this section if the individual has disenrolled from the program more than once during a specified time period.

“(d) PROGRAM.—The care coordination services program under this section shall include the following elements:

“(1) BASIC CARE COORDINATION SERVICES.—

“(A) IN GENERAL.—Subject to the cost-effectiveness criteria specified in subsection

(b)(1), except as otherwise provided in this section, enrolled individuals shall receive services described in section 1905(t)(1) and may receive additional items and services as described in subparagraph (B).

“(B) ADDITIONAL BENEFITS.—The Secretary may specify additional benefits for which payment would not otherwise be made under this title that may be available to individuals enrolled in the program under this section (subject to an assessment by the care coordinator of an individual's circumstance and need for such benefits) in order to encourage enrollment in, or to improve the effectiveness of, such program.

“(2) CARE COORDINATION REQUIREMENT.—Notwithstanding any other provision of this title, the Secretary may provide that an individual enrolled in the program under this section may be entitled to payment under this title for any specified health care items or services only if the items or services have been furnished by the care coordinator, or coordinated through the care coordination services program. Under such provision, the Secretary shall prescribe exceptions for emergency medical services as described in section 1852(d)(3), and other exceptions determined by the Secretary for the delivery of timely and needed care.

“(e) CARE COORDINATORS.—

“(1) CONDITIONS OF PARTICIPATION.—In order to be qualified to furnish care coordination services under this section, an individual or entity shall—

“(A) be a health care professional or entity (which may include physicians, physician group practices, or other health care professionals or entities the Secretary may find appropriate) meeting such conditions as the Secretary may specify;

“(B) have entered into a care coordination agreement; and

“(C) meet such criteria as the Secretary may establish (which may include experience in the provision of care coordination or primary care physician's services).

“(2) AGREEMENT TERM; PAYMENT.—

“(A) DURATION AND RENEWAL.—A care coordination agreement under this subsection shall be for one year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in paragraph (1).

“(B) PAYMENT FOR SERVICES.—The Secretary may negotiate or otherwise establish payment terms and rates for services described in subsection (d)(1).

“(C) LIABILITY.—Case coordinators shall be subject to liability for actual health damages which may be suffered by recipients as a result of the care coordinator's decisions, failure or delay in making decisions, or other actions as a care coordinator.

“(D) TERMS.—In addition to such other terms as the Secretary may require, an agreement under this section shall include the terms specified in subparagraphs (A) through (C) of section 1905(t)(3).

“SEC. 2207. ADMINISTRATION AND MISCELLANEOUS.

“(a) IN GENERAL.—Except as otherwise provided in this title—

“(1) the Secretary shall enter into appropriate contracts with providers of services, other health care providers, carriers, and fiscal intermediaries, taking into account the types of contracts used under title XVIII with respect to such entities, to administer the program under this title;

“(2) individuals enrolled under this title shall be treated for purposes of title XVIII as though the individual were entitled to benefits under part A and enrolled under part B of such title;

“(3) benefits described in section 2202 that are payable under this title to such individuals shall be paid in a manner specified by

the Secretary (taking into account, and based to the greatest extent practicable upon, the manner in which they are provided under title XVIII);

"(4) provider participation agreements under title XVIII shall apply to enrollees and benefits under this title in the same manner as they apply to enrollees and benefits under title XVIII; and

"(5) individuals entitled to benefits under this title may elect to receive such benefits under health plans in a manner, specified by the Secretary, similar to the manner provided under part C of title XVIII.

"(b) COORDINATION WITH MEDICAID AND SCHIP.—Notwithstanding any other provision of law, individuals entitled to benefits for items and services under this title who also qualify for benefits under title XIX or XXI or any other Federally funded program may continue to qualify and obtain benefits under such other title or program, and in such case such an individual shall elect either—

"(1) such other title or program to be primary payor to benefits under this title, in which case no benefits shall be payable under this title and the monthly premium under section 2203 shall be zero; or

"(2) benefits under this title shall be primary payor to benefits provided under such program or title, in which case the Secretary shall enter into agreements with States as may be appropriate to provide that, in the case of such individuals, the benefits under titles XIX and XXI or such other program (including reduction of cost-sharing) are provided on a 'wrap-around' basis to the benefits under this title."

(2) CONFORMING AMENDMENTS TO SOCIAL SECURITY ACT PROVISIONS.—

(A) Section 201(i)(1) of the Social Security Act (42 U.S.C. 401(i)(1)) is amended by striking "or the Federal Supplementary Medical Insurance Trust Fund" and inserting "the Federal Supplementary Medical Insurance Trust Fund, and the MediKIDS Trust Fund".

(B) Section 201(g)(1)(A) of such Act (42 U.S.C. 401(g)(1)(A)) is amended by striking and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII" and inserting "the Federal Supplementary Medical Insurance Trust Fund, and the MediKIDS Trust Fund established by title XVIII".

