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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

SATURDAY, NOVEMBER 22, 2003

The Senate met at 10 a.m. and was called to order by the President pro tempore [Mr. STEVENS].

PRAYER

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

Let us Pray.

O God our God, in our more honest moments we must admit that because a chaplain prays or because we bow our heads it does not necessarily mean that we seriously desire Your presence. Yet invited or not, You are here.

Lead us to such a knowledge of You that our actions will be supported by belief. If our eyes have been closed to Your blessings, open them. Make us ever aware of Your providential movement in our lives.

We pray today, for the Members of this body, its officers, and its servants. Help them to remember that You govern in the affairs of humanity and that the hearts of the world's leaders are in Your hands. Give them the wisdom to permit You to direct their paths. Send Your power among us and give us Your peace. We Pray in Your strong Name. Amen.

NOTICE

If the 108th Congress, 1st Session, adjourns sine die on or before November 23, 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.

Senators' statements should also be submitted electronically, either on a disk to accompany the signed statement, or by e-mail to the Official Reporters of Debates at ''Record@Sec.Senate.gov''.

Members of the House of Representatives' statements may also be submitted electronically by e-mail, to accompany the signed statement, and formatted according to the instructions for the Extensions of Remarks template at http://clerkhouse.house.gov/forms. The Official Reporters will transmit to GPO the template formatted electronic file only after receipt of, and authentication with, the hard copy, and signed manuscript. Deliver statements to the Official Reporters in Room HT–60 of the Capitol.

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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.

PLEDGE OF ALLEGIANCE

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

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

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. This morning the Senate will begin debate on the Medicare conference report. Senators who wish to make statements on this historic bill are encouraged to come to the floor during today's session. If possible, we will need to be in session tomorrow, Sunday, to continue debating the Medicare bill. It is my hope that we will be able to schedule a vote on the conference report for Monday. I will continue to work with the Democratic leadership to reach an agreement for a final vote. I do not anticipate votes this weekend. However, Senators should prepare for votes early on Monday.

At this point, I announce that no votes should occur any time until afternoon Monday, and we will be in discussion with the Democratic leadership as to the appropriate time for votes over that day.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The minority leader is recognized.

Mr. DASCHLE. Mr. President, it is my understanding that we already have an agreement where we will alternate in recognition of Senators on either side of the aisle as we debate the Medicare bill. We have several hours of requests already from our colleagues. I will not propound a unanimous consent request, but I might propose that we consider limiting at least comments today on the floor to 15 minutes to accommodate as many Senators as possible.

I know there are a lot of Senators who are going to be attempting to schedule their day around their opportunity to come to the floor. If we have that understanding, if there are four or five in line, it would seem to me it would work. As I say, I will talk to the majority leader about that. I do hope Senators on this side of the aisle will call the cloakroom or call Senator REID or myself to let us know their intentions with regard to speaking so that we can coordinate the effective use of time.

As the majority leader has already announced, we will be in tomorrow as well. So Senators will have an opportunity to speak throughout the weekend in addition, of course, to Monday. We will work with him to accommodate all Senators who wish to speak. We will work on a time certain for a vote at a later date.

I yield the floor.

The PRESIDENT pro tempore. The majority leader.

Mr. FRIST. Mr. President, as our colleagues are well aware, the Democratic leader and I have set aside all day today, and we can stay as late today as necessary. We initially said around 5, but this issue is so important, and there are so many people, as the distinguished leader implied, who do want to come to the floor, and it is the only opportunity for some to come, therefore, we are going to spend all day today on it, as much time tomorrow as necessary, and in all likelihood Monday morning.

I hesitate a little bit trying to limit people to 15 minutes because I do know some people have 30 minutes of comments, but I think that we should stress keeping the comments to as short a period as possible to make their points because we have a lot of people on both sides of the aisle who have called and said we are going to be there all day Saturday; we want to be able to participate.

With this many Senators, it does mean that people need to keep their remarks fairly short. I understand we will be alternating back and forth. We do want to keep the time equally divided so that both sides will have the opportunity over the course of the day to speak. Then if there are a number of people who have waited and are unable to talk today or tonight, if we need to go into later tonight, we can come in a little bit earlier tomorrow or stay longer tomorrow as well.

Again, I appreciate the cooperation of all of our colleagues because it is not customary for us to be in session on Saturday, and certainly not on Sunday, but in order to pay respect to people's schedules over the holidays and to address this very important issue, we have elected to spend all day today and possibly tomorrow.

The PRESIDENT pro tempore. The minority leader.

Mr. DASCHLE. I ask the majority leader if it is his intention to set aside a moment of silence this afternoon in commemoration of the 40th anniversary of the assassination of President Kennedy. It is my understanding that some thought had been given to that time, and I think it would be helpful, if that time has been set aside, if we could make that announcement in the interest of all Senators.

Mr. FRIST. Mr. President, I believe the time will be set aside at 12:30 today. If there is a change in that particular time, we can make that announcement very shortly.

Mr. President, I do have a statement on an unrelated issue, which I can do now or we can proceed.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

ASBESTOS LITIGATION CRISIS

Mr. FRIST. Mr. President, before entering into the debate on Medicare, I will comment on an issue that the Democratic leader and I have worked on very aggressively over the last several months, and it relates to the current asbestos litigation crisis. The current asbestos litigation system is broken, and it is clear that we in this Congress should fix it. We have an obligation, a real responsibility, to fix it.

I would like to lay out what our plans are to resolve this asbestos litigation crisis early next year. We have made very good progress toward enacting Chairman HATCH's FAIR Act, which is the Fairness in Asbestos Injury Resolution Act. I have made it a personal priority that the Senate participate aggressively in resolving this challenging issue.

Why do we call what is occurring today a crisis? First, the events that are occurring are overwhelming. The torrent of asbestos litigation has wreaked havoc on asbestos victims, on American jobs, and this havoc has extended into our economy.

Over 600,000 claims have been filed and those 600,000 claims have already cost about $54 billion in settlements, judgments, and litigation costs. Yet even after 600,000 claims and $54 billion, the current asbestos tort system has become nothing more than a litigation lottery at this point in time.

Why do I say that? First, a few victims receive adequate compensation but far more suffer long delays for what ends up being unpredictable rewards—also, if one looks at the data, inequitable awards. Some deserving victims do not receive anything at all. It is a system that there is only one real consistent winner, and that is the plaintiffs' trial lawyers.

I say that because of all of these settlements. They are taking as much as half of every dollar that is awarded to the victims.

If you look to the future, it is a problem that only gets worse. It is accelerating in the negative aspect. But if you look to the future, it gets even worse.

Future funds for asbestos victims are threatened because company after company after company is going bankrupt. About 70 companies have gone bankrupt, and about a third of those have gone bankrupt in the last 2½ to 3 years. The pace of bankruptcies of very large companies with thousands and thousands of employees is accelerating.

Again, this is an issue for us to address. That is why I want to set a schedule for that in a few minutes.

Companies such as Johns Mansville, bankrupt; Owens Corning, bankrupt; U.S. Gypsum, bankrupt; and, W.R.

Grace, bankrupt: these are large reputable companies that have gone bankrupt because of this crisis with the associated job losses.

Now the hunt is on to get new targets and to go out and sue. People say this is easy money, and the easy way is to go out in terms of bringing a lawsuit and filing a lawsuit. Thus, the hunt is on for new targets to sue. What is unfair and inequitable is that many of these lawsuits have no connection at all to asbestos. If you really look at the connection between asbestos and the victims, it is just not there.

Victims aren't the only ones who suffer but also the workers of these companies that are going bankrupt suffer. Asbestos-related bankruptcies spell doom for these workers' jobs; thus, their families, and, of course, incomes and retirement savings. Already, these lawsuits have cost more than 60,000 Americans their jobs. For those who lose their jobs, the average personal loss in wages over a career is as much as $50,000, and that doesn't include the loss of retirement wages or the loss of health benefits. Workers at asbestos-related bankrupt firms with 401(k) plans lost about 25 percent of the value of their 401(k) accounts because of this.

The economic reality of this crisis is not lost on my colleagues in this body. They understand that under the status quo the national asbestos crisis could cause our economy more than the savings and loan crisis of the 1980s and 1990s, and more than the Enron debacle or the WorldCom debacle. Member after Member from both sides of the aisle has voiced their agreement with the assessment of the Supreme Court that the system is broken and the Congress should fix it.

There is only one question: what can we do? Can we create a system better than the status quo? The answer is yes.

The FAIR Act—the Fairness in Asbestos Injury Resolution Act—has already made significant headway, and we look forward to progress today. Under the leadership of Chairman HATCH, it was passed by the Senate Judiciary Committee last July, and there have been ongoing discussions and negotiations since then.

I commend Chairman HATCH and the ranking minority member, Senator LEAHY, for their hard work on the bill.

I also want to recognize Senator SPECTER for his hard work in conjunction with Judge Becker.

I also want to note that my Democratic colleagues, organized labor, and other stakeholders have been deeply involved throughout the process. Led by Senator HATCH, bipartisan breakthroughs have been made on issues that previously have proved impossible to address, including such issues as—and there are many of them—the linchpin issue of the medical criteria that had proven historically to be so difficult and controversial.

In addition, agreements among stakeholders following the committee markup have resulted in even more modifications. The resulting bill creates a system that, while not perfect, is far superior to the current tort system for resolving asbestos issues.

I became deeply involved in the post-Judiciary Committee negotiating process, working in concert with Senator DASCHLE, as well as Chairman HATCH and Senators LEAHY, SPECTER, DODD, and CARPER, and some others on both sides of the aisle. We have made good progress. I know during the debate over this legislation all of the relevant issues have been unearthed. They have been exposed to public debate, and all parties have had an opportunity to get involved to contribute their points of view.

What emerged under S. 1125 and the current negotiations is a streamlined national trust fund for paying asbestos claimants quickly, paying them fairly, and paying them efficiently. The new system provides more certainty and efficiency for claimants, and more certainty and predictability for businesses.

Passing this bill will create enormous economic benefits. I say that because the certainty that flows from the bill will stimulate capital investment. It will also preserve existing jobs and create new jobs as well.

I had hoped that we would bring this bill to the floor before the end of this session, but we were unable to achieve that goal. Chairman HATCH and Senator LEAHY worked hard to resolve many difficult issues at the committee level. Senator DASCHLE and I, along with our staff, have continued to work with stakeholders to put more issues behind us over the past several months.

While there are several issues that remain outstanding, the core principles of an effective bill are now clear.

What are they?

First, the bill must create a trust fund that is capable of awarding adequate compensation to victims while providing more financial certainty and finality to the business community. The new funding proposal that I put on the table would generate payments that would exceed by $10 billion the expected funds which victims would receive if the current flawed tort system is left intact.

Second, the legislation must establish a schedule of claims values that will ensure victims consistent and equitable awards. We cannot tolerate the current system where payments can depend on where a plaintiff lives or which is capable of awarding only pennies for every dollar promised.

I am also prepared to consider further modest increases in claims values as requested by the Democrats and as requested by organized labor, provided that any new increase is targeted to the most severe disease categories where the relationship to asbestos exposure is most certain.

We must make sure, however, that lung cancer claims not caused by asbestos are not allowed to overwhelm the fund.

Third, the fund must be a nonadversarial program that ensures prompt payment of awards to eligible claimants while minimizing transaction costs, including attorney's fees. Care must be taken to ensure that the fund is established on an expedited basis, and adequate moneys are available to pay exigent claims from the outset.

Fourth, we must preserve the bipartisan medical criteria included in S. 1125 as reported by the Judiciary Committee. Only by ensuring the use of real diagnoses of asbestos-related illnesses can the fund avoid the pitfalls that plague the current mass tort system.

Fifth, and finally, asbestos victims should not bear the risk of inadequate funding or incorrect predictions about future claims, as is the case under the current tort system.

The legislation should make clear that if the fund cannot guarantee that victims will receive all of their claims, a program review is triggered, and if not corrected the fund should end and claims should revert to the tort system. To work, however, such a reversion would have to be to Federal court and should contain certain additional protections to ensure the current litigation morass is not recreated.

Such an approach reduces, if not eliminates, the need to worry about which claims projections are correct.

Clearly, a more thorough discussion of these observations, recommendations, and outstanding issues is warranted.

I ask unanimous consent that a document entitled ''Moving Forward in Asbestos Injury Resolution Act, S. 1125'' be printed in the RECORD at the conclusion of my remarks.

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

(See exhibit I)

Mr. FRIST. Mr. President, this allows a more complete discussion of the principles and observations I have made thus far. I do hope people take a look at that document.

As for the future, if we intend to make good on our collective hope to pass legislation, at some point the ongoing discussions and negotiations must cease and a bill must be brought to the floor. Victims are still going uncompensated today, companies are still going bankrupt today, and the economy is still unnecessarily burdened. We must act.

The minority leader as well as Senator LEAHY and other Democratic Members have made clear to me their interest in working toward consensus legislation. It is clear we still need a little more time for discussion. Consequently, we will not force a vote on the FAIR Act this session. Instead, I will give stakeholders more time to negotiate a compromise. There will, however, be a limit to these discussions because we must act. Thus, I will commence floor action on an asbestos bill by the end of March 2004. Again, I will commence floor action on an asbestos bill by the end of March of 2004.

There is no perfect solution to the current asbestos litigation crisis, but it is clear that maintaining the status quo is unacceptable. We have a responsibility to act, and we will act in this body. We must not let this historic opportunity to enact fair and meaningful reform pass in order to pursue a perfect solution that is unachievable. The time has come for the Senate to fashion the right solution to one of the most pressing issues facing us, facing our economy and this Nation today.

EXHIBIT I

MOVING FORWARD ON THE FAIRNESS IN ASBESTOS INJURY RESOLUTION ACT, S. 1125—STATEMENT OF SENATOR FRIST

To bring an end to the current asbestos litigation crisis, Congress must pass legislation creating a national no-fault asbestos trust fund (''Fund'') that ensures adequate compensation to victims, while providing financial certainty to the business community. This kind of program would provide more direct compensation, more quickly to victims than the current system can deliver. Moreover, it would provide that compensation without the bankruptcies or the lost workers' jobs, incomes, and retirement savings that asbestos personal injury litigation produces. It represents, therefore, a tremendous achievement in the creation of a solution to a problem whose future economic consequences are enormous—in the magnitude of more than $100 billion if the claims stay in the tort system.

This past July, under the leadership of Chairman Hatch, the Senate Judiciary Committee approved S. 1125, the Fairness in Asbestos Injury Resolution Act (''FAIR Act''), which establishes the framework for reaching a bipartisan solution. To reach a consensus, we must build upon that structure, making improvements where possible but not jeopardizing the two most fundamental elements of the legislation—adequate, timely, and equitable compensation for claimants and financial predictability for the business community.

I. ENSURING ADEQUATE COMPENSATION FOR VICTIMS

According to the two actuarial studies on the magnitude of the problem, one by Tillinghast-Towers Perrin and the other by Milliman USA, ultimate loss and expenses under asbestos personal injury litigation are projected to reach $200 to $265 billion. With $70 billion already spent, total estimated future costs thus range from $130 to $195 billion. Victims, however, can expect to receive barely half that amount in actual compensation.

According to RAND's analysis of asbestos compensation, transaction costs under the current system—plaintiffs' attorney fees, defense costs, and expenses—consume more than half of the money that goes into the asbestos litigation system. In other words, only about 40 cents on every dollar spent in the asbestos tort system actually reaches victims. Thus, while today's system has a future price tag of $130 to $195 billion, victim compensation is estimated at only $61 to $92 billion of that total.

If adopted, the Act will rein in those runaway transaction costs and provide quick, certain, and fair payment for victims. In fact, my funding proposal, which has been agreed to by the defendant companies and insurers, will actually provide asbestos victims at least $10 billion more than they would receive if the current litigation crisis is left intact.

The primary source of funding under the Act is derived from mandatory contributions: the Act (as reported) required $104 billion in total mandatory contributions from defendants and insurers. In reaching that total, companies and insurers were to be assessed equally and according to specific statutory provisions. Meanwhile, confirmed bankruptcy trust contributions are estimated to provide an additional $4 billion, bringing total mandatory funding under the Act (as reported) to $108 billion.

That funding proposal represented a very fair amount to solve the problem, and provided victims more in direct compensation than they would receive under the current system. The Committee, however, went well beyond this benchmark during markup. S. 1125 (as reported) included significant additional funding provisions. An amendment offered by Senators KOHL and FEINSTEIN authorized the Administrator to compel companies and insurers to pay additional contingent contributions of up to $31 billion, and allowed the Administrator to request back end contributions that could have reached a combined total of $48 billion.

The net effect of these changes to the Act was dramatic. S. 1125 (as reported) could have required businesses and insurers to provide compensation at up to two times the most credible estimates of total future plaintiffs' recoveries under the tort system. As a result, insurers almost uniformly withdrew their support for the Act, calling it ''dangerously unaffordable'' and ''potentially worse than the existing system.''

In order to get the legislation back on track, I initiated a mediation process between insurers and defendant companies. We were able to reach agreement on such major issues as overall funding, allocation of funding obligations, and insurance policy erosion, and gain renewed insurer support for the Act. The agreed-upon revisions not only garnered the support of the business community and insurers for the Act, but would also ensure greater Fund liquidity.

Under my funding proposal, insurers would make nominal mandatory contributions of $46.025 billion on an accelerated payment schedule. Meanwhile, defendants would pay $57.500 billion in total mandatory contributions and, if necessary, defendants would provide $10 billion in additional contingency funding. Most importantly, with confirmed bankruptcy trust assets and interest earned, my proposal would provide at least $10 billion more than the current tort system. It will also preserve one of the great breakthroughs that made widespread business community support for the Act possible—the landmark agreement on a fair and reasonable formula for sharing the funding obligation among defendants. Chairman Hatch is to be commended for shepherding the larger business community to his unprecedented agreement.

In addition, my proposal would better address the Fund's liquidity needs than the Act (as reported). The greatest stress on the Fund is expected to be in the early years when it is required to pay pending as well as current claims. In order to address the resulting liquidity demands, the Act (as reported) allows the Administrator to borrow against the Fund in an amount equal to that of the following calendar year's anticipated contributions. My proposal would give the Administrator authority to obtain billions of dollars of additional funds, if needed, by expanding the Administrator's borrowing authority. All of the Fund's repayment obligations would be fully collateralized by the defendants' and insurers' mandatory contributions, ensuring that federal monies are not put at risk.

Although there are still some funding issues to be worked out, the progress we have made to date is the result of unprecedented cooperation between industry and insurers to find an acceptable solution to the asbestos litigation crisis. We are confident that we can bridge the few remaining differences in the time frame provided.

II. AWARD VALUES

A further step on the path to providing fair compensation for asbestos victims is the establishment of a schedule of claim values that will result in consistent awards. The history of awards under the current tort system is one plagued by uncertainty and unfairness to asbestos victims. Many plaintiffs receive little or nothing, or die before their cases can be heard in court. Of those who do receive awards, the amount of compensation typically depends more on where and when the claims are filed than on the nature of the plaintiffs's illness. In one 1999 Mississippi case involving 4,000 plaintiffs, allocation of a $160 million settlement was based on how far plaintiffs lived from the courthouse in Mississippi. The Mississippi residents each received $263,000. Similarly situated plaintiffs from Ohio, Pennsylvania, and Indiana received only $14,000 each. (See David Cosey, et al. v. E.D. Bullard, et al).

As introduced, S. 1125 contained claim values that were among the highest of any federal compensation program: For example, the award value for claimants compensated under disease level X (mesothelioma) exceeded by three times the maximum death benefits generally available under the National Childhood Vaccine Injury Act, one of the most generous of comparable existing federal programs. Claimant compensation under the FAIR Act's other most serious disease levels was also very generous compared with existing federal programs. Moreover, although the Act's claim values were based loosely on those awarded in existing bankruptcy trusts, it ultimately paid more in real dollars. The Manville Trust, for example, has a scheduled value of $350,000 for mesothelioma claimants, but is only able to pay 5 cents on the dollar, resulting in an award of $17,500. Under S. 1125 (as introduced) such a claimant would have received $750,000—about 43 times the amount actually paid by the Manville Trust. Nonetheless, many Democrats indicated that the values under the Act should be even more generous to claimants.

During Committee consideration of S. 1125, a bipartisan amendment offered by Senators Graham and Feinstein significantly increased the claim values. This amendment was approved by a 14–3 vote of the Judiciary Committee. The Committee also considered and rejected an amendment offered by Senators Leahy and Kennedy to provide even higher claim values. That amendment misallocated funds too heavily toward those with illnesses less clearly linked to asbestos exposure. In addition, the Committee adopted an amendment to index claim awaard values to inflation, further providing billions of dollars in additional payments. Moreover, all claimants meeting Level I requirements—potentially over a million exposed workers—would be eligible for medical monitoring reimbursement and would have their statute of limitations tolled so that, if they do get sick, they would have recourse to all the benefits of the Fund. Since the Committee's consideration, Democrats and organized labor have suggested that the medical monitoring should include the out-of-pocket cost of the physician's examination. I believe this is reasonable and should be in the final bill.

With the changes reported out of Committee, the scheduled values under the FAIR Act were even more generous than before. Continuing an example previously mentioned, S. 1125 (as reported) set the Level X (mesothelioma) claim value at an amount that was not three times, but four times

higher than the death benefits generally available under the National Childhood Vaccine Injury Act—a difference of $750,000. Similarly, in the bill as reported, mesothelioma claimants would have received not 43 times, but 57 times the amount at which the Manville Trust actually compensates similarly situated victims.

Finally, as introduced, S. 1125 granted the Administrator broad authority with respect to the timing of award payments. Organized labor expressed concerns that payments would drag out over a long period of time, and argued that claimants should receive payments over three to four years. The Judiciary Committee addressed this concern by providing that payments should be disbursed over a period of three years, and in no event more than four years from the date of final adjudication of the claim. Organized labor has continued to express concern, however, that there is no standard to guide how much of their awards claimants should receive each year. Again, this concern should be more adequately addressed, if possible. To address organized labor's concerns, negotiators have accepted a presumption for payment of awards over three years in the following percentages: 40 percent in the first year, and 30 percent in each of the next two years. However, if necessary to protect the fund from short-term liquidity problems, the Administrator has the authority to make payments in equal 25 percent installments over four years.

Notwithstanding the Committee's action to substantially increase claim values, my Democratic colleagues and organized labor continue to believe further increases are warranted. Although I believe the values in S. 1125 are more than fair, even generous, in a no-fault system, and will bring more to claimants in the aggregate than the current system, I am prepared to consider further modest increases in claims awards in an effort to forge a bipartisan consensus, provided they are targeted to categories most uniquely caused by asbestos exposure (versus other possible causes). Consistent with the express philosophy of S. 1125, the greatest increases must be targeted to the most severe disease categories in which the causal relationship to asbestos exposure is most certain.

A remaining challenge, and a prerequisite to any additional increase in claim values, is to address the concern that the criteria for eligible claims under Level VII are sufficiently broad that they could potentially sweep in claimants whose lung cancer is not caused by asbestos but by alternative causes, such as smoking. The American Cancer Society estimates that in 2003 alone there will be over 170,000 new lung cancer cases from all possible causes—or 30,000 more than the Fund's highest projected total of eligible claims over 50 years and over 110,000 more than the highest projections made by Dr. Mark Peterson (who testified before the Senate Judiciary Committee during the debate over the FAIR Act) for the same period. Exacerbating that risk is claims experience demonstrating that well over 90 percent of Manville Trust lung cancer claimants are current or former smokers. There is a substantial risk that, in moving to a no-fault system and eliminating the need to establish asbestos as the cause of the disease, compensating a large number of smoking-caused lung cancer claims could jeopardize the solvency of the Fund. If the current exposure criteria do not adequately narrow eligibility to those lung cancer claims where asbestos exposure significantly increases the risk over smoking, the Fund could potentially collapse.

Accordingly, a provision should be added to the legislation to make sure that lung cancer claims not related to asbestos exposure are not allowed to overwhelm the Fund's ability to compensate claimants who have disease caused by asbestos. I will continue to work with my Republican and Democratic colleagues to craft a program review which would authorize the Administrator (in consultation with Congress) to protect the fund if the total number of Level VII claims substantially exceeds projections.

III. ADMINISTRATION AND STARTUP

In addition to ensuring the availability of adequate funds to pay fair and consistent awards to asbestos victims, another critical element of any solution is to create a system that ensures prompt and efficient payment of awards to eligible claimants, while minimizing transaction costs. Again, this is an area in which we have made great headway towards resolution, but there are still some aspects to be worked out.

A number of parties have expressed concerns with the system for filing, evaluating, and reviewing claims established by the FAIR Act. Under S. 1125 as reported from Committee, claims would be filed with, and reviewed by, special masters operating under the guidance of the U.S. Court of Federal Claims. If a claimant were not satisfied with his or her initial award determination, the claimant could appeal to a separate panel of three special asbestos masters. From there, a claimant could appeal an adverse decision to an en banc panel of three judges of the Court of Federal Claims, sitting as the United States Court of Asbestos Claims. Appeals from the Court of Asbestos Claims would be heard by the U.S. Court of Appeals for the Federal Circuit. A separate Administrator would manage the Fund and pay final claims awards. Because the system was court based, there was no provision authorizing the promulgating of substantive regulations, which could help guide special asbestos masters through the establishment of generally applicable policies for claims evaluations and eligibility determinations. Instead, these issues have necessarily been addressed on an ad hoc basis in the context of individual claims determinations.

This court-based system was heavily criticized by Democrats and by organized labor as too complex and adversarial from the perspective of claimants. Labor in particular has insisted instead on an administrative review process, which it believes could resolve more claims in less time using a no-fault, non-adversarial system. With an administrative process, substantive regulations could be utilized to establish generally applicable presumptions and to help guide those evaluating claims to ensure eligibility criteria are fairly and consistently applied. Such a process could also be more ''user friendly'' and would allow claimants themselves, if they so desired, to navigate the process for filing claims without the need to retain counsel. While all parties recognize that legal representation may be beneficial or even necessary at some level of claims review, organized labor has consistently expressed the desire for an administrative system that minimizes the need for attorneys in order to maximize the recovery of a award values by claimants.

I recognize the benefits of such a system. I believe we can find common ground on developing a non-adversarial system that can effectively and quickly deliver benefits to claimants. I urge the parties to continue working towards a consensus on this issue. Such a system should significantly reduce transaction costs. We should therefore include a provision limiting plaintiffs' attorney fees to ensure that actual awards to victims are maximized. If done correctly, a new administrative process can also address another problem with the bill as reported by the Committee, by ensuring that the program is operating and processing claims in the minimum amount of time following passage of the FAIR Act.

On a related note, S. 1125, as introduced, provided that the new federal trust fund would be the exclusive remedy for all asbestos claims under state and federal law, and that all other remedies were preempted and barred as of the date of enactment. Exclusivity and finality are key elements of the necessary reform. The current tort system has failed victims, and it has done so largely because filing claims on behalf of the unimpaired has become too profitable a business for too many lawyers. Any legislation we pass must end the massive misallocation of limited funds to unimpaired claimants and their lawyers at the expense of those who are ill from asbestos-related disease. We cannot continue to tolerate the expenditure of limited funds into this broken system, a system which spawns inventory-style settlement agreements entered into by attorneys on behalf of claimants who have not even been identified much less bound by the agreement. Nor can we leave insurers and businesses exposed to collusive default judgments or other efforts to evade the Act's exclusivity provisions. Similarly, the bill should plainly foreclose all asbestos-related litigation by claimants against insurers and businesses, including direct actions. In short, given the consensus that the tort system is terribly flawed, we cannot allow the current abuses to persist. Proposals that would have the effect of continuing the status quo—and draining resources that would otherwise be available under the Fund for the truly impaired—are unacceptable.

During the markup, Democrats, organized labor, and the trial bar expressed concerns that asbestos victims could be faced with a period of time during program startup when they would have no remedy for their injuries—all tort suits would be preempted but the Fund would not yet be processing claims. In response to this concern, the Committee adopted an amendment offered by Senator Feinstein, which provided that the preemption and bar on asbestos claims would not be effective until the Administrator determined that the Fund was ''fully operational and processing claims.'' Until that time, all remedies would remain available under state law, and defendants' and insurers' contributions to the Fund would be offset by ''the amount of any claims made payable'' during the startup period.

The Feinstein amendment was intended to address the legitimate concern that asbestos victims could face a potentially lengthy period of time during which they would be without a remedy. Unfortunately, the amendment would leave the current tort system, with all of its inherent problems, intact for too long and would allow some parties to manipulate this interim period for their personal benefit. No one wants to see the expectations of asbestos claimants undermined by the kind of legal chicanery that created the current crisis. If not fixed, the amendment could cause the very problem the bill is attempting to fix—even more bankruptcies and the continued diversion of resources away from legitimate victims.

Moreover, in practice, the Amendment would effectively doom the prospects of the Fund. As was the experience in states that have recently adopted tort reform laws, such as medical malpractice limits, the pending demise of a segment of the tort system inevitably leads to a flood of claims before the courthouse door is effectively closed. Under the Feinstein amendment, awards to plaintiffs, but not defense costs, could be offset against future Fund contributions. As a result, settling claims would be cost free to defendants and insurers, while defending

claims in the tort system would continue to be prohibitively expensive. The certain result of this provision would be a very strong incentive, perhaps even a duty for publicly traded companies, to immediately settle all pending claims at potentially elevated values in order to avoid the expense of defending even the most illegitimate claims. Because all these settlement costs would be offset against Fund contributions, the financial effect on funding would be disastrous. Therefore, it is clear that the amendment is not the right solution to a very real problem.

To ensure that victims are not left without a remedy for an unjust period of time, I believe we need an alternative to the Feinstein amendment that will address the concerns raised by (1) authorizing the creation of an administrative program on an expedited basis that will be capable of quickly processing the most serious claims, and (2) enhancing the funding provisions to ensure adequate funds are available from the outset to pay these exigent claims on an expedited basis. The bill as reported by the Committee goes a long way toward ensuring that the Fund receives the mandated contributions within a reasonable time frame. Since that time, there has been a number of innovative suggestions relating to the funding and administrative provisions that would work in concert to address the concerns raised, without the dire consequences of the Feinstein amendment. I am confident we can resolve this issue, so that claimants with the most serious injuries are not left without a remedy, and I intend to continue working in conjunction with my Democratic colleagues toward a solution.

IV. ELIGIBILITY AND MEDICAL CRITERIA

Once the necessary funding is assured, and an administrative process is in place to manage claims fairly and efficiently, the next essential element is to make sure that available resources are directed to the most deserving claimants. In contrast to the existing tort system, in which many if not most asbestos claimants are unimpaired, the FAIR Act will ensure that awards are directed principally to those who have suffered the most from exposure to asbestos. This is assured through the consensus eligibility criteria in the bill, which set forth the applicable exposure, latency, medical, and diagnostic requirements for receiving compensation from the Fund.

The basic premise of the FAIR Act is to ensure that true victims of asbestos disease receive fair and consistent awards. To be eligible for compensation from the Fund, claimants must satisfy the eligibility criteria for various disease categories. The FAIR Act also provides a mechanism for consideration of exceptional cases, where claimants can clearly establish the presence of an asbestos-related disease but may not satisfy the otherwise applicable medical criteria. Exceptional cases, as well as those related to ''take home'' exposures where asbestos was brought into the home by an occupationally exposed person and those related to the high levels of environmental exposures of residents and workers in Libby, Montana, are eligible for review by a Medical Advisory Committee, made up objective, experienced physicians, to determine whether the claimant is eligible for compensation. Because the medical conditions of Libby residents are currently being studied by various agencies, claims filed by Libby claimants are automatically designated as exceptional medical claims and referred to the Medical Advisory Committee.

The consensus criteria reflected in S. 1125 provide a solid foundation to ensure that eligibility decisions are based on sound medical practices and real diagnoses by the claimants' physicians. As a doctor, I cannot emphasize enough the importance of a diagnosis by the claimant's physician. The success of the program hinges on ensuring that the Fund compensates only those with conditions caused by asbestos exposure and not other causes. Only by ensuring the use of real diagnoses of asbestos-related illnesses can the Fund avoid the pitfalls that plague the current mass tort system.

The eligibility criteria reflected in S. 1125, as reported, are the result of an unprecedented agreement among the various stakeholders working to find a solution to the current asbestos litigation crisis. I commend Chairman Hatch and Ranking Member Leahy for an achievement few thought possible. I appreciate how complex and contentious an issue the medical criteria presented. The approval of these criteria by a unanimous vote in the Judiciary Committee markup created the opportunity we have for an historic achievement.

V. PROTECTING VICTIMS FROM RISK

From the very beginning, one of the key goals of S. 1125 has been to ensure that compensation is directed at those legitimately ill from asbestos exposure and is awarded on a timely basis. The bill accomplishes this fundamental change from the status quo by moving from a system that compensates claims of questionable validity to one based on sound medical evidence and real doctors' diagnoses.

Nonetheless, legitimate concerns remain about the accuracy of estimates of the number of future claimants that will be eligible for compensation under the Act. Obviously, prior attempts to forecast asbestos claimants have proven inaccurate, leaving the very people who most deserve compensation with no real recourse. For example, claims to the Manville Trust have exceeded initial projections, and the Trust has been forced to reduce claim values to the point where today the Trust pays claimants as little as five cents on the dollar. Congress cannot and will not recreate the Manville experience.

Various experts have developed estimates about future claims, and the Congressional Budget Office has offered its own predictions based upon its review of the available evidence. The truth, however, is that there is no guarantee that any of these estimates is accurate. The legislation creates new eligibility criteria and establishes a new system for processing claims, one designed to weed out unimpaired claimants and those who suffer from diseases not caused by exposure to asbestos. Since there is no comparable system operating today, what is happening with the existing private asbestos trusts can at best offer only some general indication of what may happen over the 50-year life of the proposed Fund. Obviously, this reality makes it even more important for Congress to make sure that if we establish a national asbestos trust fund, that we also make sure that asbestos victims have someplace to go to seek compensation if the Fund cannot handle all future claimants.

The FAIR Act, as reported by the Judiciary Committee, includes an amendment offered by Senator Biden that requires the Fund to terminate and claims to revert to the tort system if funding proves inadequate. Specifically, the Administrator would be required to certify annually that 95 percent or more of the eligible claimants that year had received 95 percent of their compensation under the FAIR Act. If not, and the situation could not be remedied within 90 days, the program would sunset immediately. Although this language clearly shifts the risk away from claimants, it unnecessarily jeopardizes the Fund from its very inception and fails to provide sufficient flexibility to address unexpected, and possibly fixable, fluctuations in claims.

I agree with the key principle that the risk of inadequate funding cannot fall on those truly ill from asbestos exposure. However, the business community cannot be subjected to an open-ended funding commitment to accommodate an unknown and unlimited number of claimants into the future. Similarly, American businesses cannot risk paying over $100 billion dollars into a Fund only to see it sunset in a few short years. Either of these outcomes would be worse than the current broken system. To succeed, the business community believes the solution must provide at least a limited window of ''peace'' to bring certainty to business and to allow the economy to recover from the burden that asbestos litigation has imposed on it.

Therefore, I propose an alternative that will balance these competing tensions while fully protecting sick victims. Under my proposal, if victims do not receive 100 percent of their claim values, the Fund would end and claims would revert to the tort system so that claimants will still have a guaranteed avenue to receive compensation. This approach significantly reduces the need to worry about which claims projections are correct. If the estimates of eligible claims over the next 50 years are too low and the funding is exhausted, then claims will automatically return to the tort system and claimants will be able to preserve their ability to receive compensation. To avoid many of the abuses that have created the current crisis, however, this reversion to the tort system must be to the federal courts and must contain certain additional protections to ensure that the current litigation crisis is not recreated. Obviously, while protecting asbestos victims from risk, my proposal does impose a price on the business community. It compromises to a degree the absolute certainty and finality that have been the hallmarks of a solution for those that must fund the program. They will be forced to bear the risk that the total program funding is not sufficient.

There is also a legitimate concern that the Fund could sunset, not because of inaccurate claims projections, but because the new and untested eligibility criteria in the FAIR Act end up compensating the wrong kinds of claims. These would include claims for injuries not caused by asbestos (for example, smoking-related lung cancers, idiopathic pulmonary fibrosis, rheumatoid arthritis, byssinosis, etc.) or because the Fund's medical, diagnostic, and exposure criteria do not sufficiently eliminate unimpaired claimants. Future victims of asbestos-related disease, as well as those funding the program, have a legitimate and strong interest in ensuring that the Fund is not exhausted because of those kinds of claims. To address that risk, I propose the Fund undertake a periodic review of the program to ensure it is compensating legitimate asbestos-related illnesses. This program review would regularly evaluate the claims submitted, the quality of the supporting evidence, and eligibility and award determinations to determine whether the Fund is compensating the wrong kinds of claimants and to provide the authority and opportunity for the Administrator to address the problem early if that occurs.

My proposal also would address another reality—under the current tort system, too much of the risk already falls on victims. Today, some victims go uncompensated because they cannot remember the product to which they were exposed. Others are without recourse because they were exposed in connection with military service and cannot sue the federal government. Other victims who should be compensated too often experience long delays before they receive payment,

waiting for their litigation and all possible appeals to be exhausted, and then only seeing half of their award, the rest taken by the lawyers. This is especially true for claimants who are suing companies that have been forced into bankruptcy. There, the legal process can take half a decade and consume millions of dollars, leaving claimants able to recover only pennies on the dollar from the resulting bankruptcy trust. In short, victims bear much of the risk under the status quo, and they will continue to bear that risk until Congress acts. My proposal protects victims from those risks, and offers asbestos victims far more protection and certainty than they have today.

The PRESIDING OFFICER (Mr. CORNYN). The Senator from Nevada.

Mr. REID. Mr. President, I want to make sure, having heard the distinguished majority leader speak about asbestos, that we understand, as he has indicated, it is a very complicated, difficult issue. But there are concerns that I have, and I think I speak for lots of people in this country. I am very concerned about how it affects business, but I am also concerned how it affects individual people.

I called Mrs. Bruce Vento this week, a woman from Minnesota whose husband served in the House of Representatives, a wonderful man. He worked in an asbestos facility for a few months as a young man. He is 58 years old, he gets sick, he is dead within a year as a result of the disease that comes from being around asbestos, mesothelioma. The average life expectancy of a person who is diagnosed with this disease is a little over a year. They die quickly.

Then we have asbestosis, where people live longer but it has a detrimental effect on their health.

What we have to do is get rid of the spurious lawsuits, those that don't deal with those two conditions about which I just spoke.

So I hope, as we proceed through asbestos legislation, we worry about and are concerned about these very sick people. People in this Senate have worked extremely hard to come up with a solution. The distinguished Senator from Utah is in the Chamber, the chairman of the Judiciary Committee. He and the ranking member, Senator LEAHY, have worked days and weeks to try to come up with something. We always get close but never quite close enough.

So I hope as we proceed, as the distinguished majority leader indicated, toward legislation dealing with this, that we keep in mind the main reason we are doing it. The main reason we need to legislate, in my opinion, is to take care of the people who get afflicted with the diseases that are related to asbestos. In the process, I hope we can ban the importation of asbestos into our country. We continue to import thousands of tons of this stuff on a yearly basis, even as we speak.

So I appreciate the concern of the majority leader. I have concerns also. But if I were giving a speech in a prolonged fashion, I would speak about the people who get sick, as Bruce Vento did, and are now dead.

Mr. LEAHY. Mr. President, I thank the distinguished Senate Majority Leader for his remarks today on the need for the Senate to consider asbestos legislation next year. I wholeheartedly agree with him on the need for reform to establish a better system for providing fair and efficient compensation to victims of asbestos-related diseases. I remain committed to working with Senator FRIST, Senator DASCHLE, Senator HATCH, Senator DODD, Senator SPECTER, and others, to forge a bipartisan solution to this complex challenge.

Last fall, as Chairman of the Judiciary Committee, I held the Committee's first hearing to begin a bipartisan dialogue about the best means to compensate current asbestos victims and those yet to come. Chairman HATCH wisely held two additional hearings this year. Our knowledge of the harms wreaked by asbestos exposure has certainly grown since last fall, as have the harms themselves. Not only do the victims of asbestos exposure continue to suffer, and their numbers to grow, but the businesses involved, along with their employees and retirees, are suffering from the economic uncertainty surrounding this litigation. More than 60 companies have filed for bankruptcy because of their asbestos-related liabilities.

These bankruptcies create a lose-lose situation. Asbestos victims who deserve fair compensation do not receive it, and bankrupt companies can neither create new jobs nor invest in our economy.

A solution has never before been closer than it is today. Since the beginning of 2003, we have come to complete accord on the idea that the fairest, most efficient way to provide compensation for asbestos victims is through the creation of a national fund that will apply agreed-upon medical criteria in evaluating patients' injuries. We have been working tirelessly with representatives from organized labor, defendant companies, insurers, and other interested parties, to craft an effective trust fund system that will bring the certainty of fair payments to victims and financial certainty to industry. A myriad of issues have been resolved, from the definitions of the panoply of illnesses resulting from asbestos exposure to a ban on the use of asbestos in the United States. We are working, even today, on the details of other aspects of this scheme, down to the fine points of the administrative mechanism for processing claims.

We have made real progress in finding common ground. But we have yet to reach consensus, and without consensus we cannot end this crisis. Too much is at stake for us to walk away when we have come so far. An effective and efficient means to end the asbestos litigation crisis is within reach, and we must grasp it. Although the year is drawing to a close, our bipartisan commitment to this effort remains strong. I look forward to continuing to work with my colleagues and all stake holders to craft a consensus bill that we can move through the legislative process and into law next year.

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

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of the conference report to accompany H.R. 1, which the clerk will report.

The assistant legislative clerk read as follows:

The Committee of Conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 1), 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, having met, have agreed that the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment and the Senate agree to the same, signed by a majority of the conferees on the part of both Houses.

The PRESIDING OFFICER. The Senate will proceed to the consideration of the conference report.

(The conference report is printed in the proceedings of the House in the RECORD of November 20, 2003, Book II.)

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, we are now on this historic piece of legislation. I want to begin a discussion of that shortly.

But since the majority leader discussed the subject of asbestos legislation, and the chairman of the Judiciary Committee, who has been largely responsible for moving that legislation as far as it has come to date, is here and wishes to make a couple of comments, I would like to yield a couple of minutes to the distinguished Senator from Utah and then regain the floor to discuss the Medicare bill.

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

Mr. REID. I am sorry, what was the concern?

The PRESIDING OFFICER. The Senator from Arizona has yielded to the Senator from Utah for 2 minutes and then will reclaim his time. Without objection, it is so ordered.

The Senator from Utah.

ASBESTOS REFORM

Mr. HATCH. Mr. President, I thank my colleague. I appreciated the remarks of the distinguished majority leader on the asbestos reform legislation. I certainly appreciate the kind remarks of the minority whip with regard to this. I think both of them spoke eloquently.

I rise today in support of the comments of the distinguished majority leader with respect to the asbestos legislation. This is an absolutely vital issue, and we have the opportunity

with S. 1125, the Fairness in Asbestos Injury Resolution Act, to correct what has been a gross injustice—both to asbestos victims and to our economy.

For more than 20 years now, compensation to legitimate victims of asbestos exposure has been delayed and diminished, while scores of companies with almost no connection to the problem have had to file for bankruptcy and hundreds of others live under the constant threat of insolvency from litigation. As a result tens of thousands of victims are not compensated and tens of thousands of workers have lost their jobs.

We've heard the statistics, but they bear repeating. The RAND Institute for Civil Justice tells us that, to date, approximately 70 companies have been forced into bankruptcy—at least three with operations in my home state of Utah.

The number of claims continues to rise as does the number of companies pulled into the web of this abusive litigation, often with little, if any, culpability. More than 600,000 people have filed claims, and more than 8,400 companies have been named as defendants in asbestos litigation.

This has become such a gravy train for some abusive trial lawyers that over 2,400 additional companies were named in the last year alone. RAND also notes that ''about two-thirds of the claims are now filed by the unimpaired, while in the past they were filed only by the manifestly ill.'' Former Attorney General Griffin Bell, amongst many others, has denounced this type of ''jackpot justice.''

To address this problem, I introduced a bipartisan bill with my friends Senators BEN NELSON, MIKE DEWINE, ZELL MILLER, GEORGE VOINOVICH, GEORGE ALLEN, SAXBY CHAMBLISS and CHUCK HAGEL. This bill creates a fund to provide fair compensation to victims, while reducing wasteful transaction costs dramatically. Let me first just dispel a few myths about this bill and set the record straight on a couple of issues. First, some Democrats and unions are saying there isn't enough money in the bill but the fact is that this bill gets more money to claimants on average than the current system does.

Let me explain how. There have been several studies of future asbestos-related costs under the current system, and the one which shows the highest reasonable estimate of prospective costs—the Milliman study— would result in approximately $92 billion for victims, after attorney fees and expenses.

Under the FAIR Act, it is estimated that claimants will receive 90 percent or more of the total funds under the no-fault, non-adversarial system. This means the FAIR Act fund—which will have $114 billion under the agreement proposed by Senator FRIST—will allow claimants to take home more than $100 billion. This is more total money than they are projected to receive under the current tort system.

But it is not just more money in the pockets of victims, it is faster and more certain compensation as well. We anticipate that claimants will not have to endure years of discovery battles and endless litigation before they get paid. Currently, some victims are dependent on the solvency of businesses to decide if they get paid or not. Under the FAIR Act, these victims will no longer have to go without payment. It is time to end the current system of Jackpot Justice where only some win and many lose.

Some have also argued that there aren't adequate safeguards to ensure solvency of the fund. Baloney. This fund—which is funded at the highest reasonable claim-rate scenario—is equipped with many mechanisms to ensure that the pay-in and pay-out requirements are met. This includes borrowing authority against future contributions.

It also includes guarantee surcharge and orphan share reserve accounts which set aside money to grow and pay for unexpected shortfalls. Another safeguard is the provision to empower the Attorney General to enforce contribution obligations and ensure collection. And beyond these, there is $10 billion in contingent funding as one more additional safety net. On top of all these safeguards, if the fund still becomes insolvent, claims would revert back to the tort system—a provision, by the way, which Democrats insisted be part of the bill.

Given that this bill is a clear net monetary gain for legitimate victims, and provides payments faster and with more certainty, I am at a loss as to why anyone could object to this bill. The unions that continue to oppose the bill risk throwing away the last, best chance to compensate fairly those who are truly sick and provide some protection to those whose jobs and pensions are at risk because of the asbestos litigation crisis.

Quite frankly, the only entity that stands to lose under this bill is the plaintiffs' bar which has siphoned off more than $20 billion of the costs incurred on this issue as of the end of last year. If the FAIR Act is passed, they will not be able to use unimpaired claims to continue to squeeze a projected $41 billion more for themselves from remotely-connected companies by abusing a broken system.

Fair is fair—I am all in support of compensating plaintiffs' attorneys for the value of their work. But when it diverts valuable resources away from sick victims, something is wrong with the system.

No one can accuse us of being unwilling to compromise in order to finally be able to address this overwhelming crisis being caused by asbestos litigation. When you look at where our bill started—and it was a good start—and where it is now, our efforts at compromise are blatantly clear.

In May we circulated a bipartisan draft measure and my staff met with Democrat staff to listen to their concerns and we incorporated several requests—even before introduction. We then embarked on several weeks of markup which saw 23 Democratic-initiated amendments adopted into this legislation. Now I didn't agree with all of them, but it can hardly be said that there hasn't been strong participation by Democrats on this bill. This chart behind me lists just some of the changes we made at the behest of Democrats; let me highlight a few of them for you.

We increased overall funding. Our bill started with a mandated $94 billion in contributions, which by most reasonable estimates should have provided sufficient resources for compensating legitimate claimants. In committee we increased base funding to $108 billion dollars. That additional $14 billion is not pocket change. We also took steps to ensure the enforcement of contributions as an added protection to the solvency of the fund.

We increased the number of claimants that would receive compensation by modifying the qualifying medical criteria and by including a provision to accommodate the unique circumstances of the victims in Libby, MT.

Moreover, we increased the amount of money that will go to claimants. Even though our original claim values would have on average provided more money to legitimate claimants, we increased the values even more. And we removed most collateral source offsets to ensure that more of the award goes directly to the claimant.

These changes listed on the chart behind me do not even include other changes that we have offered since the bill was reported out of committee to even further accommodate their requests, such as an additional $6 billion increase in overall funding and significant increases in claims values in many categories. And we also offered a more flexible borrowing authority as another safeguard for solvency.

Now I understand that some want to make further changes, including streamlining the claims process even more, and I have said I'm willing to look at such proposals. But this and other complaints have been raised without the follow up of a concrete, alternative proposal. I hope that before this issue comes up in March as the Majority Leader indicated that we will resolve the outstanding issues.