(C) Section 1853(c) of such Act (42 U.S.C. 1395w-23(c)) is amended—

(i) in paragraph (1), by striking "or (7)" and inserting " (7), or (8)", and

(ii) by adding at the end the following:

"(8) ADJUSTMENT FOR MEDIKIDS.—In applying this subsection with respect to individuals entitled to benefits under title XXII, the Secretary shall provide for an appropriate adjustment in the Medicare+Choice capitation rate as may be appropriate to reflect differences between the population served under such title and the population under parts A and B."

(3) MAINTENANCE OF MEDICAID ELIGIBILITY AND BENEFITS FOR CHILDREN.—

(A) IN GENERAL.—In order for a State to continue to be eligible for payments under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a))—

(i) the State may not reduce standards of eligibility, or benefits, provided under its State Medicaid plan under title XIX of the Social Security Act or under its State child health plan under title XXI of such Act for individuals under 23 years of age below such standards of eligibility, and benefits, in effect on the date of the enactment of this Act; and

(ii) the State shall demonstrate to the satisfaction of the Secretary of Health and Human Services that any savings in State expenditures under title XIX or XXI of the

Social Security Act that results from children from enrolling under title XXII of such Act shall be used in a manner that improves services to beneficiaries under title XIX of such Act, such as through increases in provider payment rates, expansion of eligibility, improved nurse and nurse aide staffing and improved inspections of nursing facilities, and coverage of additional services.

(B) MEDIKIDS AS PRIMARY PAYOR.—In applying title XIX of the Social Security Act, the MediKIDS program under title XXII of such Act shall be treated as a primary payor in cases in which the election described in section 2207(b)(2) of such Act, as added by subsection (a), has been made.

(4) EXPANSION OF MEDPAC MEMBERSHIP TO 19.—

(A) IN GENERAL.—Section 1805(c) of the Social Security Act (42 U.S.C. 1395b-6(c)) is amended—

(i) in paragraph (1), by striking "17" and inserting "19"; and

(ii) in paragraph (2)(B), by inserting "experts in children's health," after "other health professionals,".

(B) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(i) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b-6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under subsection (a)(1) are as follows:

(I) One member shall be appointed for 1 year.

(II) One member shall be appointed for 2 years.

(ii) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2002.

(b) MEDIKIDS PREMIUM.—

(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination of tax liability) is amended by adding at the end the following "new part:

"PART VIII—MEDIKIDS PREMIUM

"Sec. 59B. MediKIDS premium.

"SEC. 59B. MEDIKIDS PREMIUM.

"(a) IMPOSITION OF TAX.—In the case of an individual to whom this section applies, there is hereby imposed (in addition to any other tax imposed by this subtitle) a MediKIDS premium for the taxable year.

"(b) INDIVIDUALS SUBJECT TO PREMIUM.—

"(1) IN GENERAL.—This section shall apply to an individual if the taxpayer has a MediKid at any time during the taxable year.

"(2) MEDIKID.—For purposes of this section, the term 'MediKid' means, with respect to a taxpayer, any individual with respect to whom the taxpayer is required to pay a premium under section 2203(c) of the Social Security Act for any month of the taxable year.

"(c) AMOUNT OF PREMIUM.—For purposes of this section, the MediKIDS premium for a taxable year is the sum of the monthly premiums under section 2203 of the Social Security Act for months in the taxable year.

"(d) EXCEPTIONS BASED ON ADJUSTED GROSS INCOME.—

"(1) EXEMPTION FOR VERY LOW-INCOME TAXPAYERS.—

"(A) IN GENERAL.—No premium shall be imposed by this section on any taxpayer having an adjusted gross income not in excess of the exemption amount.

"(B) EXEMPTION AMOUNT.—For purposes of this paragraph, the exemption amount is—

"(i) \$17,415 in the case of a taxpayer having 1 MediKid,

"(ii) \$21,945 in the case of a taxpayer having 2 MediKIDS,

"(iii) \$26,475 in the case of a taxpayer having 3 MediKIDS, and

"(iv) \$31,005 in the case of a taxpayer having 4 or more MediKIDS.

"(C) PHASEOUT OF EXEMPTION.—In the case of a taxpayer having an adjusted gross income which exceeds the exemption amount but does not exceed twice the exemption amount, the premium shall be the amount which bears the same ratio to the premium which would (but for this subparagraph) apply to the taxpayer as such excess bears to the exemption amount.

"(D) INFLATION ADJUSTMENT OF EXEMPTION AMOUNTS.—In the case of any taxable year beginning in a calendar year after 2001, each dollar amount contained in subparagraph (C) shall be increased by an amount equal to the product of—

"(i) such dollar amount, and

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2000' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.

"(2) PREMIUM LIMITED TO 5 PERCENT OF ADJUSTED GROSS INCOME.—In no event shall any taxpayer be required to pay a premium under this section in excess of an amount equal to 5 percent of the taxpayer's adjusted gross income.

"(e) COORDINATION WITH OTHER PROVISIONS.—

"(1) NOT TREATED AS MEDICAL EXPENSE.—For purposes of this chapter, any premium paid under this section shall not be treated as expense for medical care.

"(2) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The premium paid under this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(A) the amount of any credit allowable under this chapter, or

"(B) the amount of the minimum tax imposed by section 55.

"(3) TREATMENT UNDER SUBTITLE F.—For purposes of subtitle F, the premium paid under this section shall be treated as if it were a tax imposed by section 1."

(2) TECHNICAL AMENDMENTS.—

(A) Subsection (a) of section 6012 of such Code is amended by inserting after paragraph (9) the following new paragraph:

"(10) Every individual liable for a premium under section 59B."

(B) The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end the following new item:

"Part VIII. MediKIDS premium."

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to months beginning after December 2002, in taxable years ending after such date.

(c) REFUNDABLE CREDIT FOR COST-SHARING EXPENSES UNDER MEDIKIDS PROGRAM.—

(1) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

"SEC. 35. COST-SHARING EXPENSES UNDER MEDIKIDS PROGRAM.

"(a) ALLOWANCE OF CREDIT.—In the case of an individual who has a MediKid (as defined in section 59B) at any time during the taxable year, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to 50 percent of the amount paid by the taxpayer during the taxable year as cost-sharing under section 2202(b)(4) of the Social Security Act.

"(b) LIMITATION BASED ON ADJUSTED GROSS INCOME.—The amount of the credit which would (but for this subsection) be allowed under this section for the taxable year shall be reduced (but not below zero) by an amount which bears the same ratio to such amount of credit as the excess of the taxpayer's adjusted gross income for such taxable year over the exemption amount (as defined in section 59B(d)) bears to such exemption amount."

(2) TECHNICAL AMENDMENTS.—

(A) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period "or from section 35 of such Code".

(B) The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

"Sec. 35. Cost-sharing expenses under MediKids program.

"Sec. 36. Overpayments of tax."

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2002.

(d) REPORT ON LONG-TERM REVENUES.—Within 1 year after the date of enactment of this Act, the Secretary of the Treasury shall propose a gradual schedule of progressive tax changes to fund the program under title XXII of the Social Security Act, as the number of enrollees grows in the out-years.

ORDER FOR ADJOURNMENT

Mr. GRASSLEY. Mr. President, we want to make sure there is time this evening for Senators BINGAMAN and LEVIN to give their remarks. 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, following the remarks of Senator BINGAMAN and Senator LEVIN.

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

The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I thank the chairman of the committee. I appreciate the chance to speak briefly on this bill. It is a very important piece of legislation. I congratulate the Senator from Iowa on the hard work he has put into this legislation. I do not share his conclusion about it at this stage, but I certainly admire the work he has put in and admire the good job he does as chairman of the committee on which I serve.

When the 2000 Presidential campaign was underway, I saw one of the debates between then-Governor Bush and then-Vice President Gore. Both of them in that debate endorsed the enactment of a prescription drug benefit for seniors for Medicare beneficiaries. I remember thinking when I saw that, this is one good thing that will come out of this campaign in the next few years, no matter who wins. But what I had in mind as a prescription drug benefit was a very different animal than what we have in these 1,100 pages that have been referred to repeatedly.

What I had in mind was a benefit where Medicare beneficiaries would be able to sign up for a prescription drug benefit. It would be voluntary. They

could sign up or not. They could then pay a monthly premium. They would get a card. They could take that card, go to the pharmacy and get their prescription drugs. They might have to pay a copay. They might have to pay some deductible. But it was basically the adding of a prescription drug benefit to Medicare. That is what I thought both candidates were talking about.

That is not what we have in these 1,100 pages. Had we decided to enact that, it could have been done in a much smaller document.

I regretfully have to oppose the conference report for H.R. 1 as it comes before us tonight and tomorrow.

I will cite six reasons I have come to that conclusion. The first reason is that the bill, in my view, over time, will undermine traditional Medicare.

The second reason is that the bill requires the Government to overpay private health plans by tens of billions of dollars.

The third reason is that the bill actually will harm many senior citizens who are intended to benefit.

Fourth, the bill will increase drug costs rather than reducing them.

Fifth, the bill will dramatically increase the complexity and volatility of the Medicare system for many of our seniors.

Finally, the sixth point is that the bill will increase the financial burden on States and make it more difficult for each of our States to maintain the benefits they provide through their Medicaid programs to low-income patients.

Let me start with the problem that I see of this bill undermining traditional Medicare. Today, 88 percent of all of those 41 million people who are served by Medicare are enrolled in traditional Medicare. The major thrust of this bill is not to add a prescription drug benefit but instead to do what is euphemistically referred to as "modernize" Medicare.

Now, there are definitely some things we should do to modernize Medicare. I would agree with that. But as that term is used in this discussion, most of the time it is a code word, meaning that we should move people—seniors and disabled individuals—out of traditional Medicare into the private health care system. That is what is meant by a lot of our colleagues when they talk about modernizing Medicare.