We cannot delay any longer—we need to ensure that the truly sick get paid, while providing stability to our economy by stemming the rampant litigation that has resulted in a tidal wave of bankruptcies, endangering jobs and pensions. This crisis reaches far and wide—and it hurts everyone.

On Monday, this body will pass an historic bipartisan Medicare bill that will provide our seniors with drug benefits.

We can and should use this spirit of bipartisanship to come together on the asbestos issue.

I thank Senator FRIST for his leadership on Medicare and the constructive role he is playing on asbestos. Working together I am confident that Senators DASCHLE, SPECTER, LEAHY and DODD will all join together when we bring the asbestos bill to the floor in March.

Mr. KYL. Mr. President, I say again, this asbestos legislation, discussed by the leader, is very important for us to conclude early next year, and I make the point again, were it not for the work of the chairman of the Judiciary Committee, we would not be at the position where we hope to be close to finishing that legislation at some point.

Mr. CRAIG. Will the Senator yield to determine where we might be this morning?

There are several in the Chamber who wish to begin to speak on the Medicare prescription drug issue. Have we established any order for that purpose?

The PRESIDING OFFICER. There is no order other than to alternate speakers.

Mr. REID. Mr. President, if the distinguished Senator will yield for a response?

Mr. CRAIG. I will be happy to yield.

Mr. KYL. I will be happy to yield to the Senator from Nevada.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. What is in place is an agreement, gentlemen's in nature, that we would go back and forth. We are trying to work out an agreement where we would divide the time between proponents and opponents until 11 o'clock tonight. That has not been done yet, but there is something that has been typed up.

The reason going back and forth may not be fair is someone may speak for an hour and a half and someone else may speak for 10 or 15 minutes. So we have to come up with something better than that. That is what we are trying to do now.

Mr. KYL. Mr. President, might I suggest that during the time I am speaking, those who would like to speak in conjunction with the Senator from Nevada begin to work up a schedule. I would be happy to propound a unanimous consent request when that is concluded to reflect the agreement, at least for the next several hours, if that could be done.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, this is a historic day. Obviously, when one goes back to 1965 and thinks about the creation of Medicare, a lot has changed since then. We are here today to begin debating in the Senate a bill which passed early this morning in the House of Representatives, has long been advocated by President Bush, and which many people have worked on for a very long time, to try to modernize our Medicare system which, after 35 years, we recognize in this new 21st century needs to be changed to some extent.

For example, during that period of time, prescription drugs have become a major component—indeed, in many cases the first component—of treatment for ailments, disease, and afflictions of people.

Mr. President, 35 years ago prescription drugs were used to alleviate symptoms of pain and occasionally to treat conditions, but more intrusive methods were the order of the day at that time. The Medicare program for seniors reflects the conditions then by covering hospital stays and physician benefits, but not outpatient prescription drugs. The prescription drugs which have over the last 35 years become a key, if not the key, component of medical treatment have not been a part of Medicare because they were not as key in 1965. So we know we need to add prescription drug coverage for our seniors and for those who are disabled and who qualify for Medicare.

There are other changes we know, also, that would help to strengthen Medicare, to ensure that as we proceed to provide Medicare to the baby boom generation, we will be able to do so with the highest quality of care possible, at prices that both they and the American people can afford and, as I say, which really encompasses the new concepts of modern medicine in this treatment.

So the question was how we would develop a system to provide prescription drugs as a component of Medicare. There were several different options, but the option that has been finally settled upon is one which I can support, and as someone who actually advocated a somewhat different approach, I would like to speak to those primarily who, like me, were not particularly pleased with the initial direction in which this legislation proceeded, to talk about why, at the end of the day, it is the best we can do under these circumstances and I think under any foreseeable circumstances of the near future, and therefore why it is important to move forward with this legislation.

It is momentous, it is huge in terms of the amount of money we are talking about, a commitment over the next 10 years of $400 billion. That was the amount that Congress agreed to with the adoption of our budget and the crafting of this legislation. We resolved that this money would be set aside to provide this prescription drug benefit and make changes in Medicare to ensure the benefits of Medicare would be available to everyone in a quality way during the 21st century.

Let me discuss first of all some disappointments I have with the bill because these have been discussed by others and I want them to know I am very cognizant of the concerns that have been expressed.

I served on the conference committee that crafted this legislation and I spent literally hundreds of hours working with colleagues through these issues. Some of the battles we fought, I helped to prevail on, others we did not prevail on. But it is the nature of compromise between the two bodies and between the two parties, especially when the Senate is almost equally divided that no one is going to get everything they think is best.

Let me first of all talk about the approach that was taken here and why in some respects I think we made some wrong turns, but how we have tried to recognize that and to ameliorate the effects of those wrong turns as much as we could.

There was a sense in this country, because there are many people who could not afford all of the prescription drugs they need in their treatment, that the Medicare plan had to be modified to ensure they could have access to those drugs at a reasonable cost. That was an approach that many Members thought would best utilize the funding available, to provide the maximum amount of benefit to those who most needed it.

Somewhere along the way, a major decision was made which fundamentally altered that concept. It was a decision that was strongly favored by the AARP, for example, a group which I am very pleased to say is in support of this legislation and has taken a strong role in educating America about the benefits of this legislation. That decision was to make the benefit of prescription drugs universal; that is to say, to make it available to all Medicare-eligible people, not simply to try to help those who needed the help the most.

The first result of that was it significantly reduced the amount of money we could make available to those who need it the most because, obviously, if you provide a universal benefit, you are providing it to everyone who qualifies for Medicare basically equally to those who do not need the benefit, because they have more money, as well as those who do need the benefit. Once that decision was made, it reduced the amount of money we could allocate to help those who needed the help the most. I regret that. We could have structured a plan that would have more targeted the benefits where they were needed the most.

In addition, we created some other problems. One of the problems is, employers who provide prescription drug retiree benefits will have less incentive to do that in the future because the Government will do so if they do not. Many will argue, why should we spend our money, our corporate funds, to support the prescription drug retiree benefits that we have done in the past when, if we stop that coverage, the Government will pick it up? The result of that was we had to allocate over $70 billion of this money to be paid to these business plans, union plans, and even government plans, that provided retiree health care benefits with drug coverage. We had to provide that money to them to enable them to continue providing the coverage. Some call it a subsidy. It is a fair term, I suppose. But one might say we are paying them three fourths of what it would cost the Government, to provide this particular benefit.

So from the Government's point of view, we are saving money because if these company plans did not continue the coverage, the Government would have to pick up 100 percent of the cost. Nevertheless, it took a chunk of the money out of the program to pay for benefits that are already being paid for by somebody else, thus further reducing the amount of money we could allocate to those that need the care the most.

So those are just two examples of problems created by this initial decision.

The original idea of many Members was that we should provide more choices to seniors. Many Members came to that conclusion because Federal Government employees such as Members of Congress have a lot more choices in our drug coverage. We are entitled to enroll in something called the Federal Employees Health Benefits Program, or FEHBP, and we have a lot of health insurance options. These insurance options are integrated healthcare plans. They provide all of our care, from hospitals to doctors as well as prescription drugs.

A lot of Federal employees, 10 million strong, like those kind of plans. Many are PPOs, preferred provider organizations, where you go to any one of the doctors on a list who has signed up with that organization, or you can even go out-of-network, you can go to a different doctor, and that is still OK. This was the concept the President originally announced and it is a concept I strongly supported because it would maximize choices.

At the same time, we recognize that a lot of people would still want to maintain what they currently have, what we call traditional fee-for-service Medicare, and simply add a drug benefit on top of that. We did not want to take that choice away. So the concept was to have basically two choices: Stay in traditional Medicare with the new drug benefit, or sign up with one of these new insurance programs, a PPO or what we call today Medicare+Choice, which is predominantly HMOs. That choice has been created in this legislation. The choice is a good choice.

I regret, however, that I don't think we have given the health insurance option a good enough chance to attract very many beneficiaries. There are efforts in the bill to do that, but I think we put too many restrictions on the PPOs, in particular, to expect they will be very successful. For one thing, we strongly regulate how much they can be paid. As a matter of fact, their payment rates are directly tied to what we pay in regular fee-for-service Medicare. That is price control. Congress and the administration set the prices that can be paid under the traditional Medicare Program. We were trying to get away from that heavy price control with this new insurance option. Unfortunately, in an effort to make sure we could keep the costs ratcheted down and compare those costs to what we are paying for traditional Medicare, there is a direct relationship between what we pay in traditional Medicare and what will be paid on the private health insurance side. It is not really like regular private insurance. This is very highly regulated, controlled price, controlled private insurance as the alternative to fee-for-service Medicare.

I think it is less likely those PPOs are going to succeed as a result of that. Nevertheless, we at least, for the first time, have the concept of private health insurance as an option to traditional fee-for-service Medicare for all beneficiaries.

Senator NICKLES, in particular, and I worked strongly to increase the flexibility that the insurance option could provide so there could be literally dozens of products out there like the FEHBP for Federal employees, and people could decide what was best for them. Again, unfortunately, that flexibility has been greatly limited in this legislation, primarily because of concerns by the Congressional Budget Office that if very much flexibility were provided, the cost of the program could exceed the $400 billion.

As a result, the options that are offered by these private plans will be very limited. For example, as you will hear others get into the details of the legislation, especially the drug benefit—and my colleague, the Senator from Iowa, the chairman of the Finance Committee, Mr. GRASSLEY, is in the Chamber. I know he will go into great detail about precisely how this works.

When that occurs, and you see how this benefit is going to be provided, one of the things you will see is that even though there is a very generous benefit—the Government will pay 75 percent of your drug costs up to $2,250, after a $250 deductible; so it will pay about $1,500 worth of drug benefits—at that point, then, the individual is going to be responsible for a little under $3,000 worth of drug benefits, before the catastrophic coverage of 95 percent Government-paid kicks in. Some people refer to this as a donut hole.

Obviously, with $400 billion allocated to the problem, we are not going to be able the pay all of everybody's drug costs. There is not enough money in the Federal budget for us to do that. As a result, you can only cover what that amount of money will cover.

Well, it is hoped that the private sector insurance option will provide different ways of ensuring against that donut hole, ensuring against that out-of-pocket expense that individuals will have to pay. But, unfortunately, that cannot be done under this legislation. The threshold can be raised, but the out-of-pocket amount still has to remain the same. As a result, there is a limitation on the insurance product that can be offered.

Again, Senator NICKLES and I had hoped there would be a lot more flexibility. I am hoping in the future we can loosen this up so these health insurance options can act like regular insurance options.

Another point: If you go to an insurance company today, a preferred provider organization, and you would like to get treatment from a different doctor who is not in their network, you can go to that different doctor. The plan will only pay an agreed-upon amount, and then you are billed for the difference between that and the physician's reasonable and customary fee. That is standard practice today.

That cannot be done under the way this legislation is written. That has to be fixed as well. Right now there is a price cap on that, and, therefore, it will discourage people from going out of the network, which will discourage people from signing up with PPOs in the first place.

These issues will have to be addressed later because we did not give sufficient flexibility to the insurance company alternative in this current bill. Again, I am speaking primarily to those who, like me, approach this with the idea that we could provide coverage similar to FEHBP coverage that the President originally articulated as the goal, and as someone who did not win all of the battles in this negotiation, but who still believes that at the end of the day, this is the best we are going to do, either now or any time in the future, that I can predict, given the politics, given the closeness of the Democrat-Republican split in the Senate and in the House of Representatives and the various other factors that influenced the decisions that we made.

Let me talk a little bit more about the drug benefit. Seniors today buy Medigap insurance, and that provides them a certain degree of drug coverage. It is regulated by the Government, but I think a lot of seniors believe they have pretty good drug coverage because of the Medigap insurance they have. The reality is, they are paying a lot of money for not that great of coverage. They pay almost as much money in premiums as the amount of coverage they receive. So it is not completely dollar for dollar, but it is not the kind of insurance that ordinarily we would think of.

As a result, the drug benefit that we provide here will be more substantial for the amount of money that is paid. But I do fear a lot of people will see the drug benefit we provide here as less than they are able to obtain today through their Medigap insurance, and it is going to be incumbent upon all of us to explain to people how this drug benefit will work. Again, it calls for us to try to loosen up the way the private insurance market can provide the drug coverage to meet seniors' objectives, not all of which are precisely the same.

Therefore, in order to convince them there are good alternatives to what they have today, since they are not going to be able to purchase the new drug benefit through the means of

Medigap insurance anymore—that will be done through a different mechanism—it is going to be important for us, I think, to provide them the maximum type of flexibility and choices, something, again, that we are going to have to address in the future because it is too restricted in the bill as we have it written today.

There are other items—and I do not want to dwell on the negative—but just to cite two or three others to show areas in which we could have done better.

Today, we reimburse physicians and hospitals in a very irrational way. It is very tightly controlled. It is price controls. We never get it right. We tend to want to save costs, so we do not reimburse them enough, and then hospitals begin to shut down, doctors begin to get out of Medicare, and we realize we have made a horrible mistake. So then we ratchet the payments back up, and it is a very herky, jerky way of reimbursing the very people we rely upon to provide the critical health care that we want. As a result, we have tried to figure out ways to make this more rational.

Well, the best example is in the case of oncologists, doctors who provide us drugs to treat cancer. The oncologists are not reimbursed at anywhere near what it costs them to provide this service for us. As a result, what they have to do is to buy the drugs for the chemo part of chemotherapy, and they mark up the value of those drugs, sell them to the patient, and that is how they get reimbursed for what they do. Of course, people have said: Well, it is a huge markup. They are making a lot of money off these drugs. And it is true that there is a huge markup. It is not a rational way of reimbursing them.

So what we tried to do was to go back and fix the basic formula, called the practice expense formula, to figure out how much it really costs those doctors to stay in business to provide this all-critical care for cancer patients, and we begin to re-adjust that formula so it will pay them more, and, at the same time reducing the markup they get on the drugs so they would not have to be paid out of that pot of money, in effect.

Well, we got about halfway there, but we still have more work to do on that particular formula. So it is just an example of how the Medicare system served seniors well, but there are clearly things in it that need to be fixed if we are going to continue to provide high-quality care and to ensure that we have physicians and hospitals that can stay in business to take care of us.

Cardiothoracic surgeons are another group. The very best of these surgeons go into the operating room with their own team. This is life and death. They have teams that work together for years. They have had a lot of experience in doing what they do. But they do not get reimbursed for their team members, their nurses, and so on. What they have to do is pay for that out of their own pocket. You can obviously see, at a certain point, they are not going to be able to provide the high-quality care. What they have to do is basically go into the hospital and take whoever the hospital has at that time. They do not work together as a team, and they provide about half as many people as some of these surgeons need in order to provide the highest quality cardiac care.

Here is another area in which we could have provided at least a demonstration project or two to figure out how best to reimburse these cardiothoracic surgeons. We failed to do so in this legislation. We need to do that in the future. Cost containment was another matter. We wanted, given the fact this legislation could explode in cost, to have something in this bill that would ensure that the costs would be controlled.

There is a section in here that purports to do that, but it is largely illusory. It basically says, at a certain point in time we have to get together and make some recommendations. The President has to send some recommendations down to us. We do not have to act on them, of course. And it is really very hard to change the rules of the Senate to force us to act on something like this.

So I just want to let my conservative friends know that, no, there is not good cost containment in this legislation. But I would also ask them to think about one other thing; and that is, there is no free lunch. If you want high-quality health care, you are going to have to be willing to pay something for it.

I think sometimes conservatives look at one side of that ledger but not the other. We have to do everything we can to ensure that taxpayers can afford this expense. But we also do not want to be penny-wise and pound-foolish when it comes to providing quality health care for our seniors and for others who are on Medicare.

Indeed, for those who say we are going to control the costs in this legislation, I would say that the means of doing so that are in the bill are primarily price controls by the Government, which have been demonstrated not to work very well, and I think we can expect that the younger generation is going to bear the full brunt of this expense.

It is a $400 billion expense over 10 years. It is not taken out of any kind of payroll tax or other kind of payment by the beneficiary for that segment of what we are providing. It is going to be paid for out of the pockets of people who are working to earn a living and pay for their kids' education. We have to stop and evaluate whether, with a lot of seniors who are well enough off to afford drug coverage, it is fair to ask their kids, who are struggling at this point to make a living, to bear more of the burden.

There is well over $100 billion of this, probably about $150 billion, in premiums and copays and deductibles that will go toward the benefit we are providing here that is worth $400 billion. But let us not forget that the $400 billion money is being paid by taxpayers. So cost containment is important, and it will boil down to the discipline that we in the House and Senate and the President can exercise in keeping the right balance between cost containment and providing high-quality care.

I have stressed the negatives to try to establish a point. I didn't get my way negotiating this legislation despite hundreds of hours of work in the conference committee. Nobody got 100 percent of what they wanted. For those conservatives who are disappointed because of the kind of things I have been talking about here or the lack thereof that shows we really missed a historic opportunity to make the bill better, I would like now to address why I think, nevertheless, they should support the legislation.

It boils down to the fact that it is extraordinarily difficult with something this big and this complicated and important to so many people, with every Senator and every Representative having a very big stake in trying to get it right, to reach the kind of compromise that is going to make any particular group happy.

I note there was a scathing op-ed piece against one of the Democratic Members who was substantially involved in these negotiations, criticizing him for not representing his point of view well. I can't tell you how wrong the writer of that piece was. From my perspective, that distinguished Senator got far more than I did out of this. He won more of the battles than I did.

I think one should be a little bit careful about simply putting the ideology out there and saying, because one side didn't get everything it wanted, therefore it is a bad bill. The reality is that under the circumstances we face today, I think it would be impossible to put together a bill that would provide drug benefits for our seniors that would do it any better than what we have done here.

Why do I say that? Some people say, let's let this bill fail and we will come back and simply provide a drug benefit to those who need it the most. I think we have gone too far for that. Groups such as AARP are not going to support that. Their support is very important for a program such as this. I don't think a lot of Senators would support that. So even though that might have been how I would have liked to have started this process, I don't think that is going to pass.

Do we let 2 or 3 more years elapse without providing a drug benefit? I don't think that is an alternative. So I would challenge anybody who says this bill isn't perfect to demonstrate to me how they could cobble together a majority to provide an important drug benefit and still achieve all of the objectives they want to achieve and get it passed.

We do need to include prescription drugs in Medicare. They haven't been included, and we all know this is the preferred method for treatment by most physicians for many illnesses and diseases today. We also need to ensure that those who don't have coverage can get it. The options we provide in this bill at least get us part way down that road.

Importantly, we will be reducing the costs of prescription drugs both to third party payers, whether it be the Government or the employers, as well as the seniors for the part they have to pay. How is this done? There are a variety of mechanisms in the bill. One of them is the fact that the Government and the private plans will be buying in bulk. Everybody can understand that concept. You can buy for a lower cost if you buy in bulk. Another is that there are a lot of incentives to use fewer drugs, to use generic drugs, drugs that are based on a formulary that more specifically fits the particular patient's need, and not to have a lot of extra drugs sitting around in the drug cabinet. Almost all of us have extra drugs sitting around, which is probably not a very healthy thing. It is a costly thing as well.

There are a lot of incentives built in this legislation that should permit us to reduce the cost of drugs both for the third party payers as well as for the seniors themselves for the portion they are going to have to take care of.

Another important thing in this legislation is that we at least go a little way toward rationalizing the system of paying the doctors and the hospitals and other health care providers that have not been adequately reimbursed. There were large cuts in store for hospitals and doctors. Those cuts are no longer in place. In fact, there are very modest increases for physicians and hospitals: A 1.5 percent increase for the physicians, instead of the 4.5 percent cut that was going to take place starting January 1 if we did not act. At least there is modest support for those that we really count on when the chips are down to take care of us.

As I said, if we defeat this bill now, I don't see how we can come back and provide these things, how we can get consensus to do it anytime in the near future.

Another important item is the health savings accounts provision. Many of us have believed for a long time this could really provide a long-term way for people to build up the savings they can apply toward health care for insurance and out-of-pocket expenses so that they won't need to rely as much on Medicare when they get to be eligible for Medicare.

We know one of the reasons we have high-priced drugs is that Americans have to bear almost the full burden of the cost of production of drugs since other countries, such as our friends to the south and north, have price controls on how much they can reimburse the drug companies for their prescription drugs. This is unfair trade. It puts all of the burden, a cost shift, on the American consumer. This bill provides instruction to our Trade Representative to come up with a way to deal with those other countries to get them to share more of the burden of the expense of producing these important drugs for us.

We also include the affluence testing of the Medicare Part B premium for those at the very wealthy end of the spectrum; a senior who makes over $80,000 a year, for example. I think it is not too much to ask them to pay a little bit more in their Medicare premium for the coverage they receive.

We index the Part B deductible so we don't have to come back every 10 years and have Congress pass a law. This will basically keep up with the cost of inflation. We also include a change for so-called 340B hospitals. These 340B hospitals are public safety net hospitals, and we enable them to purchase their inpatient drugs cheaper than they can purchase them today. I introduced legislation earlier on this subject, and I am pleased we have that provision included here.

Then finally a provision that is important to those States such as the border States—Arizona, Texas, California, and others—that are required under Federal law to provide treatment to illegal immigrants because of the law called EMTALA, the Emergency Medical Treatment and Active Labor Act, that says no emergency room can turn away a patient whether that patient can pay or not.

Because emergency rooms now are faced with treating illegal immigrants under this requirement and because the Federal Government has not been able to enforce the law to prevent those people from coming into the country illegally in the first instance, we believed it was important for the Federal Government to at least help these hospitals defray some of the expenses they are incurring, which in some cases are so severe, it is forcing hospitals to consider closing down and certainly shutting down emergency room care.

That can't be. American citizens should not suffer because of a law that requires that we provide care to illegal immigrants. We can at least reimburse those hospitals for a portion of the cost they bear. This bill provides $250 million a year for 4 years to provide that kind of reimbursement.

There are a lot of positives in the bill. There is a lot more I know the chairman of the Finance Committee will discuss in more detail.

What I want to do is discuss it from the standpoint of somebody who has been critical, who has constantly said: We can do better. We are missing opportunities. We ought to do this in a way that is more flexible, that looks more like the FEHBP. I didn't win a lot of those battles, but we have an opportunity to at least implement a plan that we have a possibility of making better over time as people see the advantages of the concepts we have put in the legislation.

We have the knowledge that at least in the foreseeable future, because we are adequately reimbursing those people upon whom we rely for care, that we are going to have that care provided to us in a quality way and that our seniors will not suffer because we didn't consider it important enough to provide for them the very best.

Without this legislation, they will continue to pay more than they should for prescription drugs. They won't receive as much in the way of prescription drug coverage or care. And that will be a shame at a time when this country has the capability of providing that kind of care.

Notwithstanding all of the concerns I have noted, the challenges we need to face in the future, we should support the legislation.

I chair the Health Care Subcommittee of the Finance Committee in the Senate. I intend to have hearings next year into areas that may need improvement. I look forward to working with my colleagues to improve this historic legislation as we move forward. We owe our senior citizens no less.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, we are alternating back and forth. It is obvious that it is not fair. The Senator from Arizona did not speak for an inordinate amount of time. If somebody comes and speaks for 5 minutes who is opposed to the legislation and someone speaks for 45 minutes in favor of it, that doesn't work out. I am somewhat at a loss as to why we have not worked out an arrangement that the time between now and 11 o'clock be equally divided between proponents and opponents, with no limit as to how much they could speak.

If someone who wanted to speak in favor of the legislation were here and there was nobody to speak in opposition, that person could go ahead and speak. For reasons I don't understand, the floor staff has not gotten that approved by the managers and leadership.

The Senator from West Virginia is here in the Chamber. He is going to speak against the legislation. With the agreement now in effect, it would be his time to speak. I know the manager is here. Is that OK with the Senator?

Mr. CRAIG. Will the Senator yield? I know the Senator is going to speak at 11 o'clock. I was told I could speak. The Senator from Illinois has been here for some time. I understand both of these Senators anticipate fairly lengthy statements. I do not. I anticipated no more than 10 minutes. Is it possible that I could slip in there somewhere?

Mr. REID. Mr. President, I think the Senator from West Virginia would be happy to yield for 10 minutes to the Senator; is that right? I don't know that to be the case. This shows how unfair this whole situation is.

Mr. CRAIG. Exactly right.

Mr. REID. I cannot imagine what is holding up the UC to allow the time to be divided equally.

I yield to the Senator from West Virginia. He has an obligation. That is why he is here at 11. The Senator from Illinois said he would be happy to yield, following the statement of Senator BYRD, to the Senator. He has that right anyway; he doesn't need consent to do that.

Mr. BYRD. Mr. President, in any event, the distinguished Senator from Illinois would be recognized at the same time—if I understand the request of the Senator from Nevada. If the Senator from Idaho goes first and then I go next, then the Senator from Illinois would go; or if I go first, and the Senator from Idaho goes next, then the Senator from Illinois would go. So the Senator from Illinois, through his gracious courtesy, which is so characteristic of him, either way, that would suit the Senator from Illinois.

That being the case, I have no problem with yielding to the Senator from Idaho next, if he can limit his statement to 10 minutes, which I understood he would.

Mr. CRAIG. I would do that under a unanimous consent, certainly.

Mr. REID. Just understand that following Senator BYRD is Senator DURBIN. There could be as much as an hour and a half. I want to make sure everybody understands that.

Mr. President, I ask unanimous consent that the Senator from Idaho be recognized for up to 10 minutes, and then the Senator from West Virginia, followed by the Senator from Illinois.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BYRD. I will not speak longer than 20 minutes.

Mr. CRAIG. Will the Chair signal me when I have spoken for 9 minutes?

The PRESIDING OFFICER. The Chair will do so.

Mr. CRAIG. Mr. President, the Medicare conference report now before the Senate, brings to fruition President Bush's early and strong commitment to prescription drug relief, and it reflects nearly 6 years of difficult congressional debate.

The Senator from Iowa is here in the Chamber. He has played a key role in shaping the final package, in hours and hours of work with our majority leader and with leaders from the other side, to try to strike a critical balance.

This historic legislation, like the 38-year-old program it seeks to reform, is indeed expensive, complex, and unweildy but it is a compromise I can and will support, although not without some very strong reservations.

This bill is a solid step toward accomplishing two core goals: Providing prescription drug relief to seniors in need, and strengthening Medicare's future through greater market competition.

This legislation also includes dramatic improvements in consumer choice through health savings accounts, and perhaps the best package of rural health care improvements Congress has ever considered. I know its impact on the rural hospitals of Idaho will be significant.

Despite its deep and undeniable faults, this bill offers a rare opportunity unlikely to return for several more years, if ever—years in which millions of seniors will continue to suffer for lack of needed drugs and years in which the retirement of America's baby boomers will draw ever closer, and the modernization of Medicare will become ever more urgent. No, it is not perfect, but to hold out for perfection would risk a permanent sacrifice of much that is good and necessary in this legislation.

As chairman of the Senate Special Committee on Aging, I have chaired several hearings examining many of the hard questions in this debate—including the long-term demographic and financial pressures facing Medicare, and the importance of integrating competitive alternatives into Medicare's future. I am pleased to see some of these themes reflected in the legislation before us today.

Mr. President, my reasons for supporting this legislation are straightforward:

First, the legislation provides long overdue drug relief for our Nation's seniors. Nearly every health insurance plan in America today contains drug coverage. It is time Medicare did, too.

Beginning in 2006, seniors who decide to enroll in this completely voluntary new program and will pay a premium of about $35 and will receive a 75 percent subsidy for the first $2,250 in annual drug costs, after meeting an initial $250 deductible. And after a senior's annual drug costs reach $3,600, Medicare will cover 95 percent, providing essential relief for those seniors with catastrophic drug needs.

Overall, the average senior enrolled in this program will see annual drug costs reduced by 44 percent to 68 percent. In the nearer term, prescription drug discount cards will be available, offering seniors drug discounts of up to 10 to 25 percent.

Second, I am very pleased that the bill devotes the greatest share of its relief to seniors of modest and low income, those who need it the most.

For these seniors, the relief will be even greater than in the basic package. In Idaho, nearly 35 percent of our Medicare beneficiaries are likely to qualify. Seniors whose incomes fall below about $13,500 for an individual or $18,200 for a couple will receive deeply discounted premiums and deductibles, and those whose income is below about $12,100 for an individual or $16,200 for a couple will have no premium or deductible and will pay only a few-dollar copayment for each prescription.

The important thing to keep in mind is that the proportion of seniors today who have no private drug coverage at all is relatively small—about 25 percent—and it is on these seniors, as well as those whose current coverage is inadequate, that this bill is focused. In short, those in the greatest need get the greatest benefit and that is as it should be.

Third, the bill before us today seeks to bring Medicare into the 21st century, not just by providing prescription drug coverage, but also by offering seniors the choice to enroll in federally supervised but privately operated health care plans—that same kind of choice and coverage currently enjoyed by other Americans under 65.

Medicare today remains weighted down by rigid bureaucracy and complex regulations—regulations that are already beginning to drive doctors and other health care providers out of the program. Even more distressing, the heavily bureaucratic Medicare Program has utterly failed to keep up with the kinds of medical innovations and coverage options most of the rest of us take for granted.

By contrast, this bill's new competing regional preferred provider plans will give seniors one-stop shopping for comprehensive and integrated coverage, including prescription drugs, preventive care, care coordination, and protection against very high catastrophic medical bills—benefits which are largely unheard of in today's Medicare Program. Even more encouraging, six large-scale demonstrations, beginning in 2010, will test direct price competition between private plans and traditional Medicare. Although not as extensive as I would have wanted, these competition-based reforms are nevertheless the most substantial steps Medicare has ever taken toward bringing marketplace innovation into the program.

Importantly, all of these new choices will be completely voluntary. Seniors who want to keep their current coverage and stay in the traditional Medicare will be free to do just that. No senior will see any reduction in any Medicare benefits under this bill. No benefits will be taken away—none.

Fourth, this legislation contains landmark improvements in the ability of Americans to take charge of their own health care through expanding the use of health savings accounts.

To a greater degree than ever before, this bill will permit individuals to build significant tax-free health care savings for use in meeting a family's health care needs, including long-term care. As we try to encourage those who are becoming seniors to acquire long-term health care insurance, here is a way to finance it and finance it with tax-free dollars. Together with high deductible insurance for very high medical expenses, this approach puts control of health care where it belongs—in the hands of the individual citizens of our country.

This is something I have been fighting for since I first came to Congress, and I believe this bill's health savings account provisions are among its most important accomplishments.

Fifth, I am tremendously pleased, as should be every Idahoan, that this bill includes an unprecedented package of nearly $25 billion in improvements for rural health care. Senator GRASSLEY can be extremely proud of the work he has done to ensure the stabilizing of rural hospitals and rural health care. Most importantly, this legislation achieves a permanent evening out of rural and urban Medicare reimbursement rates. For far too long, doctors and hospitals in Idaho and other rural States have suffered under payment classifications and reimbursement levels that put them at a significant disadvantage—and that makes the already difficult task of providing rural health care even more daunting.

Sixth, the conferees have included, for the first time, a requirement that high income seniors (those making over $80,000 individually or $160,000 as a couple) pay slightly more in Medicare premiums than those who are less well off.

In the decades to come, I believe our children will thank us for recognizing that America's taxpayers simply cannot afford to continue subsidizing care for the wealthiest among us at the same level we provide for the less well off.

Finally, I believe it is important to recognize that the conferees have taken great care to include protections against something I know has concerned many seniors—namely, Will this bill cause me to lose the drug coverage I already have? The final bill includes very significant assistance to employer-sponsored plans to help assure their continued participation in retiree health care. Indeed, some are concerned that this assistance is, in fact, too substantial. But Congress's intent on this issue is clear: Seniors who are happy with the coverage they have today should be free to keep it.

The underlying framework of this bill is a sound one, and it follows the strong and guiding principles laid out by President Bush earlier this year—namely to strengthen traditional Medicare and keep it as an alternative for those seniors who want it—but also to provide a new foundation for the future, one built on choices, competition, and innovation.

This said, however, I remain gravely troubled by certain aspects of this bill.

First, it troubles me deeply that this legislation will add substantially to an entitlement program whose long-term future is already sobering in the extreme. Even without a new $395 billion drug benefit, Medicare is expected to spend nearly $3.9 trillion over the next 10 years—and by 2075, these costs will nearly triple.

Nothing can change the fact that desperately hard choices lie ahead, regardless of what we do this year. Nevertheless, what we sow today, future generations will reap.

Second, I am disappointed that the conferees chose not to adopt firm expenditure restraints if and when Medicare cost growth rises faster than currently projected. Nearly all honest observers predict that this bill will ultimately cost more than the $395 billion over 10 years that is now budgeted. Such a cost restraint measure would have gone a long way toward assuring future generations that we are serious about fiscal restraint and preserving a viable Medicare program for our children and grandchildren.

Third, I believe this bill should have moved Medicare more assertively toward a 21st century competitive approach, with an even greater role for private plans and the innovation they generate—an approach patterned, for example, after the highly successful program now available to Members of Congress and other federal employees. As it is, this bill makes a credible start in that direction, but much more remains to be done.

And finally, I am concerned by this legislation's very high level of complexity and prescriptiveness. Of course, Medicare legislation is never simple. However, this bill runs to many hundreds of pages and is very heavy with exceptions, rules, and carveouts—including literally dozens of provisions and billions of dollars relating to specifics of provider payment.

This bill's new competitive alternatives, if they succeed, are intended to take us away from this kind of micromanagement. Unfortunately, if the complexity of this bill is any guide, we may yet have a ways to go.

My concerns about this bill are very serious ones. However, on balance, I believe this legislation is a positive step forward for America's seniors, for the Medicare program, for Idaho, and for the country as a whole.

President Bush deserves tremendous credit for making Medicare and prescription drugs a top priority this year, as do Majority Leader FRIST, Senator GRASSLEY, and the other conferees for bringing us to where we are today.

Medicare urgently cries out for a better future, and America's seniors desperately need meaningful prescription drug relief. This legislation moves solidly toward reaching both of these goals, and I urge my colleagues to stand with the President and support its passage into law.

I close by thanking the Senator from West Virginia for his courtesy. I will adhere to our agreement. I yield the floor, and I thank my colleague.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. Mr. President, our friend, the distinguished Senator from Idaho, who serves on the Appropriations Committee, is welcome. I thank him for his kind references to me.

I thank the Chair, Senator CORNYN of Texas, who has had the good fortune of presiding over the Senate on many occasions this year. I say, I have had the good fortune of speaking on almost every occasion that the Senator from Texas has presided over the Senate, and he presides so well. He presides with a degree of dignity and skill and aplomb that is so rare as a day in June.

I also thank my majority whip, the best whip the Senate has ever had. And I have been the whip. I was the whip for 6 years. But I say—I will repeat the words of a great poet—''You're a better man than I am Gunga Din.''

HARRY REID is a better whip than I was, and it wasn't because I didn't do my best. I don't grow lax in any job. Any duty that is placed on me, I do my very best. But he is a jewel, HARRY REID.

Let me thank the Senator from Illinois also, the distinguished Senator, Mr. DURBIN. He is always so gracious, but he can afford to be gracious. He is so able, an inimitable debater. He can speak at the drop of a hat, and the hat won't hit the ground. That man, DURBIN, is a very fluent and ready speaker. I am so pleased that he is my friend and that he is a Senator on my side of the aisle. I thank him for his courtesies on this beautiful morning in November.

It is a beautiful morning. May I say to the young pages who are here so early in the morning:

> Ah, great it is to believe the dream
> As we stand in youth by the starry stream;
> But a greater thing is to fight life through
> And say at the end,
> The dream is true!

Mr. President, I had hoped to be out here on the floor talking about a plan to give senior citizens a prescription drug benefit for Medicare.

I had hoped to be extolling the virtues of a bill that would give needed relief to the millions of our Nation's elderly citizens who have been serving their country and their communities for so long and who are entitled to needed relief. Instead, the Congress will be voting on a measure that would undermine Medicare—undermine Medicare, I say. Listen to me. Hear me now. The elderly citizens who are watching through those electronic lenses, and also the sons and daughters of the elderly citizens as well, will be affected. So instead of voting on a measure that would give relief to the elderly citizens of this country, we are going to vote on something else.

In speaking of the elderly citizens, I speak of the young people as well. Why do I say that? I say it because I can remember the days when there was no Social Security or Medicare Program in this country. I used to go by the old county poor farm in Raleigh County, and as I traveled by there many years ago I would see sitting on the porch up there at the old county poor farm, sitting just within sight of the road, those old people in their rocking chairs. They had no dreams to look forward to. When they grew old, as some of them did—and those coal miners especially grew old early in life—they had no place to go, no place to go but to the homes of their sons and daughters. They would stand with their hats in their hands waiting to be taken in by their children. What a life.

Then there came to the White House of this country a crippled man, a man

who was paralyzed, a man who could not walk, as I can walk even at my young age of 86. There they stood waiting at the gates of their children hoping that they could be taken in. Then that man came to the White House and a Democratic Congress worked with him to give to the people of this country, the elderly citizens and their children, that promise. He fulfilled that promise of Social Security so that no longer would the old folks stand at the gates of their children with their hats in their hands. They could live out their lives with dignity and not be such a burden to their children.

Then I remember Medicare when it came. I was a Member of the Senate and voted for that program. That was when Lyndon Johnson, a great Democrat, was President of this land. Again, the Democratic Congress, working with that Democratic President, gave to the country this program of Medicare, the most successful program that the country has ever had, a program that today's Senators know and trust.

The Congress should be fashioning a real prescription drug benefit. That is what the American people have been told we are doing, but we are not doing that. Instead, the Congress debates a major restructuring and a step toward the privatization of Medicare.

I watched them tearing a building down,
A gang of men in a busy town.
With a ho-heave-ho and a lusty yell,
They swung a beam and a sidewall fell.
I asked the foreman, ''Are these men skilled,
As the men you'd hire if you had to build?''
He gave me a laugh and said, ''No, indeed!
Just common labor is all I need.
I can easily wreck in a day or two
What builders have taken a year to do.''
And I thought to myself as I went my way,
Which of these two roles have I tried to play?
Am I builder who works with care,
Measuring my life by the rule and square?
Am I shaping my deeds by well-made plan,
Patiently doing the best I can?
Or am I a wrecker who walks the town,
Content with the labor of tearing down?

That is what we are doing here. That is what we are about to do. That is what we are getting ready to do. That is what the seniors and their children of this country are about to see happen. This building which was built by careful hands, by caring hands, is about to be torn down.

This is a debate that has largely been hidden from the public, a debate for which our Nation's seniors did not ask. They did not ask for this.

The conference report before us was hatched behind closed doors. We see so much of that time and again under this Bush administration—programs, plots, hatched behind closed doors. Most Members of Congress have been largely excluded from the backroom deals—largely excluded from the backroom deals—that produced this conference report.

Some have asserted this legislation is merely a Trojan horse designed to get rid of Medicare. I hope that is not true, but there is something awfully suspicious about this particular horse that is galloping through the Congress.

We need to slow down and consider the unintended consequences of this massive bill. We may be signing off on the assisted suicide of Medicare as we know it. This legislation takes the first step to undermine a health care system that has benefited millions of retirees, and it is all happening within legislation designed to enhance Medicare to provide a drug benefit. Proponents are selling it one way but may be doing something quite different. You know the old magic tricks? I can remember vaudeville. I can remember when the vaudeville shows came to those coal camps in the hills of southern West Virginia and the actor would say: Watch my right hand, watch my hand, watch my hand. Don't look at this one. Watch this hand. Don't look at what's going on over here.

There is my friend from Maryland—he knows; he remembers—Senator SARBANES, one of the great pillars of the Senate, one of the truly great Senators, a thinker in the tradition of the venerable Socrates: PAUL SARBANES.

So proponents are selling it one way but may be doing something quite different—a classic bait and switch. But seniors are not falling for the bait. Many letters coming to me clearly reveal a genuine fear that this Medicare bill will leave seniors worse off. West Virginians have not been clamoring for enrollment in HMOs. They don't want restrictions on their choice of doctors. They have not been pushing for a new Medicare system that could leave them bouncing in and out of private health plans. My constituents are rightly fearful at the thought of having to pay significantly higher premiums just to stay in their current Medicare plan.

Some analysts of this bill estimate that as many as 29,000 beneficiaries in West Virginia will lose their retiree health benefits as a direct result of this bill and that as many as 45,000 Medicaid beneficiaries in my State will pay more for the prescription drugs they need. I thought our goal was to help seniors, not hurt them, as this bill may do.

Senior citizens across America are fed up with fast rising drug costs that they cannot afford. They are traveling by the busload to Canada—yes, traveling by the busload to Canada and Mexico—just to obtain the medications prescribed by their doctors. And this bill does nothing, zilch, to help reduce the price of prescription drugs. In fact, this legislation explicitly prohibits the Federal Government from directly negotiating with pharmaceutical companies to use the bargaining power of 40 million senior citizens to lower the cost of prescription medicines. This is something the Veterans' Administration, the Department of Defense, the Medicaid Program do every day to save money on drugs. Why in the world are we prohibiting Medicare from saving money?

Unfortunately, this bill offers more of a figleaf than sufficient prescription drug coverage—a figleaf. Do Senators remember the first question that was ever asked in the history of the human race? It occurred during the evening, during the cool of the day when God came walking through the Garden of Eden looking for Adam and Eve. There they were in that paradise—how it might have been, how it might have been. God came through in the cool of the evening looking for Adam, and it was there and then that God asked that first question:

Adam, where art thou? Adam, where art thou?

Adam was hiding. Adam and Eve were hiding. They were trying to hide from that all-seeing eye that pierced through every veil. Yes, they were hiding back in the bushes with a figleaf—a figleaf.

That question: Where art thou? These seniors, senior citizens all over this country, are going to be asking their Senators: Where were you? Where were you when the critical moment came?

I hear the siren call: ''You better take it. It's all you are going to get.''

This Senator will never bow to that siren call. And there are others who will not.

Rather than building on the traditional and successful Medicare Program, the measure in front of us would force Medicare beneficiaries to rely on a private, untried, untested, drug-only insurance market for their prescription drug coverage. Is that what our seniors want? Is that what the people of West Virginia want? No. No.

It would cover less than a quarter of the Medicare beneficiaries' estimated drug costs over the next 10 years. The complicated coverage formula has a large, gaping hole smack in the middle, providing zero coverage just when seniors might need that coverage most—a large hole, large enough for Attila the Hun to drive his thousands of horsemen through.

This legislation includes copayments, premiums, and deductibles that may be unaffordable for many low- and middle-income seniors. A closer look at the fine print of this legislation reveals that private insurers could choose to charge seniors double or even triple these amounts. Seniors may find that their premiums could fluctuate dramatically based upon where they live and how healthy they are. At the same time, the Federal Government will be handing over billions of taxpayer dollars to for-profit insurance companies, just to get them to participate in Medicare.

Let's face it, the kind of prescription drug benefit that we have repeatedly promised to our Nation's seniors and they now rightly expect would cost at least $800 billion during the next decade. Drug costs for senior citizens alone are expected to total almost $2 trillion during this same period. Yet the Bush administration and congressional leadership have only set aside $400 billion for a Medicare prescription

drug benefit. Although, isn't it remarkable that we can afford to spend $1 billion a week—$1 billion a week—in Iraq?

I will have plenty more to say about that. I made 62 speeches on that gargantuan mistake. I will make some more, the Lord willing.

Missiles? Yes. Medicines? No. Missiles? Yes. Medicines? No.

Where are the priorities of this administration? Where are the priorities of the Congress?

It seems that this Congress is trying to pull the wool over the eyes of our Nation's seniors hoping to claim victory and keep seniors in the dark until they become painfully aware of the fine print in this legislation upon a visit to their local pharmacy—in 2006. That will be my next election year, 2006, the Lord willing.

In the Book of James, we are told always never to say, I will go here, I will go to this city or to that city, I will buy this, or I will buy that tomorrow, but always to say, the Lord willing, I will go to this city or I will go to that city and I will buy this or that. So, the Lord willing, 2006 is my next election day. Eighty-six is not too old. I am 86 years old. Abraham lived to be 175, Isaac lived to be 180, Jacob lived to be 147, Moses, 160; and so on.

Mr. GRASSLEY. He lived to be 120.

Mr. BYRD. Was I wrong on that?

Mr. GRASSLEY. Moses lived to be 120, not 160.

Mr. BYRD. All right, 120. The distinguished Senator from Iowa corrected me. But he won't correct me on this bill. He won't correct me on the tragedies of this bill. But I accept his correction. I will go look it up to make sure.

As lobbyists for the pharmaceutical and health industry swarm all corners of the Capitol, the Congress is on a mad dash to pass this bill before Thanksgiving, regardless of its contents or its flaws, so long as it can be called prescription drug coverage. Unfortunately, when it comes to their health care security, it appears our Nation's senior citizens will find that they have little for which to be thankful.

I have heard some Senators argue that something is better than nothing. Is that what we are being given? Something rather than nothing? Nothing?

They try to rationalize a bad bill by claiming that this may be our last chance and you had better take it; something is better than nothing. They argue that we should vote for this now and fix the bill's problems down the road. I have been down that road. I have seen that and heard that many times in my 51 years in Congress. This conference report is a pill that is too bitter to swallow.

I am one of perhaps only a handful of Senators in this body who voted to create Medicare. I can say to you, Mr. President, that it was not created overnight. It was not created in the hidden dungeons, in the hidden subterranean caverns under this Capitol. It was created in response to a private sector that would not offer affordable and reliable health insurance to the elderly and the disabled.

Few can argue that seniors are not better off today as a result of Medicare. We should not turn our backs on one of the most successful Government initiatives ever created. We should seek ways to strengthen Medicare, not dismantle it.

Senior citizens who need life-sustaining medicines want us to get it right. They trust us to get it right. We should reject this bill and work to pass a bill that does get it right. Thanksgiving is an arbitrary deadline. It means nothing when measured against the potential damage that could be done in haste—haste that could jeopardize the health care security of generations to come. We should do better for our senior citizens. We owe them that much.

In closing, I thank Senators who have worked hard on this bill, Senators who have toiled late into the nights and weekends. I thank Senator GRASSLEY. I thank Senator BAUCUS. I thank all Senators. I thank all Senators for listening.

By the way, as to Joseph, how long did he live? He lived to be 110 years old.

The PRESIDING OFFICER (Mr. BENNETT). The Senator from Nevada.

UNANIMOUS CONSENT AGREEMENT

Mr. REID. Mr. President, I am sure the Chair can protect the majority if there is a problem. We need to get this unanimous consent agreement, which has been approved by both sides.

I ask unanimous consent that the time until 11 o'clock tonight be equally divided between the opponents and proponents; provided that when time expires on either, it be in order for either side to consume additional debate time; further, that the debate time used beginning with Senator KYL's statement this morning be counted against the time allotment. I further ask unanimous consent that notwithstanding the order for an alternating fashion following the remarks of Senator DURBIN, it be in order for two Republicans to speak consecutively, one Senator for 20 minutes and the other Senator for 15 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. Mr. President, further, so Senators will have some understanding as to when they can speak, I ask unanimous consent that the Democrat order be Senators STABENOW and REED of Rhode Island following Senator DURBIN, and that the Republicans be Senators SNOWE, CORNYN, COLLINS, BENNETT, HATCH, BOND, NICKLES, and GREGG.

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

The Senator from Illinois.

Mr. DURBIN. Mr. President, before saying a few words about this Medicare bill, I would like to say a few words about the senior Senator from West Virginia. This man is such an amazing person. At 86 years of age, what he brings to public service and what he brings to the Senate is incredible.

I was in the Chamber earlier this morning when Senator BYRD arrived. He said he would like to say a few words. I said, quite honestly, I am ready to follow you into battle any day. I deferred to him, which I was happy to do. He is a grand person and such an amazing Senator.

I have been fortunate to represent a congressional district in Illinois and the State of Illinois for over 20 years on Capitol Hill, and I have many favorite moments. But in the top tier of those favorite moments was the time in a conference committee downstairs from this Chamber involving Senator BYRD, and I would like to tell those who are following this debate about that experience because I still marvel at what he did that day.

He came to a conference committee on the Transportation appropriations bill facing a critic in the House who said that Senator ROBERT C. BYRD of West Virginia had put too much in this bill for the State of West Virginia. And your critic from the House was going to have his day with you at that conference committee.

As some people know who follow the Senate, the appropriations conference committees gather at a large, long table and the House Members sit across the table directly from the Senate Members. So your critic in the House came and took his seat with a sheaf of papers prepared to do battle with you over the Transportation appropriations bill. You arrived and just fortuitously happened to sit directly across from him at that table. He began his peroration about how terrible it was that West Virginia would have so much in this Senate bill and he was going to do something about it. He went on for all of 15 minutes. He got red in the face, his arms were waving, and finally he was spent. He had nothing more to say.