There are two good reasons for moving people out of traditional Medicare into the private health care system, as I see it. I could certainly favor doing that if we could accomplish these purposes. The first, obviously, would be to make the program more efficient and save money—save some taxpayer dollars by moving these people out of the Government plan into a private plan.

The second, of course, would be if we could improve services, increase the satisfaction of Medicare beneficiaries by moving them into the private plan.

Let me just show this chart. Medicare cost growth: This relates to the

first of those two points. Medicare has historically controlled costs far better than either private health care plans have, or even better than the Federal Employees Health Benefits Program, FEHBP. We all take great pride in the FEHBP program and talk about how this is a great benefit and we should extend it to others.

Between 1969 and now, Medicare's costs have increased at an annual rate of 8.9 percent a year, which stands in contrast to the 11 percent growth rate in the private health insurance arena and 10.6 percent growth rate in FEHBP. So the ideology of this drive to modernize Medicare or move people out of traditional Medicare into the private system does not match the evidence. In fact, the recent record is even more dramatic. Between 1996 and 2003, Medicare's per capita growth was 4.2 percent compared to 5.9 percent for private health plans and 5.3 percent for FEHBP.

Medicare wins the contest going away. But maybe some are willing to pay higher costs, so this chart should make that point. The red line shows the increase in costs from 1970 to the end of the century in private insurance. The blue line shows the increase in the cost of Medicare. They have both gone up, but Medicare has gone up less rapidly. We might still be willing to pay more—pay the amount required to put people on this red line if, in fact, we had greater patient satisfaction by doing so.

There is a recent study by the Commonwealth Fund, published in Health Affairs, and it is reflected on this chart. It is hard to read because the colors are too similar. What is reflected is that of those with private health insurance, there were 51 percent of those who were satisfied, and 62 percent of those in traditional Medicare were satisfied with their coverage. That is the case, despite the fact that Medicare benefits are less generous and its beneficiaries are more elderly and disabled and have higher health needs than individuals in the private health care system.

So the bill seeks to move people out of traditional Medicare into private health plans. It does so by dramatically overpaying the private health plans.

Let me move to my second point. Since managed care is not more efficient than traditional Medicare, the conference report concludes that the way to get people into these private health plans is to spend billions of dollars in overpayment to those plans.

The legislation begins by setting its benchmark for payments to private plans at 109 percent of what Medicare fee for service would have to spend for those beneficiaries. It does so in other ways as well, including giving health plans money that Medicare otherwise would pay to a disproportionate share of hospitals, to graduate medical education, and the cost of veterans retiree health care.

It makes no sense to me to subsidize and pay health plan payments that Medicare intends, or could have, for safety net hospitals or teaching hospitals or veterans retirees. These HMOs do not provide unpaid services to the poor. They do not educate our Nation's medical students. They do not provide health care to our veterans. Yet the conference report provides payment for such services.

It makes no sense, but it is intended to camouflage the fact that private health plans cannot compete with traditional Medicare if they merely receive the amount traditional Medicare spends to provide these services to beneficiaries. So that is not enough.

The other thing that is done is that we, in this bill, provide a \$10 billion to \$12 billion stabilization fund. That stabilization fund essentially is money that the Secretary of Health and Human Services has available to add to what private plans are receiving and further advantage them over the traditional Medicare system if he or she determines that that is necessary in order to keep them providing services to this portion of our population.

Of course, the other issue that I think is extremely important is that these private health plans, under the legislation, are fully free to engage in practices that allow them to enroll healthy Medicare beneficiaries and shift the sicker and the more costly or elderly beneficiaries into the Medicare system. They do this by adjusting their benefits. They do this by designing their benefit packages and marketing them to the healthy segments of the society.

Some might ask how do they do this. I will give you an example. Some private plans impose a higher cost share for services such as chemotherapy or renal dialysis than traditional Medicare in order to encourage those who have contracted cancer or renal failure to enroll, to leave the private plan and to go back into traditional Medicare.

Proponents of the bill say what they are trying to do by getting these private plans involved is to foster competition. Obviously, we all favor competition, but I do not see that it is particularly competitive for us to provide this kind of very major subsidy.

When you add together the 109 percent payment to the private plans and the risk selection in which they are permitted to engage, private plans will be paid an estimated 25 percent more than the cost of traditional Medicare for each enrollee, for each beneficiary. This amounts to \$1,920 more per enrollee in the year 2006.

A third problem is the bill actually does harm. I mentioned what many of my colleagues have already mentioned, and that is the 2.7 million retirees who are expected to lose their prescription drug coverage once we enact this legislation.

Also, the Congressional Budget Office analysis says as to low-income beneficiaries, there are 3.4 million low-in-

come beneficiaries who will benefit from this; there are 6.4 million low-income beneficiaries currently enrolled in Medicaid who will be worse off. It is hard for me to see how that adds up to a major benefit for a lot of those people who are expecting a benefit under this legislation.

Let me talk a minute about drug costs. What will this bill do for drug costs? When I talk with seniors in my State, the No. 1 problem they cite to me when it comes to prescription drugs is the enormous growth in the cost of those drugs.

I have concluded, reluctantly, that not only will this legislation not bring down drug costs but it will actually cause them to go up. Surveys indicate that Medicare beneficiaries cite this as their No. 1 problem. The Congressional Budget Office has concluded the conference report will actually raise the price of drugs by 3.5 percent overall.

The legislation that is before us, this 1,100 pages, delivers to hundreds of private drug companies and HMOs an insurance-administered drug benefit that vastly dilutes the purchasing power of Medicare. Rather than Medicare purchasing the drugs in bulk to achieve significant savings, the medication splits Medicare's purchasing power into hundreds of purchasing pools and eliminates the significant leverage that Medicare could have in controlled costs.

This bill expressly prohibits Medicare from negotiating for prices. People need to focus on that. Here we are setting up a program where Medicare is going to pay for prescription drugs, and we are prohibiting Medicare from negotiating as to the price it is going to pay.

Consumers Union came out with a report last week saying the proposal's modest benefits, coupled with an expected high growth of prescription drug prices, could result in major disappointments for many of these Medicare beneficiaries. Medicare beneficiaries at most prescription drug expenditure levels will actually face higher out-of-pocket costs when they have coverage in 2007—that is one year after the bill is implemented—than they do in 2003 when they have no coverage.

That is an incredible finding, in my view. For example, it only provides people with a benefit of around \$1,000 for the first \$5,000 in prescription drug spending. When you couple that with weak cost containment provisions, the Consumer Union finds that the average out-of-pocket spending for beneficiaries rises to \$2,900 in 2000 compared to \$2,300 in 2003 for beneficiaries with absolutely no prescription drug coverage.

Let me also move to this final chart to talk about the problem of complexity and volatility. I heard some of the majority leader's comments earlier this evening. He indicated that one of the great advantages of this bill is that it would reduce paperwork. I would

love to understand that. How we can enact this enormous piece of legislation and see it reduce paperwork is a mystery to me.

This is a chart that was put together by the Medicare Rights Center. It tries to set out some depiction of how this is all going to work. I can't begin to explain it to you at this point, but I can tell you that you can study it for a great length of time and still not understand how it is going to work.

Most people receiving benefits through Medicare choose traditional Medicare. They like the stability of traditional Medicare.

The Washington Post today had a story about the problems beneficiaries who have enrolled in Medicare+Choice have encountered: the changing benefits that health plans offer on an annual basis; the changes in premiums and copayments; the problem of health plans coming in and out of the marketplace. We have had that problem in my State of New Mexico. Health plans come in, advertise, sign up a lot of people, and 6 months or a year later they announce they are not making money and they pull out. They send a letter to everybody and say: Sorry, we decided not to provide your benefits. Those people come to my office and say: What are we going to do?

This is a volatility in the system that most people on Medicare do not appreciate. I see that increasing dramatically under this legislation. How in the world we can see less paperwork, how in the world we can see less complexity and less volatility as a result of this bill escapes me.

A final point I want to make is the impact on States, expanding on this concept of "do no harm." This legislation has potentially major negative consequences for our States. In the first 3 years of the bill, the Congressional Budget Office estimates that the costs, or the unfunded liability of the bill to the States in their Medicaid programs, will be \$1.2 billion.

We are, in effect, adding \$1.2 billion in costs to the Medicaid Program at a time when States have been begging for relief from the Federal Government due to the growing Medicaid costs that States have experienced because of the slow economy and the growing beneficiary roles.

States have had to make rather dramatic cuts in their Medicaid programs because of these changes, and this \$1.2 billion in additional costs to them will result in additional cuts in Medicaid.

There is a misconception, I believe, about this legislation, and that is, people think that because Medicare is taking over the payment for dual-eligibles—that is low-income individuals who are eligible for Medicaid but also old enough to be eligible for Medicare—since Medicare is going to take over that expense, people think this is going to save the States money.

First of all, until the year 2008 under this legislation, States do not receive any benefit from the Federal assumption of drug costs for dual-eligibles or

low-income beneficiaries who currently get their prescription drugs from Medicaid. That is 5 years from now before they receive any benefit. States expecting to get savings from this bill, in the words of the National Conference of State Legislatures, will be "deeply disappointed."

In addition, this report contains what is called the clawback or the reverse block grant. This is a new concept to me, but it is a fascinating one. Instead of the Federal Government giving a block grant to the States, the Federal Government legislates a requirement on the States to give the Federal Government a block grant.

It is through this clawback or reverse block grant the Federal Government demands that States pay the Federal Government for any savings the Federal Government estimates the States might gain from the new Medicare Program.