Then, as I recall, you turned to the chairman—which could have been Senator Hatfield of Oregon—and asked if you could be recognized.

The Senator began his remarks, and that is what I thought was the most remarkable moment, saying, in the history of the United States there is an exchange of speeches between two individuals which defined Federalism as we know it and the role of small States like West Virginia in the Senate and larger States. That exchange was between Daniel Webster and Robert Hayne.

Senator BYRD went on to say, Webster's reply to Mr. Hayne was delivered on January 20, 1830. And then Senator BYRD added, ''and if my memory serves me, it was a Thursday.'' He proceeded to give an important history lesson to all who had gathered, Members of the House and the Senate, about why West Virginia had a fighting chance in the Senate but might not have that same chance in the House, as each State has

two Senators, of course, in this Chamber, and represented proportionately in the House.

I was absolutely spellbound by his performance that day in that small room. When it was all over, of course, West Virginia fared well in that appropriations bill, as it always has since Senator BYRD has been here to make sure his State was not shortchanged. I was in the House at the time, and a few years later I came to the Senate and said to Senator BYRD: Of all the things you said in the speeches, when you said, ''If my memory serves me, it was a Thursday,'' I still remember those words.

Senator BYRD said: Well, Mr. DURBIN, if I am not mistaken, it was a Thursday.

I said: I am not questioning you; I am sure it was a Thursday.

Later in the day, he called me over to his desk and pulled out a perpetual calendar, and said, yes, January 20, 1830, was a Thursday.

It says a lot about this Senator, not only his reverence for history and this institution, but the fact that he brings to many of these political battles an insight that many Members admire so much and respect. Whether you are on his side or not, you best sit back and listen closely when Senator BYRD takes the floor because he brings to each one of these debates the very best in public debate and the very best in public service.

This Senator was happy to step back and listen very carefully as the Senator from West Virginia made another compelling argument on a very important and historic piece of legislation.

Mr. SARBANES. Will the Senator yield?

Mr. DURBIN. I am happy to yield.

Mr. SARBANES. I listened to the able Senator from Illinois with great pleasure because I strongly share his feeling and views about Senator BYRD. I took the floor for a brief moment to underscore the extraordinary contribution that Senator BYRD has been making to the national debate in the recent period on issues of critical national importance. He has taken to the floor time and time again and spoken with a clear strong voice. He has sounded a clarion call to the country. I know from people I talk to that voice is reaching into many corners across the land and prompting Americans to think deeply about the issues that confront the Nation, and even more deeply and fundamental about how we go about conducting our business and making these decisions.

The vote last night in the House of Representatives was held over for 3 hours in order for the Republican leadership to twist arms in order to change the outcome, which was already up on the board, where they had lost by two votes. That rollcall vote was held open indefinitely. My able colleague from Maryland, Congressman HOYER, remarked afterwards, it would be as though you had election day, the time came for the polls to close, and you held the polls open for another 15 hours while you went out and somehow found the votes to assure you the result. It is an abuse of the democratic process.

The Senator from West Virginia has always spoken. He sounded a loud trumpet about our Nation. We are deeply in debt to him and appreciate that.

Mr. DURBIN. I thank the Senator from Maryland. I might just add something I have said in the Senate and I told Senator BYRD during the debate on Iraq. I went to my church in Chicago with my wife—this is highly unusual in my church—as we came back from communion, and we are kneeling, an elderly man came up to me and leaned over on his way back from communion and he said: Stick with BOB BYRD.

I came back to tell Senator BYRD that his message reached beyond this Chamber and beyond the State of West Virginia. It has been not only heard, but it has been applauded by the Nation of grateful people who are glad you are here in service to our country and continue to be. If you reach the age of Methuselah, Abraham, Isaac, or Moses, I hope I am still here to defer to you and listen carefully as you make these presentations.

Mr. BYRD. Mr. President, will the Senator yield?

Mr. DURBIN. I am happy to yield.

Mr. BYRD. Mr. President, I am deeply grateful to these two fine Senators for the kind words they have just spoken, Senator DURBIN and Senator SARBANES. I will go to my everlasting resting place with love and gratitude and affection and admiration and respect for these two Senators and how they have served the Nation and this institution and been loyal and true to the Constitution of the United States forever. I shall think of them and be in their debt. I thank the Senator.

Mr. DURBIN. I thank the Senator from West Virginia.

The Senator from West Virginia, when he came to the floor, gave us an important message. He asked us to look at this very carefully. This, my friends and fellow colleagues, is a proposed law. It is huge. But that is not uncommon. And that should not be a reason to vote against it. The reason to vote against it is what is contained in this law, this proposal, this bill.

When we started this debate about prescription drugs for seniors, overwhelmingly the President, the Republicans, Democrats, all agreed on one thing: We needed to find a way to provide affordable prescription drugs for senior citizens. Medicare, as good as it is, provides good care through hospitals and doctors but not enough help when it comes to paying for prescription drugs. We understood that needed to be done.

The solution was obvious from the start. The solution to this challenge was to put under the Medicare Program a voluntary, comprehensive, and universal plan to pay for prescription drugs, to use the same successful model that has guided us for 40 years in keeping seniors healthy through good doctors and good hospitals, and also provide prescription drugs. We knew if we did that, it would work as Medicare has worked. The proof of Medicare's success is the fact that seniors are living longer, they are healthier, they are independent, and they are strong.

But there was a criticism of using this so-called Government approach. The criticism came from political extremes that argue that the Government shouldn't be involved, and also from the pharmaceutical industry which understood full well, if Medicare could bargain for seniors across America, Medicare could bring down the prices of prescription drugs just as the Canadian Government has brought down the price of those same drugs for its citizens.

The pharmaceutical companies lived in dread that Medicare would be able to have cost control and competition and bring down the price of drugs.

So we started on this convoluted path to find an alternative. The first suggestion was, why not let private insurance companies provide this prescription care benefit? Let them compete. There is nothing wrong with that from this Senator's point of view. If private companies want to offer prescription drug benefits and compete with Medicare, so be it. Let's see what happens. Let's see if that competition will also help seniors.

But they said, wait a minute, we are not wanting these private companies to compete with Medicare. We want Medicare out of the business of competition completely. That was the starting point for the Republican approach to prescription drugs. Of course, the pharmaceutical companies applauded this because if they do not have to answer to Medicare with 40 million Americans under its protection but, rather, to smaller companies, they have more bargaining power. So we went through this long exercise in the Senate about this proposition that private insurance companies would somehow provide prescription drug benefits to seniors.

I offered an amendment on the floor, supported by most of my colleagues who are here today, that said: Give Medicare a chance to compete. We did not prevail. In fact, we did not get any votes from the other side of the aisle. The Republican approach to this from the start was to say they believed in Medicare, but then to turn their backs on Medicare when it came to prescription drug benefits.

Well, eventually we were faced with the prospect, in the Senate bill, of either accepting their approach, and moving toward prescription drugs for seniors, and passing it out of the Senate, or doing nothing. Most of us voted to move the bill forward and into the conference committee. But, sadly, that was not the end of the story.

When it came to the conference committee, there was a new political force

at work, not just the people who wanted to keep Medicare out of the prescription drug business but a new group from the House of Representatives with a much more radical agenda. What they wanted to achieve was not just private insurance companies offering prescription drug benefits, they, in fact, wanted to privatize Medicare itself.

We started by wanting to add a benefit to Medicare, and now the House Republicans, and their cohorts in the Senate, have said: We want to change Medicare. We want to make certain that Medicare as you know it will not be there in the future.

One of the proponents of this point of view was former Speaker of the House Newt Gingrich, who this week came to the Republican House caucus and said: Vote for this bill; this is a good bill. That should be proof positive to anyone listening that this is a bad bill. Because it was that same Speaker Newt Gingrich, whom I served under in the House, who said, at one point, that we should allow Medicare to wither on the vine. There was no personal or political commitment by Speaker Gingrich to Medicare. And for him to endorse this huge bill is proof positive to me that within the four corners of this bill are threats to Medicare we need to take seriously.

This morning, as I came to the office, on Saturday, I had an e-mail from one of my staffers who fields the phone calls that come into my office. She wrote and said: Senator, something unusual is happening out there. When you first started debating prescription drugs under Medicare a few months ago, the phone calls were generally positive. Seniors were saying: Let's do it; we have waited too long. But she said: Something's happened. There is a sea change out there. The phone calls are overwhelmingly negative now.

Seniors have come to understand this bill not only does not give them good prescription drug coverage but it is a full-scale assault on Medicare itself, and they are calling every office, congressional and senatorial office alike, saying: Defeat this legislation.

Now, doesn't that tell us something? Doesn't it tell us something, that what we started off in believing—that seniors wanted prescription drugs—has now been rejected by them when they learned what is at stake? And there is a lot at stake.

This bill will raise Medicare premiums, something which lower income seniors will find very difficult to deal with. It will force seniors into HMOs. And you know what that means. That means insurance companies will pick their doctors and their hospitals for them and say that they will lose the right to choose their own doctors and hospitals.

Of course, that is the grand old Republican plan: that Medicare as we know it would change; that, instead, we would be dealing with HMO insurance companies. And I can tell you, I have yet to run into a senior citizen anywhere who endorses HMOs, nor many doctors who believe they are very good when it comes to quality health care. Yet that is the solution that is being offered here.

It is not bad enough that my friends on the Republican side of the aisle have said they want to move toward private insurance companies and privatizing Medicare. They do not even believe in the value of the free market in this experiment. Because they are not saying to HMOs: We want to open the door and give you your chance to compete. No. They are coming through with more than $10 billion in Federal taxpayers' subsidies to be given to these HMO insurance companies so that they capture more and more seniors out of Medicare.

Think of that. The Republican free market, entrepreneurial spirit that is being sustained by a $10 billion Federal slush fund for HMOs so they can take more and more seniors out of Medicare.

What is even worse, as they draw seniors out of Medicare, they will look for, as most insurance companies do, the healthiest of the seniors, leaving behind the poorest and the sickest seniors in Medicare, meaning that the costs of Medicare per person are going to go up, and Medicare will become more expensive, and perhaps less popular from a budget point of view.

That is the grand plan here: Starve Medicare; have it wither on the vine. Newt Gingrich's vision for Medicare is finally realized in this 1,200-page bill. Speaker Gingrich rides again. He has prevailed. His was the voice that prevailed when it came to the contents of this bill.

Sadly, too, this bill will eliminate drug coverage for millions of Americans. We have had a Congressional Budget Office review of what happens when this bill goes into effect.

Mr. President, 2.7 million retirees will lose the private insurance coverage they currently have. Understand who these people are. These are people who have worked for a lifetime for a company, with the understanding they would receive a retirement benefit which included prescription drug coverage. And when this goes into effect, this proposal that has been brought before us, the Congressional Budget Office and other sources tell us 2.7 million Americans will lose their prescription drug coverage. They may lose all of their health coverage during retirement.

Over 100,000 of these unlucky retirees are in my State of Illinois. For them, if for no other reason, I will be voting no on this. I will be voting no because, frankly, we are basically saying: We want to reward HMOs. We want to reward pharmaceutical companies at the expense of people who have worked a lifetime for security in their retirement and will lose it because of this bill.

How can we, in good conscience, stand here and say we are going to create a mechanism where companies will have the rationale and the opportunity to drop their retiree health care coverage? That is sad. Medicare was created because seniors across America did not have a helping hand when it came to doctors and hospitals. And now, in this effort to privatize Medicare and reward the big drug companies, we are going to provide less coverage for seniors across America.

Let me speak for a moment about the pharmaceutical aspect of this bill. We know if we have competition, we can bring prices down. We also know if the Government shows leadership, as they have in Canada, prices of drugs will come down. But the pharmaceutical companies have prevailed. The pharmaceutical companies have won the argument.

The most important question asked about any piece of legislation before the Congress is this: Who wants it? Who wants this bill?

First and foremost, the pharmaceutical companies want this bill because there is no effort to bring down the cost of drugs that American families and seniors have to pay—no effort whatsoever.

We had a provision included that called for generic drugs, one way to try to get good drugs that are lower priced in the hands of seniors, and it was weakened dramatically in the conference. We had an opportunity, through a provision proposed by the House of Representatives, for reimportation of drugs from Canada and Europe so seniors had a chance to get a break there if they could not afford the drugs here in the United States. That was dramatically weakened, too. And the Bush administration has vowed they will never let it happen, they will not allow reimportation to happen.

So if you do not have generics encouraged, and you do not have reimportation, and Medicare is not competing for cost, what it means is the pharmaceutical companies have their prayers answered, their dreams come true. They will continue to hike the cost of pharmaceuticals and drugs, and this Government and this bill will do nothing to stop it, and seniors across America will find this so-called prescription drug benefit of little or no value as time passes. Because if the cost of drugs goes up 10 or 15 percent a year, no matter what the Federal Government offers, in the end, there is little to show for it—less and less each and every year.

Mr. SARBANES. Will the Senator yield for a question?

Mr. DURBIN. I am happy to yield for a question from the Senator from Maryland.

Mr. SARBANES. Am I correct in my understanding that under this bill, the Government, through Medicare, could not, in fact, bring its weight to bear in order to lower the cost of prescription drugs through a buying program, where they are a heavyweight in the scale—

that the bill actually precludes that from happening?

Mr. DURBIN. The Senator is correct because Medicare is not given the option of offering prescription drug coverage here, an option which most seniors would gladly endorse. And the reason is obvious: If Medicare can bargain on behalf of 40 million Medicare recipients, it has the bargaining power to bring down the cost of drugs for seniors. The pharmaceutical companies hate that concept, ''like the devil hates holy water,'' to quote our old friend Senator Bumpers, who used to say that on the floor from time to time.

They don't want competition. They don't want cost control. They have won the day.

The Senator from Maryland has turned on his television at home in the last few days and weeks and maybe heard his name mentioned on television commercials that are being paid for by the pharmaceutical companies saying: Senator MIKULSKI, Senator SARBANES, vote for this bill. They are spending millions of dollars saying vote for this bill because this bill will mean millions and millions more in profit for those same pharmaceutical companies.

Mr. SARBANES. Will the Senator yield for a further question?

Mr. DURBIN. I am happy to yield.

Mr. SARBANES. In addition to precluding the Government from bringing its weight to bear in purchasing in order to lower the cost of drugs because they would be a very big purchaser and obviously they would have an impact, some have said: Well, let's at least allow for the reimportation of drugs from other countries, particularly Canada. Some of our people have been going to Canada in order to get their prescription drugs. They cross the border, and they can buy them at 40, 50, 60 percent less than they pay in this country. So there were provisions that passed to allow reimportation. Am I correct that, in effect, this bill eliminates that?

Mr. DURBIN. The Senator is correct. This bill gives the last word to the Bush administration and the head of the FDA who have said categorically they are opposed to reimportation. The reason they are opposed is that it would be more competition for pharmaceutical companies that want to charge higher prices in the United States. I have believed all along that we are not importing drugs from Canada, we are importing leadership from Canada. The Canadian Government has stood up for its citizens and said: We are not going to allow the drug companies to raise their prices every single year. This Government, this Congress, refuses to show the same leadership, and now is effectively blocking the reimportation of drugs that seniors need to survive.

Mr. SARBANES. Will the Senator yield for a further question?

Mr. DURBIN. I am happy to yield.

Mr. SARBANES. I also understand there was an effort to clear the path for generic drugs to become available. Of course, generic drugs sell at a lesser cost than brand name drugs. A lot of the pharmaceutical people are opposed to that.

It is also my understanding that this bill fails to carry through on the efforts to make it easy to bring generic drugs to market. Am I correct in that respect?

Mr. DURBIN. The Senator from Maryland is correct. It is another success story for the pharmaceutical industry because they bring the drugs to market, brand name drugs, under patent, and during a period of time they have a right to sell them exclusively in America. But when that patent runs out, then other companies can make that same drug and sell it, usually at a much lower cost. So the pharmaceutical companies that make the brand-name drugs found ways to delay the process so that the generic drugs could not replace the brand-name drugs, so they could continue to make millions and millions of dollars off the brand-name drugs even when their patents expired. We changed that in the Senate.

We put in language that said we are going to move toward generic drugs so consumers can have affordable drugs. And, frankly, in conference committee, the pharmaceutical companies won again, another reason they are running ads about this Senator and the Senator from Maryland saying vote for this bill right now, because they know it means more money to an industry that is already the most profitable industry in America.

Mr. SARBANES. Will the Senator yield for one final question?

Mr. DURBIN. I am happy to.

Mr. SARBANES. I hate to intrude on his time, but this is a very important point. With this legislation, the pharmaceutical companies have, in effect, slowed the ability of generic drugs to come to market, which would be one source of competition that would lower their prices. The reimportation provisions have been written in such a way that it is completely in the hands of the administration whether reimportation of drugs, say, from Canada is allowed. The administration has been very clear that they are opposed to doing that. The legislation also, in effect, knocks out the Government from being a direct purchaser and controlling the prices.

Every source that potentially could exercise some pressure or influence on the pharmaceutical companies to lower or restrain their prices is being blocked out by this legislation. So the end result is that it is an absolute bonanza for the drug companies. Would you say that is a reasonable perception of what this legislation does?

Mr. DURBIN. I would say the Senator from Maryland is correct. I would refer him to a Bloomberg News article yesterday with the headline ''139 Million Dollar Lobby Blitz Thrown at Medicare Bill.'' And it leads by saying:

> Health care companies, led by drug makers Merck & Co. and Eli Lilly, spent a record $139.1 million in six months to lobby Congress on a Medicare bill that will help the elderly buy prescription medicines. The pharmaceutical companies were the biggest spenders in the health care industry putting money into this lobbying effort.

The Senator knows, as I do, that if you find pharmaceutical companies working feverishly night and day to pass this legislation, it isn't because they want to make less money. They want to make more money. So we have the GOP, which could now be the acronym for the Greedy Old Pharmaceutical companies; that is what is pushing this legislation. That is proof positive that the seniors will be the losers.

The seniors understand that, as do families across America. It isn't bad enough that it is just pharmaceutical companies that are going to make out so well. The same thing is true about HMO companies, the HMO insurance companies with the more than $10 billion Federal slush fund so they can compete with traditional Medicare, $10 billion, and a reimbursement level of 109 percent for these same companies for their expenses while they are competing.

Then to add the crowning touch is something called health savings accounts. I would say to the Senator from Maryland, you are going to recognize this song after I sing a few lyrics. A company called Golden Rule Insurance Company, originally out of Evansville, IL, now based out of Indianapolis, with a man named Mr. Rooney as its CEO, has been locked at the hip with the Republican leadership on Capitol Hill since Speaker Gingrich took over in the House. That is when they dreamed up this idea of medical savings accounts and said: Here is the wave of the future. We can replace health insurance as we know it with the Golden Rule model of medical savings accounts, resulting in our efforts in 1996 of a demonstration project to so see if this flawed concept would work. So few people were interested in signing up for it, it was a failure on its face.

Guess what. In this bill there is a $6 billion subsidy for health savings accounts. In other words, not only are we guaranteeing record profits for pharmaceutical companies, not only are we creating a $10 billion slush fund for HMOs to take seniors out of Medicare, we are putting $6 billion into this boondoggle health savings account. I was on the floor watching the Energy bill yesterday and thinking it was scandalous that we were putting $2 billion into the MTBE and oil industry—$2 billion. They did us better with this bill. The Republican conferees came back and said: Let's up the ante; let's make it $6 billion to subsidize this crazy concept of health savings accounts engendered by the Golden Rule company, one of the greatest benefactors of the Republican Party on Capitol Hill. If that isn't proof positive that this bill has gone astray, I don't know what is.

I say to seniors who continue to call congressional offices, keep the calls coming in. Let me suggest to them as well that if many of them happen to be members of AARP, here is that telephone number. Call your friends at AARP, ask Mr. Novelli, who has endorsed this boondoggle, why in the world has he turned his back on seniors? Why is he not fighting for more competitive drug prices? Why isn't he trying to stop the HMOs from privatizing Medicare? And why are we putting a $6 billion subsidy in here for friends of the Republican Party, the Golden Rule Insurance Company. I think seniors across America get the message.

There was just a poll taken this week of members of AARP, which I hope Mr. Novelli will have a chance to read.

The poll shows that once seniors have been told what is in this bill, 65 percent of the members of AARP said they should stop trying to pass this bill and work for a better plan, and only 18 percent of the members of AARP supported it. So by a margin of almost 4 to 1, the members of AARP are saying to their leadership: You have it wrong.

I think, frankly, it is a burden now on AARP to come back to its roots and decide whether it is going to stand up for seniors or for pharmaceutical companies and HMOs. I hope the seniors across America who are as upset about this as many of us are will call AARP and tell them to stop spending millions of dollars trying to pass this bill. Instead, they should try to save Medicare first, and they should say basically don't sell out the seniors of America.

AARP is now in lockstep with these pharmaceutical companies and HMOs. They have forgotten their mandate, which is to stand up as a voice for seniors across America. That is unforgivable. I think they are going to find a lot of their members tearing up their cards and walking away from this organization. It has become very political and insensitive to the seniors across America.

Mr. SARBANES. Will the Senator yield for a question?

Mr. DURBIN. Yes.

Mr. SARBANES. The Senator made reference to a better bill. The very able Senator from Illinois, in the course of debate in the Senate, offered a better bill, which I was very pleased to support. That bill would have been a very significant and substantial step forward. Among other things, it did not have this ''donut'' in coverage that is in this bill.

As I understand this bill, at a certain point—I think $22.50 in drug cost—and beyond that, up to $3,600, the burden falls back on individuals; is that correct?

Mr. DURBIN. The Senator is correct.

Mr. SARBANES. In the Senator's bill that didn't happen; is that correct?

Mr. DURBIN. That is correct. This is a moving target. The fact is that there is a gap in coverage for prescription drugs built into this proposal so that the sickest seniors with the highest prescription drug costs will find some coverage on the front end of the year for their illness and then find themselves paying out of pocket $2,850, if I am not mistaken, before they get more coverage from the prescription drug benefit. So this so-called donut hole is one that I think seniors who are really sick and those who need expensive drugs should be aware of.

The bill we offered said Medicare will come in and compete for lower drug costs and the savings we can gather for lower drug costs will close this donut hole.

Mr. SARBANES. Will the Senator further yield for a question?

Mr. DURBIN. Yes.

Mr. SARBANES. Would we not also have been able to not have a donut hole if these moneys the Senator made reference to that are going to the HMOs—the $10 billion, I think you said—

Mr. DURBIN. Yes, a $10 billion slush fund for HMOs.

Mr. SARBANES. Also $6 billion—

Mr. DURBIN. Yes, for health savings accounts, for their buddies at Golden Rule.

Mr. SARBANES. So that $16 billion could have been taken and put directly to improve the benefit for our seniors, could it not?

Mr. DURBIN. The Senator is correct. The Senator starts with the same premise I do—that seniors are most comfortable with Medicare. If this started off as an added benefit to Medicare, this bill would have been much smaller and more understandable and supported by seniors. But when they rejected that and said, we are going to go to private companies, they really opened up all sorts of problems. They guaranteed profitability, put in slush funds, and they complicated it to the point where most seniors will struggle to understand it. This didn't have to be the case.

When you are out to privatize Medicare and reward pharmaceutical companies and help HMOs, that is where you end up.

Mr. SARBANES. As I perceive it, all of these things that are being done—the HMOs, the medical accounts, the limitation on Medicare being able to act directly, and so forth—if this stack of papers on the desk represents the Medicare Program itself, they are circling around it to undermine and undercut it. This bill has taken on an added fundamental dimension.

So as we look at this bill, we have to look at not only its shortcomings in adding prescription drugs to the Medicare Program, but we have to perceive that built into the bill are a number of efforts being put into place that will undercut the Medicare Program itself. Is that a reasonable view of the potential of this legislation?

Mr. DURBIN. The Senator is correct. There are those who began this debate saying: We are going to change Medicare. Well, they had their way. Many came here saying: We want to help seniors pay for prescription drugs. If we had stuck to our original goal and focused on what seniors really want and what works, I think we would have achieved this result through Medicare a long time ago. It would have been at the expense of the profitability of pharmaceutical companies.

I say to my friend, who follows some of these corporate reports more than I do, this pharmaceutical industry is the most profitable in America. Look at this chart. Profits as a percentage of revenue in 2002: No. 1, pharmaceutical companies, with 17 percent return on revenues. Return on assets: No. 1, pharmaceutical companies, with 14.1 percent. Then they were nosed out when it came to return on shareholders' equity by household and personal products, but they are still No. 2, with 27.6 percent profit as a percent of equity.