When we take the period between 2004 and 2013, the amount the States will have to pay back to the Federal Government is \$88.5 billion. Now, that is a big number, \$88.5 billion. The conference report requires States to write checks to the Federal Government in the amount of \$5.7 billion in 2006. This goes up to \$14.9 billion in 2013. Over that 7-year period, that is a 261 percent increase in the amount the States have to pay the Federal Government.

One may ask how they go up that much. It goes up that much because the Federal Government has built into this a 15 percent compounded inflation rate, and that is being imposed on the States. The States have nothing to say about it. If the States want to participate in Medicaid, they will pay that amount back to the Federal Government.

State general revenues, tax revenues, will not go up 15 percent annually during those 7 years. So States are rightfully upset by this clawback. They rightfully point out that they are being required to now pay an inflation rate for something they do not control. The clawback, or the reverse block grant, is increasing by 261 percent over 7 years.

What this is going to do is to put increased pressure on State budgets which will result in cuts in Medicaid, cuts in education, cuts in transportation. This should not be an acceptable outcome for those of us in the Senate. The bill we sent to the conference from the Senate loaded a \$10 billion burden on the States. Now that it has come back to us, it has an \$88 billion burden that we are loading on the States as part of this legislation.

I would add one other point about this burden. There is a group of 20 States that have a cap that is imposed upon them through Medicaid's disproportionate share hospital program. That cap says they can receive no more than 1 percent of the total Medicaid spending in their State. That compares to 8 percent, which is the national average.

The 20 States I am talking about are called low-DSH States. New Mexico is

one of those States. I authored legislation to increase that 1 percent to 3 percent, not to get it up to the national average, which would have been 8 percent, but to get it up to 3 percent. That would have allowed the disproportionate share hospitals in my State, instead of receiving \$9 million a year, to receive a total of \$45 million a year.

Unfortunately, the conference report cut the amount my State would receive from \$45 million down to \$10 million. Current law is \$9 million. Under this bill, we would go to \$10 million instead of going from \$9 million to \$45 million.

In sharp contrast, Louisiana's share of the Medicaid DSH funding goes from \$500 million to \$600 million next year. This is an unacceptable disparity, in my view. Louisiana's \$100 million increase is more than the \$43 million increase that is provided to all of the 20 low-DSH States combined. This precludes States such as mine from protecting their safety net hospitals and dealing with the fact that the uninsured rate in our States has increased by 4 million people over the last 2 years.

In conclusion, it is my view that Congress does its worst work under the circumstances we are being presented with tonight and tomorrow. It is late in the session. There is no time for adequate review of the 1,100 pages that have been put on each of our desks. We are being pushed up against a totally artificial deadline. This is not the end of the Congress. It is barely the middle of the Congress. There is no reason this bill has to be passed before we leave for Thanksgiving. We could either come back after Thanksgiving or we could take it up in January.

I have a letter from the Democratic Governors Association which says: We urge you to reject any efforts to vote on this legislation before you know its full content and cost impact on your State and the people we both serve.

This is to all Members of the Senate from the Democratic Governors Association. They go on to say: Any rush to judgment without the necessary information may have both short- and long-term consequences that could prove to be irrevocably severe.

We do not know the consequences of this legislation that we are being urged to pass tomorrow. We owe it to senior citizens in this country to understand what we are doing. We owe it to the taxpayers of the country to buy health care services for seniors without overpaying for those health care services. We owe it to the public to do all we can to reduce health care costs. Unfortunately, we are doing none of these things if we take up this bill and pass it tomorrow.

I hope Senators will join me in voting not to send this bill to the President in its present form.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Mr. LEVIN. Mr. President, first, I commend the Senator from New Mex-

ico for his analysis of this bill. I listened to the last part of it and I thought it was exactly on point. I particularly would like to emphasize his last point, which is that this is not the end of the Congress, this is just the end of a session, or nearing the end of a session.

With 4 days' notice of a bill of this complexity—now, I think the bill itself is about 700 pages and there are hundreds of pages of commentary that go with it, but the idea that we should take up a bill of this complexity, when seniors are just having the first opportunity after 4 days to try to fathom what is in it, is a terrible mistake.

The Senator from New Mexico was exactly right in urging that we not rush to consider this bill tomorrow and to adopt this bill. It took a great deal of effort to create Medicare. It was not until 20 years after Harry Truman first proposed the idea of a guaranteed health benefit for seniors that President Lyndon Johnson signed the Medicare Program into law. It was fitting that Harry Truman was the program's first beneficiary. He paid his \$3 premium and he enrolled in Medicare in 1965.

We are confronting in this bill a turning away from Medicare's noble purpose. That purpose was to create an insurance pool for all seniors, where the risks and financial burdens are shared—not for the profit of insurance companies or pharmaceutical companies but for the common good. The legislation before us is a fundamental and ill-advised restructuring of Medicare under the guise of adding a prescription drug benefit to the program.

Many Members of Congress have worked for years to bring a Medicare prescription drug benefit to fruition. While the Senate-passed version of this bill had enough flaws to cause me, along with a number of colleagues, to vote against it, at least I was hopeful that some of these flaws would be corrected in the conference committee. Unfortunately, the prescription drug plan before us not only worsens the prescription drug program as adopted by the Senate, it has become a millstone dragging Medicare down with it.

The promise of a prescription drug plan is being used to begin the unraveling of Medicare. First, there are the dangers for seniors created by the prescription drug provisions themselves. The Congressional Budget Office estimates that up to 25 percent of retirees, with existing prescription drug coverage through a former employer, would lose that coverage under this bill's plan. That is about 2.7 million senior citizens who currently have good private insurance and are paying less now than they would have to under a Medicare prescription drug plan. That is 2.7 million retirees who will lose benefits, above and beyond the number of retirees who are projected to lose their benefits under the current trend of employers reducing prescription drug coverage for their retirees.

The tax subsidies for employers included in this conference report are not enough to entice employers to keep their drug coverage for those 2.7 million retirees.

Another fundamental flaw with the prescription drug benefit in this legislation is the lack of a guaranteed Medicare prescription drug plan. In the Senate bill, in the absence of two competing private plans offering a senior a prescription drug benefit, Medicare was the fallback. This approach was gutted in conference. Here is what the conference report provides. If one insurance company in a region offers a prescription drug benefit, regardless of how unattractive it is to seniors in terms of its premiums and copayments, both of which are left up to the insurance company, and if an HMO offers coverage in that region as a substitute to Medicare, no matter how unattractive that HMO is to seniors, and assuming that HMO also offers a prescription drug benefit, the senior will not be offered the fallback Medicare prescription drug benefit.

Let me put that another way. We begin with the fact that private insurance companies offering a prescription drug policy under this bill could charge whatever premiums and copayments they want. If only one private prescription drug plan exists in a region, regardless of how unappealing it is, and one HMO offering a prescription drug plan also exists in that region, a senior has the choice of purchasing the bad prescription drug plan or leaving Medicare to join an HMO that he or she does not want to join, in order to get that prescription drug benefit. Forcing seniors to make the choice between staying in traditional Medicare or leaving Medicare and joining an HMO they otherwise would not join in order to get a prescription drug benefit is a thinly disguised attempt to unravel and privatize Medicare. That is a choice no senior citizen in America should have to make.

Also troubling is the fact that the private company which offers the prescription drug benefit, and the company which offers the managed care alternative to Medicare, can be one and the same under the provisions of this bill. In addition, the prescription drug benefit in the legislation before us has a large gap in the prescription drug coverage. Once a senior's total drug spending reaches about \$2,500 for the year, he or she will have to pay 100 percent of the cost of their prescriptions until their total drug spending reaches \$3,600. This has come to be called the donut hole. This coverage gap will leave many seniors to pay the full cost of prescriptions at a time when they most need assistance. I know of no other insurance program that is so unfairly structured in that way.

Adding insult to injury, while there is a gaping hole in coverage, there is no gap in the requirement to pay premiums. That obligation continues, even during the period that benefits are halted.

One of the most disturbing aspects of this legislation is the fact that private insurance companies can use the purchasing power of their large number of beneficiaries to negotiate lower prescription drug prices, but Medicare is prohibited from doing so. This is one of the most unacceptable ways this bill protects private insurance companies and prescription drug companies from fair competition from Medicare, all at the expense of seniors and American taxpayers.

Ask veterans how much prescription drugs cost at VA hospitals compared to their local pharmacy. Many of the drugs the VA offers are as little as half the price. The reason is the VA buys drugs in large quantities from drug manufacturers and has leverage in negotiating the prices. Instead of buying the 30-day supply of pills for someone on Medicare, why not allow Medicare to buy thousands of 30-day supplies at once for a fraction of the cost? That makes a lot of sense, but it is prohibited under this bill.

The conferees left out some other real solutions to address the high cost of prescription drugs. Both the House- and Senate-passed versions included a provision to allow seniors to buy drugs in other countries at lower prices, so-called reimportation provision. However, these provisions have been stripped from the final bill. Even though the House and Senate have voted to allow reimportation with strong bipartisan votes, the conferees ignored these votes. More important, they ignored the problem of high prescription drug costs. Americans pay more for prescription drugs than any people in the world. U.S. taxpayers' dollars help to subsidize the research and development of many prescription drugs. Yet drug companies then sell them abroad for less. Because this bill does not address the high cost of prescription drugs, needed medicine will still be inaccessible for millions of our citizens.

Unfortunately, the prescription drug benefit in this bill is what Newt Gingrich envisioned for the future of the entire Medicare Program. The former House Speaker said that he wanted Medicare to wither on a vine. To slowly chip away at the foundation of Medicare until it crumbles with a private network of managed care and drug companies eventually replacing Medicare is what he envisioned.