This bill is giving them more profit at the expense of families and low-income seniors in America. That is why the pharmaceutical companies are spending millions of dollars for television, radio, and newspaper ads telling this Congress to ''do our bidding.'' That is why they already spent $139 million lobbying Congress to pass this bill.

If the pharmaceutical companies wanted to help seniors, they could have done this long ago. They could have charged more reasonable prices, particularly to low-income seniors. But that isn't their goal. Their goal is more profitability. Sadly, they found allies with the Republican majority who are attempting to pass this bill and make certain they are more profitable.

Mr. SARBANES. If the Senator will yield on that point, in confirmation of the Senator's analysis, the markets, in the last few days, have been boosting the price of the stocks of the pharmaceutical companies. The perception in the capital markets of the smart money people is that this legislation is going to significantly benefit the pharmaceutical companies, and they are building up the stock prices, which only goes to confirm and corroborate the analysis the Senator from Illinois has made on this issue.

Mr. DURBIN. The Senator from Maryland is correct. I will make this one last reference as I see colleagues in the Chamber who want the floor.

Represented on this chart are the compensation packages for the HMOs. This is another group that is benefiting. The $12 billion slush fund will be going to HMO companies such as these on the chart. They will leave poor and sicker people behind. There will be a $12 billion slush fund and some more benefits given to HMO companies. Look at the compensation for the executives. It runs from the obscene at Oxford, where Norman Payson gets $76 million.

Mr. SARBANES. Is that per year?

Mr. DURBIN. Yes. Mr. Payson had a very good year. Alan Wise at Coventry gets $21.6 million. This man must be really gifted if he is worth that to run a managed care company, which is now

going to be in the category of companies eligible for the $10 billion Federal subsidy.

Down here is United Health Group, where R. Channing Wheeler is getting $9.5 million. I bet he was embarrassed going to the country club with his friends and only making $9.5 million.

Incidentally, United Health Group—do I remember that name from the AARP newsletter? Yes. It turns out they are in business together. It turns out that AARP, which is for this bill, is in business with United Health Group, a managed care company. Frankly, as I understand it, 60 percent of the revenues of AARP come through their insurance and advertising. Is it any wonder that AARP is pushing for this bill, when seniors are opposed to it?

I want to close because I see other colleagues in the Chamber. I say to seniors across America: If you have received your AARP solicitation and sent back your membership card, please call AARP at 1–800–424–3410. Tell them to stand up for seniors for a change, to reject this bad bill that won't result in lower prescription drug costs and will privatize Medicare.

Tell them you are opposed to a slush fund that is being created for HMOS. Tell them you think it is scandalous that we give $6 billion to Golden Rule for health savings accounts. And tell them it is time for your organization, AARP, to stand up for seniors and stand up for Medicare instead of caving in to the special interest groups and supporting this legislation.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The majority leader.

REMEMBERING PRESIDENT JOHN F. KENNEDY

Mr. FRIST. Mr. President, we discussed this morning that we will have a moment of silence at 12:30. I request we have a moment of silence.

The PRESIDING OFFICER. The Senate will observe a moment of silence.

(Moment of Silence.)

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, this moment of silence gives us an opportunity to reflect in a way that expresses our deep respect and also an opportunity to contemplate how we can capture what happened in the past and those lessons of the past and project them to the future but also in terms of carrying out our responsibilities in the Senate.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, for those of us who are old enough to remember President Kennedy, November 22 is always tinged with a sense of sadness and loss. Today, on this 40th anniversary of President Kennedy's death, we are especially aware of that loss.

One floor above us, in a corridor leading to the House side of the Capitol, there is a wonderful exhibit by a longtime Senate photographer named Arthur Scott—''Scotty.'' He was an official Senate photographer from 1955 until his death in 1976.

One of my favorite of his photos up on the third floor shows a very young-looking Senator John Kennedy playing catcher in a baseball game with other Senators in 1958. Scoop Jackson is at bat and Mike Mansfield in umpiring. John Kennedy looks more like a staffer than a Senator.

About 12 feet down that same hall hangs another photograph. This one was taken on January 20, 1961. It shows a smiling, older-looking JFK walking into the Rotunda shortly before he was sworn in as President. Next to that is another photograph, also taken in the Rotunda. It shows a grim-faced Everett Dirksen with his arm around the shoulders of Hubert Humphrey as the two men walk past President Kennedy's casket in November 1963.

Only 5 years passed between that first photograph and the last. Only 1,000 days elapsed between John Kennedy's inauguration and his death. Not long at all. Yet, 40 years after that terrible day in Dallas, President Kennedy remains vivid in our memories and he continues to inspire even people who were not yet born when he died.

There are many reasons for this, I believe.

John Kennedy believed that politics can be a noble profession. Many of us in this Senate are here, in part, because we were inspired by his belief and his example. That is certainly true of me. That belief was also shared by his brother Robert, and it continues to be demonstrated today by his last surviving brother, our friend and colleague, the senior Senator from Massachusetts.

Another reason that President Kennedy remains such a force in our national life is that he inspired us to be our best possible selves.

He led by appealing to our better instincts, not our base fears. He showed us that we need not fear great challenges, as when he said America chose to go to the moon not because it was easy, but because it was difficult. He understood that there is almost nothing Americans cannot achieve when we are united and willing to sacrifice and work together toward a common goal.

John Kennedy was, indelibly, the grandson of immigrants. He was deeply grateful for the freedoms and opportunities that America affords. But he also understood that, with rights come responsibilities. As he said so often, ''To those whom much is given, much is required.''

President Kennedy understood that the most powerful weapon America possesses is the power to do good in this world. And he transformed that belief into the Peace Corps.

President Kennedy understood that we are all connected to each other, as he said to the Soviet Premier Nikita Khrushchev when the two leaders began negotiations on the first limited nuclear test ban treaty following the near-cataclysm of the Cuban missile crisis. ''In the final analysis, we all share the same planet, we all breathe the same air, we all cherish our children's future.''

Today, thousands of people are expected to visit President Kennedy's grave in Arlington National Cemetery. They will file past that eternal flame. But we don't need to go to Arlington to pay our respects to John Fitzgerald Kennedy. That eternal flame also shines in the hearts of every American and every person on Earth who recalls what President Kennedy taught us in his too-brief life and who tries to live those lessons today.

Finally, Mr. President, I want to say a word about my friend, Senator KENNEDY. I know this is a sad day for him.

In the drawer of every desk on this floor are the names of the Senators who occupied these desks before us. I suspect we have all had the experience of seeing those names and thinking what an awesome responsibility it is to follow in such footsteps. In the drawer of Senator KENNEDY's desks are the names of two of his brothers, John and Robert. I am grateful to my friend that he chose to follow in his brothers' footsteps, despite the pain that public service has brought him and his family. It is an honor to work with him. America is better for the Kennedy family's service and sacrifices.

I yield the floor.

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

Mr. REID. Mr. President, I ask unanimous consent that the next Democratic speaker following Senator REED of Rhode Island be Senator HARKIN.

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

Under the previous order, the Senator from Maine is recognized. Does the manager of the bill seek recognition?

Mr. GRASSLEY. Mr. President, I ask unanimous consent to speak for 4 minutes and that Senator SNOWE and Senator CORNYN not lose their right to speak.

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

Mr. GRASSLEY. Mr. President, I want to speak a lot longer to respond to what the Senator from Illinois has said because there is so much that can be so successfully rebutted. I will speak to two or three very obvious statements that are wrong.

The first one is that the Senator from Illinois has never run into a senior who endorsed HMOs. Forty percent of the seniors in Miami are voluntarily in Medicare+Choice. That is an HMO. And 6 percent of the seniors in his own large city of Chicago are members of HMOs. They are there because they want to be there. They can get in or, if they leave the area in which they live to go someplace elsewhere and they

don't have HMOs, they are going to have fee for service. These seniors are there because they want to be there.

That brings me to the point that a major portion of this legislation is the right of seniors to choose. Seniors who want prescription drugs can have them or they don't have to buy into it if they don't want to. If they want to keep fee-for-service Medicare just as it is, they can stay there. They do not have to go into any of the new programs that we provide in this bill. They have the right to choose.

I believe members of the other party don't believe that seniors ought to have the right to choose because their response to Government health programs for seniors or others is more Government, more Government, more Government.

Another obvious point that was made that ought to be rebutted is the question about the AARP becoming so political. Why does the AARP support this legislation? ''Seniors are the losers.'' The AARP speaks for 40 million members. Why is it that this year when we are dealing with bipartisan legislation and the AARP backs it that they are political, but last year when they backed the Democrats in their efforts to have a partisan bill, the AARP, at that point, was not partisan?

I yield the floor.

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

Ms. SNOWE. I thank the Chair.

Mr. President, today we stand at the precipice of opportunity. Culminating a decade of work, we have before us legislation that will forever change the face of Medicare, providing every senior in America with a prescription drug benefit under the Medicare Program that will experience the largest expansion in its 38-year history.

We would not have arrived at this day without the exceptional commitment by Finance Committee Chairman GRASSLEY to advance this issue and to meld the considerable policy and political differences that have marked the development of this legislation. His efforts were nothing short of Herculean from the outset and guided us through a very challenging and contentious conference committee over the last 4 months.

He, as well as Ranking Member BAUCUS, have remained committed to the bipartisan principles that forged the Senate legislation which garnered the support of 16 members of the Senate Finance Committee, as well as in the overall passage of the legislation last June of 76 Members of the full Senate.

I also wish to recognize the outstanding leadership of the President who, in 2001, challenged Congress to enact a Medicare prescription drug benefit, propounded a set of principles, and has provided strong impetus during this home stretch for Congress to complete our work and to send to his desk legislation that he can sign this year.

I know firsthand from my conversations with the President that this is a cornerstone of his agenda, and absent his driving force, we would not be here today.

So, too, has the majority leader redoubled his longstanding and unflagging commitment to enacting into law a bipartisan bill, moving us ever closer to that goal. And thanks to the unique confluence of his skills, his unparalleled knowledge and grasp of the issues, and his single-mindedness of purpose, more than three-quarters of the Senate came to support S. 1 that we passed last June. And in bringing that to the eve of final passage of this conference report, he has typically been respectful of and responsive to wide-ranging concerns and recommendations that have been voiced by me and others. I thank him for his leadership and for shaping this process to its ultimate and I know successful conclusion of this report.

I also extend my appreciation to my colleagues, Senator HATCH, Senator BREAUX, and Senator JEFFORDS, with whom I have worked so closely on a prescription drug benefit over the last 3 years. They have been stalwarts in this fight and developed the template tripartisan bill of which so many of the principles have been incorporated in this conference report.

Certainly no one has more fiercely championed the cause than another colleague I have joined with in this battle in the past, Senator KENNEDY, who I recognize does not support this conference report but whose early involvement and passionate policy advocacy unquestionably built momentum for this issue in Congress.

Finally, I want to thank my good friend and colleague, Ron WYDEN, with whom I began my prescription drug coverage journey almost 6 years ago when we developed the first bipartisan prescription drug plan in Congress, which established the principles that we both believed were so crucial and essential to shaping this benefit. We reached across this political aisle because we recognized that only through a bipartisan plan could we ever see the light of day in enacting this kind of benefit as part of the Medicare Program.

We joined forces, as members of the Budget Committee, to carve out the 2001 budget, believe it or not, which was a $40 billion 5-year reserve fund. Well, how far we have come from the $370 billion tripartisan plan developed last year to the historic passage of S. 1 this last June of $400 billion.

But I can tell my colleagues from my own personal professional experience that Congress' journey along this road has never been easy, although it has been infinitely more arduous for America's seniors. The process has borne witness to a multiplicity of goals and philosophies across the spectrum.

Some have wanted to add a drug benefit to the existing Medicare Program that would leverage purchasing power for the more than 40 million Medicare beneficiaries, while others sought to use the issue as either a vehicle for the wholesale privatization of Medicare or full scale Government-administered benefits. Some have said we are providing too great an incentive for people to enroll in private plans, while others argue we are starving those very same plans. As some have argued, the benefits provided in a particular bill are inadequate while others submit that they are, in fact, too generous and should be limited to a low-income catastrophic plan.

Today, we essentially all agree we are well beyond one question: The question of need. Therefore, it is imperative that we acknowledge the reality that just as the journey thus far has been imperiled by the slings and arrows of those on all sides of this issue that we have heard this morning, it will not be easier with the passage of time, not when we are debating the creation of the largest domestic program in nominal terms ever, not when we are attempting the largest expansion in the history of the third largest Federal domestic spending program.

I think it is important to emphasize the extent to which this is a sizable expansion. So for those on the other side who are talking about the fact that we are not doing enough, this is a substantial beginning. When we consider all of the significant challenges that are looming on the horizon, such as strengthening Social Security and Medicare as 77 million baby boomers will begin to retire in the year 2013, all the while we are facing record-setting deficits.

We did have an optimal window for positive change just 2½ years ago when the Congressional Budget Office was projecting surpluses as far as the eye could see, about $5.6 trillion through 2011. Now we have next year's Federal deficit alone projected to be nearly $500 billion. We know the reasons: In the aftermath of September 11, the war in Iraq, a declining economy.

It begins to illustrate how quickly the tide can turn; that is, how quickly the opportunities can be lost. Just think, many of the same speakers today are standing on the Senate floor arguing from different perspectives and plans on adding a prescription drug benefit to the Medicare Program. At that time, just a year ago, the Senate was presented with a choice between a tripartisan plan that ensured coverage would be available to all seniors—comprehensive, maximum benefit possible for low-income seniors and was a permanent part of the Medicare Program. The alternate that we were debating at the time was temporary. It would have sunset and would have statutorily restricted access to drugs because it would have been a Government-run system that would have cost close to approximately $1 trillion; although at the time, as my colleagues recall, we did not have any CBO scores, so we could not possibly know or ascertain the exact cost, but we knew that it would probably be $1 trillion and

counting because it would have been a Government-run system. It would have restricted choices to seniors, and they would not have had access to the array of drugs that are available on the market today with that type of system. The benefit sunsetted after 7 years.

Those who are dissatisfied with what we have before us today should fondly recall the tripartisan bill and lament its unfortunate demise because at that time we had a plan that brought together disparate interests for a very favorable benefit. That was then and this is now.

We are here, and the conference report before us is the result of an attempt to balance the competing viewpoints not only among Members but the stunningly disparate views between the House-passed legislation and the Senate-passed legislation. The simple truth is, while I continue to prefer the Senate bill, as many of us do, it is this conference report upon which we will vote.

After careful review, I have concluded that while it is not everything it could be, it is not everything it should be, in the end, make no mistake about it, millions of seniors will benefit over the stagnation of the status quo benefit.

Margaret Thatcher once said, you may have to fight a battle more than once in order to win. Well, some of us have been fighting this battle now for nearly 6 years, and for some even longer. The bottom line is, we cannot hold hostage our seniors' futures to a political unwillingness to compromise. This bill provides us with our best available opportunity to secure for the first time a legislative foothold that honors the same basic principles that I and others have expounded upon since I first came to this issue more than 6 years ago; that in keeping with the basic tenets of Medicare, this prescription drug benefit will be universal. Everybody in the system will have access to this benefit. That is important because there were other divergent views that simply wanted a low-income and a catastrophic.

We preserved the universal principle of Medicare, and that is not to be underestimated for a variety of reasons. It is comprehensive. It is a wide-ranging benefit. It is affordable, particularly for those at the low-income scale. It is voluntary participation and not mandatory. Seniors can choose to participate if they want to. It is permanent. Unlike what we were considering a year ago on this floor, it does not sunset because the costs were so prohibitive that the benefit had to be sunsetted. We have a permanent benefit, and it provides equal benefits across the spectrum of plans. That is also very important. So everybody will have access to the same benefit, regardless of what plan they choose.

Like the Senate bill and the tripartisan proposal before that, it directs the most assistance toward those seniors with the lowest income and includes a reliable Government fallback mechanism of last resort to make sure that every senior, regardless of where they live in America, will have access to and the stability of the traditional Medicare Program. But they will also, regardless of where they live in America, have access to a prescription drug benefit so there will be that reliability, with a Government fallback program.

In its totality, looking at this conference report, it fulfills all of those principles. That is very important. It is something we cannot overlook. It cannot be minimized. It cannot be denigrating. Those principles have been captured in this legislation, irrespective of all the other disparate views that come in between. Those principles framework this conference report. Those were the principles that were in the Senate-passed legislation.

Now let's look at some of the individual components of the package before us. We should be mindful of how we arrived at this destination because we have to put this conference report in context, not only for why we are here today but what happened previously, what happened last year, what happened 4 years ago, what happened 6 years ago, because it illustrates the long journey we have taken down this road and what has happened in the House—what has happened in America, in terms of the rising cost of prescription drugs and the impact on seniors.

As this Senate passed a bill with overwhelming bipartisan support, those 76 votes I was referring to earlier, last June, the House passed legislation with the most razor-thin margin of just 1 vote—just 1 vote. We all witnessed what unfolded this morning in the early morning hours when the House with a 5-vote margin passed the conference report. Obviously, it reflects some very different views between both Chambers, among philosophies, among regions of the country. We cannot overlook that, in terms of what do we do now. What can we ever potentially do in the future that will be even better?

We see the results, obviously, in those differences. Some have referred to the benefit that is available in this conference report. I think it is important to talk about some of those issues.

We see the result, obviously, in the starkest terms reflecting different philosophies in the nature of the benefit that ultimately was designed by the conference committee to sort of split the differences, because that is what conference committees are all about. No, it can't be all one way or the other. You have to sort of go back and forth, to figure out what can you do to design an equilibrium of thought. It has to be carefully calibrated so that you do not compromise what you believe but it advances the legislative agenda on your ultimate goal, in this case designing a prescription drug benefit as part of the Medicare program. So let's look at the underlying benefit when it comes to the drug plan.

It includes aspects that are modeled after each bill. The deductible was set at the House lower level of $250. We had $275. And the conferees worked to improve this proposal by offering a benefit that had an actuarial value that was higher than the benefit from both bills. However, in providing these improvements, concessions had to be made. In doing so, the Senate's benefit cap that was referred to by other speakers—we had a $4,500 benefit cap, a spending threshold—that was lowered to $2,250. So while they got a better actuarial benefit for all beneficiaries, the spending cap was lowered to $2,250.

But in the same respect, the cost sharing provided under this cap was lowered from 50 percent to 25 percent that was in the legislation in the Senate bill.

So we had a cost sharing between Government and the beneficiary that was 50–50. But in the conference report, now the Government will provide the 75 percent and the beneficiary 25. So that is an improvement. We see it is not all perfect, but again this benefit represents the art of the compromise. You have to think again, is this better than the status quo? I think there is no question that it is because millions will stand to gain, No. 1, getting a benefit; No. 2, getting generous assistance on the low end of the income scale. But everybody stands to gain who participates in the Medicare Program, who wants to participate in accessing this prescription drug plan.

As I see it, this conference report will at least get the Federal foot in the door in providing a significant level of assistance to one out of four Americans who, right now, don't have any assistance. They don't have any assistance currently. If you look at the graphs, a quarter of Medicare beneficiaries have nothing. So are we saying this is not better than that status quo?

We also design a benefit for all seniors with a $35 monthly premium that will save 50 percent on their cost of prescription drugs. So, for example, a senior who spends $3,600 on prescription drugs will realize a saving of $1,714 annually.

Then as I mentioned earlier about the lowest income and the assistance they will receive under this conference report, which was in keeping with the principles of the Senate-passed legislation for which we received 76 votes, we find that the conferees utilized the model that was established in the Senate bill. Most critically, no senior who qualifies for one of the low-income categories will experience a gap in coverage—none. So for those under the 150 percent of poverty level, they will experience no gap in coverage.

It also means in Maine, for example, there will be 93,450 Medicare beneficiaries, more than 40 percent of the overall Medicare population, who will receive a generous benefit with no gap in coverage, not to mention that it will be at a high level of assistance—up to 150 percent, with minimal copays, in

some instances—most instances, no deductible, no premiums, and, as we know, a sliding scale on the monthly premium of 135 to 150.

The PRESIDING OFFICER. The time of the Senator has expired.

Ms. SNOWE. I did not know there was a time restriction, Mr. President.

The PRESIDING OFFICER. There was a 20-minute time limitation. The Senator may ask for additional time. The Senator's time has expired.

Ms. SNOWE. I ask unanimous consent for an additional 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator is recognized for an additional 10 minutes.

Ms. SNOWE. While the Senate has extended this to a greater number of seniors, unlike the Senate bill, this proposal ensures all seniors, even the so-called dual eligibles, will be part of this conference report. That certainly benefits my beneficiaries in Maine but 6 million nationally.

Not only do seniors deserve a subsidy to help make prescription drugs more affordable, they should also have the benefit of choice when it comes to the coverage they purchase. Seniors should not be limited in their options for coverage, so that we ensure all seniors have a choice of at least two privately delivered drug plans.

Options are important. They will have choice among prescription drugs as well. That is critically important because the choices will be there, and they will also have the benefit of a fallback to ensure this coverage and those options are available nationwide.

Finally, I want to get to the one remaining point because of time limitations. We have heard so much about the privatization of Medicare, what this would do. This conference report unquestionably represents the end of the House bill's open-ended efforts to move Medicare towards a national privatized system through an untested, untried policy known as premium support that could have led to a patchwork quilt of uneven health care delivery that existed prior to the creation of the Medicare Program in 1965. This approach would have fostered wild fluctuations in the premiums for the traditional Medicare Program whereas, incredibly, Medicare now provides all seniors with the same benefit for the same premium. Under this proposal, premium variations would have occurred not just from State to State but within a State and even within congressional districts across the country.

There are many illustrations of that point. For example, from the Center for Medicare and Medicaid, they indicated that in Miami, FL, they would pay $2,100 a year for the traditional Medicare Program compared to $900 to seniors who would pay that in Osceola, FL, for the same benefit.

When you compare North Carolina to variations from State to State, it would have been extreme.

For example, they would have paid $750 for the traditional Medicare; whereas, in Florida they were paying $2,100 for that same benefit but their premium, obviously, would be much higher.

In response to a letter that 43 colleagues and I sent—I ask unanimous consent to have printed in the RECORD two letters, along with an editorial on this subject.

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

U.S. SENATE,
Washington, DC, October 23, 2003.

Chairman CHARLES E. GRASSLEY and Ranking Member MAX BAUCUS,
Senate Finance Committee,
Washington, DC.

Chairman W.J. (BILLY) TAUZIN and Ranking Member JOHN D. DINGELL,
House Energy and Commerce Committee, Washington, DC.

Chairman WILLIAM M. THOMAS and Ranking Member CHARLES B. RANGEL,
House Ways and Means Committee, Washington, DC.

DEAR CONFEREES: The Medicare conference has reached a critical junction in its effort to craft a conference agreement to develop a Medicare prescription drug and modernization bill: The time is fast approaching when final agreements must be made if a proposal is to be developed prior to the November 7 target-adjournment date. However, many key issues remain unresolved, which will determine whether this bill can garner strong bipartisan support and ultimately become law. As you progress into this critical stage, we urge you to remain committed to the bipartisan principles contained in the legislation developed and passed by the United States Senate.

First, the Senate bill takes strong steps to provide every senior and disabled American, no matter where they live, with choices in coverage. Notably, this is done in a manner that preserves the traditional Medicare program as a viable option. This balance was achieved by providing all seniors with access to the same level of drug coverage no matter the coverage option chosen. Further, the Senate bill assures this choice will be a fair one that will not disadvantage senior citizens who remain in traditional Medicare. Accordingly, we urge you to remain committed to principles that provide a level playing field between the private sector and Medicare and reject proposals that would unduly raise Medicare premiums or otherwise advantage private plans.

Second, the Senate bill assures affordable, comprehensive coverage to those with incomes below 160 percent of the federal poverty level or $15,472 for an individual in 2006. Generous and affordable coverage for this population is essential, given that most presently do not have access to a prescription drug benefit. The conference must assure that the generous assistance provided to low income beneficiaries is maintained and reject measures that would reduce the benefits presently accorded Medicaid recipients.

Third, we urge the conferees to include a mechanism that will ensure that all seniors have access to a prescription drug benefit, no matter where they live. The Senate bill assures that private plans interested in providing this benefit can do so and will be the preferred mechanism of delivery in every geographic locality; however, it is not possible to guarantee their participation. Therefore, it is necessary that the final proposal include a ballback mechanism, as was included in the Senate bill, that will ensure that beneficiaries will have access to the drug benefit in the event that private plans are not available in a region.

Finally, we caution the conferees against including provisions that will circumvent established congressional procedures or delegate responsibilities for establishing the benefit and cost-sharing requirements to the Secretary of Health and Human Services (HHS). The responsibility for developing and overseeing benefits included in the Medicare program rests with the Congress, and this bill should not violate that principle.

Enactment this year of a bill that adds a Medicare prescription drug benefit and improves the program is a top priority for each of us. America's seniors have waited too long for comprehensive drug coverage and the addition of market-based options. However, to achieve this goal, we must continue to work together to develop agreements that will receive bipartisan support in each chamber, In 1965, the original Medicare bill garnered this level of support and a change to the program of this magnitude should be no different.

We remain ready to help you address these and other issues that will impact the final proposal, and hope you will work with us to develop bipartisan proposals that we can support.

Sincerely,

OLYMPIA J. SNOWE,
ARLEN SPECTER,
MIKE DEWINE,
EDWARD M. KENNEDY,
JEFF BINGAMAN,
BLANCHE L. LINCOLN,
JAMES M. JEFFORDS.

CONGRESS OF THE UNITED STATES,
Washington, DC, November 13, 2003.

The Hon. BILL FRIST,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR LEADER FRIST: It has come to our attention that leadership is considering the inclusion of a new version of the policy model known as premium support. As you know, this policy places the traditional Medicare program and private plans into direct competition and according to the Centers for Medicare and Medicaid Services (CMS) will lead to dramatic increases in the annual premium for the traditional Medicare program.

We are extremely concerned about the inclusion of this policy proposal in a Medicare bill. Thought some may consider this a demonstration project, we disagree. This appears to be a veiled attempt to institute this policy into law. According to CMS data this proposal could capture up to 10 million seniors, 25 percent of Medicare beneficiaries. Further, it will require them to bear the burden of cost increases associated with the demonstration project.

This policy also unfairly targets some seniors simply based on their geographic location and mandates their participation. The likely result will be significant increases in traditional Medicare premiums for seniors living in the affected areas and could destabilize the Medicare program for all seniors.

We understand that leadership and some conferees may be considering possible changes to this latest proposal. We urge you to remove this policy from the bill. We believe there are other possible options that will encourage private plan participation in the Medicare program that do not negatively impact the traditional Medicare program.

Thank you for your consideration of this vitally important issue.

Sincerely,

SIGNED BY 44 MEMBERS OF CONGRESS.

[From the Bangor Daily News, Nov. 21, 2003]

HOBSON'S MEDICARE

Never have so many dollars been put to so little use. The $400 billion Medicare bill before Congress establishes what all sides agree

is necessary—a prescription drug benefit—but blasts away at much of Medicare's foundation. It is a deal that makes all previously rejected Medicare reform look wise and generous by comparison. It is also the best deal the current Congress is likely to get.

The difficult calculation is this: Is a badly flawed bill that contains a needed drug benefit worth passing when the alternative is to reject it without the chance to enact approved legislation? The $400 billion has been set aside for funding this legislation; should it fail, the money would disappear and given the extent of the deficit for the next decade or more, would not be available next year, even in the unlikely chance a bill could be passed in an election year or perhaps after that.

Much of the debate this week has focused on the plan's intent to establish privatization pilot projects—subsidized private insurers would offer Medicare in six metropolitan areas in competition with traditional Medicare—but other aspects of it are equally important and equally troubling. The means-testing provision in the bill, for instance, raises costs for middle-class seniors; reimbursements for medical residents, harm clinic work; those who remain in traditional Medicare for the pilot program will see increases in their costs; states that could negotiate for their Medicaid-Medicare clients lose much of their bargaining power while also losing their federal support for the program. The fear remains strong among health care advocates that the entire reform is an attempt to cap the federal contribution to Medicare and shift future costs to seniors. Several of these problems are being debated now—Sen. Olympia Snowe has been in the middle of negotiations all week; imagine the time and argument that would have been saved had she been put on the conference committee. Some of these issues may be resolved but several are likely to remain as the House and Senate vote.

Some members of Congress do not support the bill for these many reasons; some don't support it because of its cost and relatively small nod toward privatization. But for those who believe a drug benefit is important and will become more important in the coming years, the choice is to vote yes, and immediately set about chipping away at some of the worst aspects of the bill. This is a terrible way to build a health care safety net for the nation's seniors, but lamenting the process is not an excuse for allowing this opportunity to pass by without approving the drug benefit.

At 1,100 pages, the Medicare bill is too long and complex to describe it merely as a sop to industry (though pharmaceutical manufacturers should love it), an ideological document (though its medical-savings accounts are a GOP crowd-pleaser) or a broad expansion of entitlements (though the drug benefit is exactly that). It is fair to say the bill is a poor version of what should have been passed years ago and now that Congress is out of time and out of money, it is about as much as the public can expect.

Ms. SNOWE. Mr. President, in that letter, we expressed our strong opposition to this ideological venture. It is important to know that significant changes were made to transform the full-scale national premium support proposal into a limited bone fide demonstration project. That is important to know.

I have it here on the chart. I hope it is something I can get back to on Monday.

It is important to know how far we have come from where it was. The open-ended privatization of the Medicare Program, starting in 2010, would have been a wholesale privatization which didn't offer any seniors any protection, regardless if they were low income, from premium fluctuations. Because it would open it up to competition in the private sector, the conferees shifted it to a bone fide limited demonstration project. We moved from that open-ended privatization to the first proposal in the conference report which provided protection for low-income seniors for any type of open-ended privatization.

They also moved to a demonstration project so it wouldn't be national—it wouldn't be permanent for one region in four metropolitan statistical areas. We said that is not enough; that is too open ended. We finally were able to reduce it to six MSAs with limited criteria. That limited the number of people who would participate in those six metropolitan areas.

It is very important, because what we had before was nationwide and open ended, which would have been a frontal assault on the traditional Medicare Program as we know it with an untested and untried approach where we don't have a scintilla of evidence whether it would work. Through our efforts and through the responsiveness of the leader and Chairman GRASSLEY, we were able to move from a nationwide approach to six metropolitan areas which includes criteria that GPO says will limit this to 1 million—anywhere from 650,000 seniors to 1 million seniors—and it would be sunset by the year 2016. It would kick in in the year 2010. It will be phased in and will be sunset in 2016.

That is important.

What is also important is the fluctuation in premiums, which I was referring to earlier. That is critical because that won't occur. Originally, there was no protection, with huge, wide variances, depending on where you live in America, and subject to undermining and destabilizing of the Medicare Program. The Congress agreed originally to fluctuations which would vary from 10 percent per year compounded. We were able to weigh in. Finally, what we have here is a reduction in the level of allowing increases in premiums to 5 percent, removing the compounding mechanism that originally would have had a total cumulative impact of 30 percent over 6 years.

We have come a long way from where this proposal was in the House that would have undermined the traditional fee for service.

When I hear speakers on the other side of the political aisle talking about privatization, I think it is important to stick to the facts of what we now have.

This is a sea change from the original initial proposal that was in the House-passed legislation. Obviously, the Senate had nothing referring to this premium support program. What we have now is a limitation to one Federal demonstration project for a legitimate avenue to experimenting with new options for potentially improving upon the Medicare Program in the future. But we cannot do it unless we absolutely have assurances that it will work.

That is what demonstration projects and programs are all about. We learn from them. I didn't want to use seniors as an experiment on the road to learning. That is why this is very limited. Now it is no longer nationwide. It is down to six MSAs.

It includes selection criteria that the Congressional Budget Office says will limit the number of impacted seniors to 1 million. It also offers protection even in that demonstration project to seniors under 50 percent of poverty level or below.

That is very important to note.

We are essentially holding seniors harmless even in those demonstration projects. But, again, this is no longer what it was in the House-passed legislation.

I think it is important that we understand that.

This is a means to evaluate anything in the future that may be potentially an improvement to strengthen the future of the Medicare Program. But, obviously, we don't want to use open-ended programs at the expense of the traditional program that has worked so well.

Ironically, in all of this, that is why this was not viable to what was in the House-passed bill—that the traditional Medicare Program worked. In fact, the Congressional Budget Office told us it would not achieve the savings that the proponents were suggesting. It would only save $1 billion potentially, and it could threaten the underlying traditional fee for service. Where would the seniors be? Where they were prior to 1965 where a lot of working Americans are—barely being able to have access to any type of health care, let alone health care with consistency, or where the costs were so prohibitive they were restricted to catastrophic coverage. Why do we want to assign that problem to our seniors until we know what could work in the future?

I can tell you that there is not one scintilla of evidence in the public sector or in the private sector that would tell you that any premium support plan would work at this point. That is why it should be confined to a limited demonstration project of no more than 1 million—it could be as low as 650,000—to learn what will work to potentially improve. It sunsets, we will learn from it, and decide what it can do for the future.

I urge my colleagues to take a very careful look at this legislation because this is a transformational moment in history, and there will be no going back.

I yield the floor.

The PRESIDING OFFICER (Mr. ALLARD). The Senator from Texas is recognized for 15 minutes.

Mr. CORNYN. Thank you, Mr. President.

Mr. President, I wanted to speak for a few minutes about this conference report which is before the Senate.

I did not support the Medicare bill voted out of the Senate. I voted against it hoping and praying all along that this bill would be improved as a result of the collaboration of the leadership in the House and the Senate in the conference. Indeed, I believe it has. That is not to say that I believe this is a perfect bill—far from it. But this bill does represent an improvement.

This bill provides coverage for those who need it most. In Texas, nearly 300,000 low-income Medicare beneficiaries who are not eligible for Medicaid and who did not have any prescription drug coverage will be covered under this new bill.

It will increase the percentage of Medicare beneficiaries in Texas with prescription drug coverage from roughly 60 percent to 95 percent.

I would like to express my congratulations to leadership, to Majority Leader FRIST, who I know has taken a personal interest in this cause as a medical doctor and as someone who has worked very hard to get us to where we are today; Chairman CHUCK GRASSLEY, who has the patience of Job and who I know has worked very closely with Senator BAUCUS, the ranking member of the Finance Committee, and Senator JOHN BREAUX of Louisiana on other side, as well as Senators NICKLES and KYL and others who specifically shared some of the concerns that I had with the Senate bill but which I believe have produced as a result of their collaboration a much improved bill, and one which I am now proud to support.

I do not view this bill as the finished product. I view this as a good start. But I think it would be a mistake to say because we view the glass is half empty as opposed to half full that we ought to vote against this Medicare conference report. I have no confidence the stars will align and the political climate will be such that we could ever get to this point any time in the near future. It is important we deliver on the promise that each Member in this Chamber made when we ran for this office and which the President made when he was elected, that we would strengthen and improve Medicare by providing prescription drug coverage for seniors who need it. The reason I am proud to support this bill today is because this represents delivery on that promise.

In the end, I don't think the American people care very much about demagoguing certain aspects of the bill. They do not care very much about partisan differences. They do not care that much, really, about some of the ideological differences, the competing ideas that now have been melded into this bill and which create, to some extent, a hodgepodge, but on balance, an improvement over the status quo. It is our responsibility to govern. Governing means delivering results and not just criticizing things that are easy enough to criticize.

Frankly, any bit of legislation that comes before this floor has defects that are easy to criticize. We are sent here to get the work of the American people done. This bill represents delivery on a promise we have made.

We spend about $1.4 trillion a year in this country on health care. We know as much money as is spent on health care that still we have large segments of the population that are underserved and who do not have access to good quality health care. Fortunately, since 1965, our seniors have been provided access to good quality health care through the Medicare Program. We also know unless you happen to be among even the most modest means in our society, you would not have coverage. For example, under Medicaid, only those who are of very modest means who fall beneath the poverty level are eligible for that free health care program. Children are provided coverage to health care under the S-CHIP program which has provided coverage for many children who come from families of modest means who would not otherwise have access.

We still have about 45 million people in the United States who do not have health insurance and who have limited access to health care coverage. That is something that we need to address. Fortunately, it is something that has been addressed, at least in part, in this bill.

For example, in my State of Texas, we have many people who are uninsured and, indeed, who are undocumented. In other words, they have come to this country without the benefit of the legal process. But under Federal law, the Federal Government says you must provide free medical care at your emergency rooms and hospitals all across the country.

Finally, rather than to foist that financial burden on the local governments and the local taxpayers and the State government and State taxpayers, this bill starts at least a downpayment to provide for that previously unfunded mandate. Indeed, it provides $250 million a year to be distributed among the States based on their percentage of population of undocumented immigrants. For example, the State of Texas will receive about $50 million a year over the next 4 years to help make good on that broken promise by the Federal Government.

Indeed, that unfunded mandate will at least be funded to that extent. It is not by any stretch of the imagination enough to make Texas whole, but it is a start, a movement in the right direction.

The other reason I am for this bill is because in 1965 the U.S. Government made a promise to our senior citizens that if you played by the rules, if you worked, if you paid your Medicare taxes, when you turn 65, Medicare would be there for you. While we know there have been enormous changes in the practice of medicine and the delivery of health care since 1965, Medicare has not changed. It is in response to the demands of that passage of time that we see this bill which does actually strengthen and improve Medicare today.

If there is one fundamental reason I am for this bill it is because I think it is the best this body and our counterparts across the Rotunda are able to come up with at this time. It would be unconscionable to leave our seniors without prescription drug coverage, especially after all Members in this Chamber and elsewhere have campaigned on that issue, year after year after year, and left perhaps too many people skeptical or maybe even cynical about whether we actually intended to follow through on our campaign promises. This bill represents the kind of results I think they deserve and the kind of results that make good those promises we have made.

As I say, I believe this is a good start. This is not a finished product. One of the best aspects of this bill is it changes the nature of Medicare to some extent by turning at least to some small degree from the command and control model that says the Federal Government knows best, which provides no choice, no alternatives, no opportunities for seniors to actually get better service or better health care by having some competition in the marketplace. Now, 38 years after Medicare was first passed in 1965, we see better coverage under this bill. We see more choice. We see coordination of medical therapies because, of course, many people are on multiple types of therapies, even drugs that may interact. This bill provides for a coordination of those medical therapies in a way that will enhance and protect the health of our seniors, not damage them.

This bill places an important emphasis on prevention. This is one of the areas on which we need to do a lot more work. Frankly, it is much more humane and much cheaper and, indeed, much more compassionate to prevent disease than to wait until it has occurred and then try to treat it, perhaps with some or no success. This bill does provide for screening for cardiovascular disease, for diabetes, for greater access to mammography so that breast cancer can be diagnosed earlier, and it will provide an opportunity for every senior, as they go into Medicare, to get a complete physical examination so that if there is some way we can prevent them from becoming ill or perhaps address that illness much more effectively and efficiently by getting to it earlier, we can improve the quality of life and also save the taxpayers money when it comes to treating full-blown illnesses as they run amok.

This bill is a vast improvement over the status quo because it has strong provisions for prevention of fraud, waste, and abuse. It is inevitable in a bill this big, some $400 billion over the next 10 years, that there is potential

for fraud, waste, and abuse. I congratulate Chairman GRASSLEY and the conference committee for writing into this bill important protections that will allow for the detection, indeed, for the investigation and hopefully for the prosecution of fraud, waste, and abuse when it comes to the taxpayers' dollars.

I know the chairman of the Finance Committee shares a passion for protecting people in the rural parts of his State, and certainly across the United States. I share that passion with him.

I still remember when I was campaigning up in the panhandle of Texas, a place where there is low-population density, in a rural part of our State where the county judge, who is the chief administrator for the county government, came up to me. She was concerned about her mother. She said the doctor for her mother, who was 80 years old, had refused to continue to accept Medicare patients. And this individual's mother had no other way to pay for her health care other than Medicare. So literally she lost access to the only doctor she had ever had and that she had ever known, at least during that period of her life.

This bill addresses that concern, too, by providing greater access to health care in rural parts of our country, and it imposes reimbursement rates for doctors and hospitals. Frankly, I have always thought it was wrong for us to try to balance the budget on the backs of health care providers because, frequently, these people provide free health care out of the goodness of their heart, for which they have no hope of compensation. I think it is only just and it is only right that we provide for fair and adequate reimbursement for treatment of Medicare patients. Frankly, that is the only way we are going to continue to see ready access for our seniors to the health care they need.

There were two reasons I was very concerned about the bill as it left the Senate. One was because it lacked any means testing; in other words, the young man or young woman who earns minimum wage would be expected, out of their Medicare taxes, to pay for the prescription drugs of Bill Gates or Ross Perot from my State, someone who is more than capable of paying for their prescription drugs. I, frankly, thought it was unfair to foist that on the minimum-wage worker.

Then the other concern I had was that I wanted to make sure we were not providing incentives for employers who maintain health insurance coverage for their employees after they retire, to simply drop them and create a greater burden on taxpayers.

I think both of those issues have been addressed.

Finally, Mr. President, I think the provision of health savings accounts represents a tremendous victory for those of us who believe that individuals ought to have greater choice, greater opportunity to manage their health care costs, by taking pretax dollars to pay for medical costs that are not otherwise covered by insurance.

So for all those reasons, I congratulate again Chairman GRASSLEY and those who have worked so hard on this bill. I know it has not been easy. It is not perfect, but, again, I do not think we should let the best be the enemy of the good. So I will proudly support it and work with Chairman GRASSLEY and others to see that this gets to the President's desk for signature as soon as possible.

Mr. President, I yield the floor.

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

The Senator from Rhode Island.

Mr. REED. Mr. President, I ask unanimous consent, with the concurrence of Senator STABENOW, that I be allowed to go in her place and she go in my place in the order of speaking.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Mr. President, reserving the right to object, could I ask, is that in line with what we have agreed to?

Mr. REED. Absolutely. The original order was that Senator STABENOW speak as the next Democratic speaker.

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

The Senator from Rhode Island is recognized.

Mr. REED. Mr. President, opinion has already been registered with respect to this Medicare proposal before us today. I think one of the more interesting comments was from the Des Moines Register editorial board, describing this legislation as ''a big, sloppy kiss to the pharmaceutical and insurance industries.'' That is essentially what this bill is. It is a huge payoff to pharmaceutical companies and to the insurance industry. It is not really about giving seniors what they deserve and what we have all labored for many years to provide them with; and that is, comprehensive drug coverage.

There is another fallacy that is operating, too, in our debate today. That fallacy is that this bill is the best we can do, so let's just move on. I think it is a fallacy because I checked this morning the discussion of the vote early, early this morning in the House of Representatives. Apparently, the last few votes that were arm-twisted into supporting this bill from conservatives in the House was based upon the logic that if this bill failed, the next bill, which would come promptly after this bill, would be, from their perspective, worse; but from the perspective of seniors, much better because it would not represent ''a big, sloppy kiss to the pharmaceutical and insurance industries.'' It would represent a commitment to provide prescription drugs—real prescription drugs—and maintaining the Medicare system. And that is what seniors want.

So I believe we can make this bill better simply by holding our ground, by debating it extensively, by not rushing to judgment, by not surrendering to artificial deadlines of the Thanksgiving holiday or even the Christmas holiday.

This is the largest proposed change in the Medicare Program since its inception in 1965, and to rush through this in a few hours, not because of the substance of the bill, but because of the timetable for airplanes and trains to get home for the holidays, is wrong. We should stay here and do our job, just as thousands and thousands of young Americans are staying across the globe and doing their job to protect us.

I think there is another issue here, too; and that is the notion that this is the end of the privatization argument. On the contrary, this is the beginning of privatization. That is the quid pro quo for the support, particularly support of conservatives, of this bill in the House and here in the Senate. I can envision and anticipate that with each new reconciliation bill that is forced upon us, with a procedure that does not allow unlimited debate in the Senate, we will see again and again the slow erosion of the traditional Medicare Program, under the guise of cost savings, under the guise of competition, under the guise of so many other claims and so many other excuses.

So we are at a position where we are looking at legislation that represents, again, a massive giveaway to pharmaceutical and insurance companies, that does not provide an adequate benefit for seniors, and that really does begin the privatization of the Medicare Program.

Since 1965, Medicare has provided dependable health care for our seniors. But we have all recognized in the last decade or more the rise of pharmaceuticals as a principal, and expensive, way to treat diseases. We have all recognized that Medicare must adjust to this change. We have urged and fought to get an adequate benefit for our seniors for drug coverage.

Now, in Rhode Island, with 14.5 percent of the population over 65, this is of central concern to me. And I have worked very hard, as so many others have, to try to get a good drug benefit program, but not at the expense—not at the expense—of Medicare.

Now what has happened is that the administration, their allies in Congress, the pharmaceutical industry, and the insurance industry have all gotten together and have attempted not just to provide a drug benefit that is adequate for seniors, but to provide a drug profit bonanza for the pharmaceutical companies and the insurance companies and to alter fundamentally the shape of traditional Medicare.

Now, in the wake of the Gingrich revolution in 1995, Newt Gingrich declared his intention of letting Medicare wither on the vine. His undisguised hostility to Medicare met a swift rebuff from Democrats but, more importantly, from the American people because they understand the critical need and the value of Medicare.

Today, this hostility to Medicare persists, but it has been camouflaged

under the cloak of a prescription drug benefit. As a result, we are on the verge of a historic bait and switch. Under the guise of providing drug coverage, the Bush administration is beginning the unraveling of the Medicare Program. The bait is drugs; the effect is the slow unraveling of the Medicare Program.

This bill was cobbled together by the administration, by their allies in Congress, and by lobbyists for the drug and insurance industries to entice support based upon the notion of a drug benefit. But the goal, ultimately, and the plan, in effect, is to privatize Medicare.

There is a memorable scene in America cinema in the movie ''Patton,'' of George C. Scott, who plays the illustrious general, watching the retreat of the German forces from the Battle of El Guettar.

He bellows at the top of his voice: Rommel, I read your book.

Of course, the obvious inference is people will declare their intentions years before and then carry them out. And that is exactly what is happening here. If you read the Gingrich book, if you read the conservative ''book'', this is about the privatization of Medicare. Now it might take a few years because tactically the lessons have been learned since 1995. You can't get up on the rooftops and announce: We are ending traditional Medicare. This is a program that allows, in my view, more choice than an HMO because traditional Medicare allows seniors to choose their doctor, to change their doctor. In fact, if you ask most seniors if they could, they would have that choice without any type of condition whatsoever.

That is what is happening here. The intention is clear. But the tactics have been adjusted since 1995, since they ran into popular opposition. Now it is a subtle change, a series of changes over time, reconciliation bill after reconciliation bill. That would be incredibly disastrous to the system and a disservice to our seniors.

The drug benefit is scheduled to begin in roughly 2006. Conveniently, it is after the 2004 election, and it also allows additional time to fiddle with the benefits before any of this becomes real in the lives of our seniors. One can anticipate that these benefits will be adjusted as our fiscal crisis becomes deeper and as we try desperately to constrain costs within not just this program but every other program. The benefits, as they exist today, are a monthly premium averaging about $35, a deductible of $250 or so before Medicare covers 75 percent of an individual's drug costs. But because of inadequate funding in this bill—the $400 billion was never enough—and because of the lavish contribution to HMOs in a $12 billion slush fund, the lavish contribution to health savings accounts of $6 billion, we already have defects within the drug protection for our seniors because if a senior's drug costs reach $2,200, Medicare will pay nothing until that senior has already paid out of pocket $3,600. There is a gap, the proverbial donut hole. Must this donut hole exist? One could argue it has to. But certainly, if we had extra resources, if we had the $18 billion that this bill lavishes upon HMOs and insurance companies, why don't we simply close the gap? Because we are not interested in providing the best benefit under available resources to seniors. There is another priority: Let's go ahead and begin the slow privatization of Medicare.

There are those who say: Well, something is better than nothing; we will take anything now.

Again, we can do better. We could do better in this Congress because the fear last night that motivated those last few holdout votes was that the Senate would do better, that we would bring another bill to the Senate and to the House, and that bill would not have such a big gap; that bill would not be such a big sloppy kiss to the pharmaceutical and insurance industries; it would be something seniors could use, something seniors could use much more effectively than what we are presenting them today.

They should recognize, too, that ''something is better than nothing'' doesn't apply because the price of that something is the withering away of Medicare. We know what this is about. We know that if unchecked, that is what you will insist upon and demand over each coming year.

Medicare works because it covers every senior. It spreads the risk. An essential, fundamental point of any insurance plan is spreading the risk. It works also because Medicare is willing to subsidize the cost of providing health care to seniors. The reason the private insurance industry did not cover seniors before 1965 is simple: It was too expensive. They couldn't make any money on it.

It took the Government to say: We will use public resources to subsidize the health care costs of these seniors, and we will try to do it in an efficient way by first cutting out the overhead of a private health insurer, cutting out the profits of a private health insurer, making this a nationally based program having the broadest possible coverage for all seniors. That is the essence of Medicare.