Apparently AARP, which once stood for preserving social insurance for America's seniors, agrees with Mr. Gingrich. The AARP executive director and CEO wrote the forward to the former Speaker's book entitled "Saving Lives and Saving Money," and later commented that "Newt's ideas are influencing how we at AARP are thinking about our national role and in our advocating for system change."

With this bill, the chief cooks of the Republican Party are following Newt Gingrich's "wither on a vine" recipe for the future of Medicare.

The six so-called premium support demonstration projects created by this bill are the opening act for the privatization of Medicare. Proponents argue that Medicare's costs won't come down without a private sector competitor. But this bill, while purporting to promote competition between Medicare and private insurers, tilts the playing field against Medicare. First, there is a \$12 billion so-called stabilization fund, which is in reality a slush fund. It is a slush fund for insurance companies to subsidize their policies. The \$12 billion in slush money is not available to traditional Medicare, only to the private insurance companies.

Second, the claims of the insurance industry that they will and must accept every senior who applies are disingenuous. Here is why. Private insurers will have the flexibility to alter and change their plans, to be able to cherry-pick the healthy senior. For example, if an insurance company designed a program with a very low monthly premium but with high copayments and high deductibles, this would be an incentive for a healthy senior to enroll, someone who could risk having to pay high copayments and deductibles because he or she has relatively infrequent medical treatment. Less healthy seniors, whose frequent medical treatments make it difficult or impossible for them to pay high copayments and high deductibles, would be left for the Medicare program to cover. This is privatization plus. It simply cannibalizes Medicare. Subsidizing insurance companies and allowing them to cherry-pick the beneficiary population means that insurance companies will be profiting mightily, while leaving the U.S. taxpayer to pick up the tab of insuring the less profitable population.

How did we arrive at this ill-conceived legislation? Democrats were all but shut out of the conference committee which wrote this bill. Only two Democrats were allowed to participate in the conference negotiations. This massive shift in Medicare's approach and purpose was delivered publicly to us about 4 days ago. In this bill's 700 pages are provisions to dismantle Medicare as we know it, replacing it with a network of private insurers and drug companies whose goal is making a profit.

There is a fundamental difference between private industry and government: Private companies fail if they do not make money, while government fails if we do not help citizens—especially those that cannot help themselves.

I have heard from many of my constituents in the State of Michigan who need help in getting affordable prescription drugs. Let me read you a few excerpts from letters that I have received on this issue. One constituent writes:

I am writing for your support for the Medicare Program. Please provide a Medicare drug benefit that is comprehensive, affordable and secure. Do not undermine Medicare

as a defined benefit program through privatizing it.

Another constituent writes:

We do not want a drug bill that eliminates or reduces our current prescription plan that we now have . . . When I retired . . . this plan was part of my benefit package and we felt that it is their obligation to continue it, and the cost of our drugs should not be passed on to the tax payers.

I get hundreds of messages a week like that from constituents with concerns over the privatizing of Medicare and the possible loss of existing prescription drug benefits. It is estimated that this bill, if it becomes law, would cause 138,000 seniors in Michigan currently receiving prescription drug benefits to lose some or all of those benefits. And 90,000 seniors in my State who are Medicaid beneficiaries with a current prescription drug coverage will be worse off if this bill becomes law than they are under current law.

A fundamental restructuring of Medicare of this magnitude demands careful and thoughtful deliberation. The conference report contains a large amount of new material not included in either

the House-passed or Senate-passed bills. Hastily acting on this legislation is fundamentally unfair to millions of seniors who want and deserve to be treated fairly. I predict that when seniors become familiar with this bill's details, there will be a crescendo of opposition.

The siren song you hear now principally from our Republicans colleagues is that competition is necessary to drive the cost of health care down. The reality of this bill is not competition but government subsidies for insurance companies while allowing them to carve out the most profitable segment in the business—caring for the healthiest—leaving the seniors with greatest need as the responsibility of the Federal government. Privatizing the most profitable part with a subsidy is not competition; it is a huge gift to private companies at the expense of the U.S. Treasury.

Supporters of this legislation say they are harnessing the power of the marketplace to drive down prices. The reality is just the opposite. They are hobbling the Medicare program in the

prescription drug program by letting the private provider use its purchasing power to drive down its drug prices, but not letting Medicare do the same; and in the dismantling of Medicare, by pushing people out of Medicare into private HMOs in order to obtain a prescription drug benefit.

The bill before us will begin undoing 37 years of progress in Medicare. It is an ill-advised assault on the one program that guarantees medical care to our most vulnerable population, our senior citizens. An historic opportunity is being squandered if we adopt this bill. Our Nation's seniors deserve better. I yield the floor.

ADJOURNMENT UNTIL 9 A.M.
TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9 a.m. tomorrow morning.

There being no objection, the Senate, at 10:45 p.m., adjourned until Monday, November 24, 2003, at 9 a.m.