This bill is turning that on its head. This bill is fragmenting the pool of seniors who will be covered. It is tilting the playing field against traditional Medicare by providing incentives for insurance companies. It is giving money not directly to subsidize the health care of seniors but to subsidize the bottom line of insurance companies. That is the only reason they will play in the senior market, because they are being paid to do so, paid in the form of their profits, not essentially in the form of services to seniors.

I suggest that if the market for senior health care was there to be exploited by private companies, it would have been exploited in 1965, in 1955, in 1945, but it wasn't. And we all know because this body contains people who at least have reached middle age. We all can remember in every home there was an elderly relative—a grandmother, a grandfather, an aunt or uncle—who had to live with you because they could not afford the price of health care; they could not afford the price of a nursing home. That all changed, not because private health insurance companies stepped up to the plate. It is because Medicare and Medicaid stepped up to the plate. And we are about to change that fundamentally. There are those who will say this is just a modest demonstration program. No, this is the first step. The path has been charted. The direction was declared years before. You just have to read the book.

This bill fragments senior health care coverage. It does so along the lines of age and health. By giving incentives to HMOs, it will encourage them to enroll the youngest and healthiest seniors.

Here is how you make money as a health insurance company. First you get a large subsidy from the Federal Government. Then you carefully select your risks so that they don't incur costs. That increases your profits. That is what any of my colleagues would do if they were directing an HMO, that is what I would do, because their business is to provide profits to their shareholders. That is what is going to happen. It is not because suddenly they have thought of a much more efficient way to deliver services to seniors.

Frankly, the way they derive efficiencies is to ration health care. We all know it because we have all heard the complaints from seniors and from doctors: They won't pay me for what I am doing. It takes me 6 or 7 months to get a bill through, and they give me 10 percent of what I claim as my true cost.

That is what the doctors tell me. They don't want to work with private insurers. They like Medicare. They like the fact that it is predictable. It pays them on time or certainly in a predictable range of time. That is not what HMOs do. They are in it for the money. That is the essence of what they do.

We think we can change the morbidity and the mortality rates of seniors and the costs associated with senior health care? We can't.

So what do we do? We give the HMO's subsidies, and then they will use the subsidies and the leverage of this new law to seek out the healthiest risk, and they will maximize their profits.

That is clear because Wall Street certainly has already voted on this bill. Pharmaceutical stocks are soaring; health insurance HMOs are doing very well. That is what is happening.

What happens also is that we take these healthy seniors out of the pool of traditional Medicare. Then what happens to the cost of traditional Medicare? It goes up. We no longer have the 65-year-old or 68-year-old marathon runners and triathletes. We have 85-

and 90-year-old frail elderly who need increased care. No insurance company is going to underwrite those people if they can avoid it, and they can avoid it very easily. So the cost of traditional Medicare will go up.

Then, of course, a year or two from now the people who say this is not about privatization, this is about choice, will come in and say: Look how expensive Medicare is. The private sector is doing so much better. And we will see, I think, the inevitable erosion of traditional Medicare. The irony is that we already know traditional Medicare delivers high quality at essentially a lower cost than an HMO.

A report by the trustees of Medicare this year estimated that reimbursements for HMO enrollees would exceed the average cost of traditional Medicare. That makes sense. Medicare is not advertising on every billboard in Rhode Island like the Plan 65 is. Medicare is not putting out glossy 25-page brochures describing its great programs, or advertising on the radio for profit. Medicare doesn't have to run a multimillion-dollar profit. Medicare is not paying a CEO of an HMO $26 million, or $9 million a year. It is obvious why they are running more costs.

So, again, we know this already. We have Medicare+Choice. Every year, they say ''we need greater reimbursement.'' Why are we then trying to tilt resources to induce private companies to come and do something that seniors will say general traditional Medicare does just as well? It is not about efficiency or a new innovative way of paying for health care, it is about ideology and catering to special interests—that big sloppy kiss again to the pharmaceutical industry and the insurance industry.

The Bush administration proposal, this proposal, divides seniors along the lines of income. For the first time, we are using means testing to determine how much someone must pay to participate in Medicare. Now, one could argue that if this was a last-ditch effort to save traditional Medicare and you had to make sufficient financial calls, you could consider means testing. But this is not about saving Medicare, this is about privatizing Medicare. This is about not saving the system but essentially destroying the system. It creates this fragmentation along the lines of income. When you start seeing the costs accumulate—when seniors start seeing those costs accumulate, a very wealthy senior might say, I don't want to participate anymore, and they will begin walking away from the system. That is not a lot of people, but once you have a public program, and people say, I don't want to participate any longer, and you see the income lines start dividing people it will undercut the support and the strength of the system.

I listened intently to my colleague from Texas say it is so unfair to have the minimum wage workers pay as much as the very wealthy who pay in. I am someone who is pretty sympathetic to minimum-wage workers. Unlike many of my colleagues on the other side, I think we can increase the minimum wage, and I think we can do that right now. They have avoided a vote on that for months and months.

Let me tell you, you have to recognize that, through our tax system, those upper income Americans are paying much more into the Medicare system during the course of their lifetime. But that is beside the point. I think that is a footnote. The fundamental point is that this program has worked so well because it is a social insurance program, not a welfare program. It is a program which every senior comes to, regardless of their health, age—other than meeting the 65-year-old threshold—or their income. It is really a common ground. That has a value above and beyond simple accounting, or who is paying what and who is doing what. So this is another way the program is divided. Again, I believe this is the wrong approach.

Now, this whole proposal eliminates the stability, dependability, and reliability of the Medicare Program. It is unfortunate that this process was essentially hijacked behind closed doors. All of the conferees didn't even meet. Two of our colleagues on the Democratic side, Senators BAUCUS and BREAUX, were admitted to the conference, but there were others who were deliberately excluded, which is against, if not the rules, the spirit of the Senate. I think that is wrong. This is not a product of the free interchange between all interested parties, this is simply a backroom deal. If they weren't willing to deal, they could not get in the back room.

This legislation will affect all seniors. That is another reason we need more time on this floor to debate this bill, explain the bill, to have the opinions registered by seniors who are not dazzled at first by an attempt or a first glimpse of a drug benefit but by the underlying reality of the bill.

There is much to be criticized in the bill, but I believe there are three general areas. First, when I was considering a drug benefit for seniors being attached to Medicare, I believed it had to meet three tests: affordability, accessibility to all beneficiaries, and uniform coverage. This bill fails those tests miserably.

In terms of affordability, seniors will pay, over the next 10 years, $1.8 trillion for drugs—a staggering total. We began this debate with $400 billion over 10 years for Federal support—much too inadequate, I believe. We were stuck with that. But as I pointed out in previous remarks, we didn't use all the money in this bill to creatively and innovatively help seniors buy drugs. It went to help the insurance companies and pharmaceutical companies.

We are beginning with a benefit scheme where a senior will have, first, a $250 deductible, roughly $35 a month premium; and if they do that, and they pay the deductible and the premiums, 75 percent of their cost of drugs up to $2,250 will be absorbed by the Federal Government.

But these deductibles and premiums will increase each year. Our seniors should know that. In fact, by 2013, CBO estimates that beneficiaries will be paying a $445 deductible and almost $60 a month premium, and a quarter of their drug costs will be deferred up to $4,000. So we are looking not at a fixed benefit for seniors over the next 10 years, we are looking at increased premiums and deductibles.

I mentioned the donut hole before. Even paying these fees, this doesn't provide for continuous coverage for our seniors for the drugs. They will spend up to $2,250, and then they will get nothing. I would like to be around in at least—perhaps if this bill passes—I hope it doesn't—a few months or years because it doesn't really begin until 2006—when our offices get flooded with calls saying: I just got a bill for my premium this month, but I was informed that I will get no help with drug costs, and I have to choose—not between eating or buying drugs, but I have to choose between paying my premium or buying my drugs. That will happen to seniors when they get in this donut hole, this gap. That will be their choice.

I hope we are preparing good answers by saying: Oh, that is just the way it works. Keep paying your premium because if you don't, you will never be able to qualify for help $2,000 or $3,000 down the road—after you have spent that much more on drugs. It is a baffling system of insurance.

It is interesting because I have heard so many people on the floor talk about and say: We are just going to give the seniors what we have in the Federal Employees Health Benefits Plan. I can tell you, we don't have a donut hole in the Federal Employees Health Benefits Plan. We don't reach a point at which our drug coverage stops, while we spend some more money. No, we have what most insurance plans have; we have continuous coverage. Our deductibles and premiums might be different, but we have continuous coverage. So this is nothing close to the Federal Employees Health Benefits Plan.

It might be an interesting experiment—maybe our plan should be changed. Maybe we should have this gap. Maybe we should experience the fact of paying premiums and not getting anything for them.

Again, this is one of the problems we have with the bill. When this bill passed the Senate, there was some good work—some. One of the areas where we had good work was in trying to cushion the blow for poor people who could benefit from this drug bill. Specifically, the Senate bill had a section also for people at 160 percent of poverty. That has been pulled back to 150 percent of poverty—the threshold for low-income assistance. It is estimated that because

of that change, over a million beneficiaries with annual incomes between $13,000 and $14,000, approximately, will lose out on their income assistance. Now, an annual income of $14,000 might be a lot of money in some States, but in the Northeast it is very difficult to get by on that.

When you are paying $800 a month for an apartment—and, indeed, we are doing so poorly at providing affordable housing for our seniors that more and more seniors are on the private market—if you are paying $800 to $1,000 a month for an apartment, that is about $10,000, $12,000 a year. And you don't qualify for this benefit? This is protection for low income seniors?

Millions more will be further disqualified by the imposition of an asset test. I must say, I voted against the Senate version of this bill for many other reasons. But, there were some commendable elements in that proposal. One was the elimination of the asset test. The asset test is back. That means if your income is below 135 percent of poverty and you have assets over $6,000, you will be disqualified for low-income assistance.

Let me put it in the vernacular. Assets over $6,000: If you have a Ford Escort, it is probably worth maybe $6,000. Certainly, if you own a Crown Victoria, it is $6,000. So let's tell the seniors right now, if they can afford to have a car or a little bit of savings, they are disqualified from the income protections for low-income seniors because of this asset test. That I think is wrong.

There is another aspect to this bill that has been much discussed and debated, and that is what are we going to do with dual eligibles, those individuals who qualify for Medicaid but also, because of age or disability, are in the Medicare system. There is a lot of discussion about the success of this bill dealing with dual eligibles, making sure they are protected. Frankly, I think the protections are ephemeral.

First, the States are not actually relieved of their fiduciary responsibility for these dual eligibles. The Governors all want the Medicare system to go in and say: You are going to take care of these people; they are Medicare individuals now with a drug benefit. Effectively what we have done is something called a clawback, I believe, which requires the States to keep paying forever.

More than that, I am told, is that before, the Medicaid systems in the State could negotiate better drug prices, and now I believe they are subject to whatever the traffic will bear in terms of prices established by this bill. And there is no cost containment on the drug companies. There are cost containments on what we can spend for seniors, but not on what the drug companies can charge. That is another real major problem with this bill.

When I go up to Rhode Island and talk about cost containment, what seniors say to me is: Hallelujah, you are finally going to be able to constrain these accelerating prices from drug companies. You are finally going to be able to do what we all want you to do—use the market creatively, not price controls but market force to get these prices down. No, because this bill essentially prevents Medicare from negotiating for drug prices effectively against the drug industry. That is why, again, it is a ''big sloppy kiss'' to the insurance industry and to the drug industry because they have their way. There will be no market power. There will be no Medicare with approximately 41 million beneficiaries saying: Give us your best price, drug companies. It is fragmented by region, by private entities. It is fragmented deliberately so there is no market power.

For those people who preach on and on about the power of the market, that we have to get away from all this command-and-control economic policy, they walked away from using the market creatively to deal with the No. 1 issue that has driven this whole debate: the ever-increasing cost of prescription drugs.

It is not an accident because the people who wrote this plan and the biggest beneficiaries of this plan are those in the drug industry.

There is another aspect of this whole issue of the States and Medicaid. We have prohibited the States from using Medicaid money to help address these increased drug costs. We have essentially said: You can't use Medicaid money for that. Again, this is not only something that is unfortunate, but it puts tremendous strain on the States.

It has been estimated that my State, over the next 10 years or so, could be paying up to $500 million to the Federal Government in this clawback. I hope my Governor is aware of that. I am going to make him aware of that because the states had always expected that the federal government would pay these costs if a Medicare drug benefit was created.

There is another issue. Because of the ambiguity of some of the language, it is unclear what happens to individuals in the TriCare Program and individuals who are in the Veterans Administration program. What happens to their drug coverage? Are they displaced? That remains to be seen.

Also, in terms of the approach to Medicare, as I said several times over, it is just not adding a pharmaceutical benefit. That is what seniors want many of us to do; create a Part D in Medicare, a pharmaceutical benefits with rules, with fair costs, and with protections. The overall effect to the Medicare Program is we are raising Part B from $100 to $110 in 2005, and then indexing it to expenditures in future years. We know that is going to keep going up, and some of the fastest growing costs in the country are health care expenditures.

By contrast, the Social Security benefits are tied to increase in the Consumer Price Index. Here is what is going to happen to seniors: The Social Security check goes up, a very modest figure because of the CPI indexing, and the part B goes up like a rocket because it is tied exclusively to the health care expenditures. In a way, it could lead to the point where Part B is more and more expensive and less and less attractive to seniors.

Again, with the means test, with deductibles, all those things, we could find initially wealthy seniors leaving the system, and that erosion could spread.

There is another aspect to this, too, and that is access to home health services. Again, there was a proposal initially to put on a copay, a co-fee, for home health care. That was defeated. I see my colleague from Maine, Senator COLLINS, in the Chamber. She led the fight to see that was protected and did it admirably and graciously, as always.

What I am reading in this bill is that we are reducing reimbursement rates for home health care providers by an estimated $6.5 billion over the next 10 years. We already know the home health care industry took a significant cut in the Balanced Budget Act. In fact, many were pushed to the brink of bankruptcy, some beyond and failed and closed their doors.

Now they have to adjust to a $6.5 billion reimbursement reduction over the next 10 years. Once again, why didn't we take some of this money going to the pharmaceutical industry and the insurance industry and keep the home health care industry strong and vibrant? We all know it is a much more efficient way to treat seniors, more so than having them traipse to the emergency room, then having them go home without home health care, and then come back a week later.

Frankly, in my view, that is what made traditional Medicare a very attractive program. We have ransacked many of the aspects of traditional Medicare to fund this experiment, this demonstration in privatization.

Another general topic of concern is the accessibility issues. There is a complicated scheme now that says we are not going to let Medicare run a drug program unless, of course, there are no private vendors. When it left the Senate, the fallback would begin to operate—i.e., a Federal program—a Medicare Program for drug provisions would operate when two drug-only plans were not available in the market. That has been changed. Now, it is a drug-only or another private plan. So essentially we are doing all we can to keep Medicare from running this drug plan, not because of efficiency, not because of anything except special interest politics and an erroneous ideological commitment to use the private market anytime, even when the market and the market for senior health care is not, without major subsidies, conducive to private plans.

If it was, why did we have to create Medicare in 1965? Because no insurance company will voluntarily enroll sick, elderly people unless they are highly

subsidized. We did it not because we had a profit motive but because the American people decided in 1965 that this society would be more decent, stronger, and the fabric of this country would be better if we devoted public resources to help seniors with their health care needs.

The other aspect of this, which time and again is repeated, is why do we need a $12 billion slush fund to do what we think private health insurance companies will do anyway? Because we do not believe they will do it anyway. We know they will not. We have to give them lots of money to participate. Why can we not use that money to strengthen traditional Medicare? Why can we not use that money to decrease the gap in coverage? Why can we not use that money to provide further reimbursement to home health care, which we know is an efficient, valuable program? This does not make sense to me on simple grounds of economic efficiency, but it does have a certain logic if one is rewarding their friends and appealing to ideological concerns.

There is another important aspect, too, and that is the fact that we have seniors, retirees, already with health care and drug benefits through their employers. Two point seven million of these retirees are in danger of losing those benefits.

There have been attempts in this legislation that comes before us to bring that gap down. In fact, it was estimated that there were about 4 million retirees who would lose their benefits under previous versions of this legislation. That has been reduced, but 2.7 million Americans—at least 9,000 Rhode Islanders—are likely to lose better private drug benefits that they have today because of this proposal.

I can guarantee my colleagues, we will hear from every one of those 2.7 million retirees—the at least 9,000 in Rhode Island—because that is not what they thought Congress was doing when it was debating a drug benefit.

As I mentioned before, not only does this approach fragment the healthy and young seniors from the older and sicker seniors based upon the cherry-picking of the insurance industry—which they will do—it also fragments them in terms of income because of the nature of this means testing. It might not happen right away, but anyone who is under any illusion that we are setting in concrete this proposal right now has not been here long enough.

I can imagine, my colleagues can imagine, with every reconciliation bill—and for those who are not devotees of the parliamentary musings every year when we come and have a special procedure where there is no filibuster, it is just 50 or 51 votes—we find all sorts of interesting provisions in that bill. We all stand up and say, oh, that is terrible, but I have to vote for it because it is the budget.

What we will find is this means testing will become broader because the principle has been established. What we will find is these demonstration programs for privatization will become larger.

Let me talk about this demonstration program. It allows for demonstration projects to be established in six metropolitan statistical areas where there is a 25-percent private plan participation. Presently, there are 41 MSAs around the country that meet this test, including most of my State of Rhode Island, as well as border communities in Massachusetts. It is estimated that almost 7 million seniors and disabled beneficiaries, one in six Medicare beneficiaries, could find themselves subject to this privatization experiment. That is a heck of a demonstration project, 7 million people.

As I mentioned before, what are we demonstrating? We have had Medicare+Choice for a while. We know the problems. We know that seniors will go into it. In fact, in my home State of Rhode Island we have about 30 percent who have gone into these managed care plans. They went in originally because of the offer of pharmaceuticals and drugs. Every year we get complaints when they change the plan, when they raise the copays, when they do all of these things. We know how it is going to work and we also know that we have to pay more and more each year to subsidize these private plans to participate. As a result, we are going to see tremendous erosion. Seven million seniors could be affected.

What does this mean in terms of their coverage as they look at the competing plans? According to the office of the actuaries at CMS, beneficiaries could pay up to 5 and 25 percent more to remain in traditional Medicare in areas where these demonstration projects are going on. However, the proposal at least caps that increase at 5 percent. Why would premiums go up? Let me go back to two basic points. We are subsidizing the private plan and then they are out carefully selecting to minimize their risks. They do not have to do it by offering inducements. They can put signs up at the health club, go to these 5K races and hand out brochures. They will not go into neighborhoods with high rates of disease. They will not go into senior centers in low-income areas where people have the kind of health issues associated with having earned a low income all of their lives. They will not do that. They will go to the country clubs, to the affluent suburbs, and sign everybody up. Then we will subsidize it.

So when one is a senior trying to make a choice between traditional Medicare and this new plan, well, if they have to pay even 5 percent more, that might make them choose the new plan—not because they have better quality, not because they maintain their doctor, not because of any substantive reason, but simply because it is a little cheaper, in the beginning. Then a year later, when they discover it is a little more expensive, and 2 years later as Medicare continues to decline, the options start evaporating.

So, again, this proposal is not only dangerous but unnecessary. We could have simply done what many Americans think we are doing, create a Medicare drug benefit.

So I believe we can do much better. We should do much better. We have the time to do much better. Anyone who is saying that we cannot spend 2 weeks or 2 months continuing to discuss this bill, I think is putting an undue premium on enjoying the holiday over the health care of seniors and the structure of our health care for seniors that has been in place for more than 35 years.

I hope that rather than beginning the path of privatization of Medicare, providing an inadequate benefit not only because we started out with insufficient funds, but then diverting those funds to take care of the insurance industry and the pharmaceutical industry, that we would go back to principles and try to create, under the $400 billion cap, a program that would work for seniors. I hope we can do that, and I hope we can continue this debate.

I yield the floor.

The PRESIDING OFFICER (Mr. BOND). The Senator from Maine.

Ms. COLLINS. Mr. President, the Senate will soon have an historic opportunity to pass landmark legislation to make affordable prescription drug coverage available to all of our Nation's seniors, as well as to people with disabilities who receive Medicare benefits. This legislation, which represents the largest expansion of Medicare in the program's 38-year history, is long overdue, and it deserves our support. Prescription drugs are as important to the health of our seniors today as a hospital bed was back in 1965 when the Medicare Program was first created.

I have long been a supporter of providing a prescription drug benefit as part of an effort to strengthen the Medicare Program, and I believe that were prescription drugs as important back in the 1960s as they are today the creators of the Medicare Program undoubtedly would have provided for that coverage. But back then the focus was on covering hospitalization.

While I continue to have reservations about some of the conference agreement's provisions, we simply cannot allow the perfect to become the enemy of the good. This historic opportunity may never come again, and we cannot afford to let it pass. We cannot allow yet another year to go by without taking action to help our seniors with the soaring cost of prescription drugs. Millions of older Americans and their families will be helped by this legislation. Millions more will be helped in the future. I, therefore, will cast my vote in favor of the conference report, and I want to take a moment to commend the majority leader, the chairman of the Senate Finance Committee, Senator GRASSLEY, Senator BAUCUS, Senator BREAUX and, indeed, all of the conferees who have worked so hard to craft a compromise and to bring this bill before us.

With recent advances in research, prescription drugs can literally be a lifeline for many patients. They reduce the need to treat serious illness through hospitalization and surgery. They allow our seniors to live longer, healthier, happier lives. Soaring prescription drug costs, however, have placed a tremendous financial burden on millions of our disabled citizens and senior citizens who must pay the full retail price for these essential drugs out of their pockets. Monthly drug bills of $300 or even $400 or even more dollars per month are not at all uncommon for older Mainers living on very limited incomes.

Lorraine White, of Winthrop, ME, wrote to tell me that she and her husband spend about $400 each month on vital prescription drugs. They live on limited income and they have had to draw down their savings to make ends meet. They wonder what they are going to do when their savings are depleted.

Time and again, seniors in Maine have come up to me to tell me they simply cannot afford the essential prescription drugs their physicians have prescribed. I remember an elderly woman coming up to me in a grocery store in Bangor and telling me she could only get 12 of the 36 pills for which her doctor had written a prescription. None of our seniors should be faced with those kinds of decisions. They should not be choosing between paying their bills and buying the pills that they need to stay healthy.

The legislation that is before us today will make affordable prescription drug coverage available to seniors such as the Whites, like so many seniors with whom I have talked in Maine, and it will protect them from these high out-of-pocket costs that are such a burden.

Under this legislation, the Whites' drug costs would be cut by more than half, and the savings would be even greater for this couple if they qualify for the low-income subsidies provided under this legislation.

The legislation before us today makes prescription drug coverage a permanent part of the Medicare Program, and it provides a benefit that will be available to all seniors and disabled individuals on Medicare, regardless of where they live.

It is also crafted in a way that, if a senior citizen is very happy with their health care insurance, the drug coverage that that senior already has, he or she does not have to take this additional benefit under the Medicare Program. It is a voluntary benefit.

Beginning in 2006, all seniors will be eligible to get both upfront and catastrophic protection for an average premium of $35 a month. Moreover, low-income seniors, those who are most burdened with the high cost of prescription drugs, will receive generous subsidies and get additional protections. The more than 12 million older and disabled Americans nationwide, including 75,000 Mainers, with incomes below 135 percent of poverty will not have to pay any premiums at all to secure comprehensive prescription drug coverage, and they will have only minimal cost sharing. An additional 18,500 low-income Mainers will qualify for reduced premiums, lower deductibles, and coinsurance rates, and no gaps in coverage.

The senior Senator from Maine spoke earlier today about this legislation, and I agree wholeheartedly with her contention that our Medicare beneficiaries will, indeed, be far better off once this legislation is signed into law. Clearly, we are providing meaningful and realistic help to our seniors, particularly those who are struggling the most—low-income seniors and those with very high drug costs.

The one drawback that I see in the way this benefit is structured, that I want to discuss right now, is that, unfortunately, it takes time for this new benefit to come on line. I fear many of our seniors believe this benefit is going to be available immediately and, unfortunately, that is not the case. But there is still help, immediate help, in this bill for our seniors. To provide some interim assistance, starting next year seniors will receive discount cards that will save them between 15 and 25 percent on each prescription drug purchase. Moreover, low-income beneficiaries will receive a $600 credit on that card, in both 2004 and 2005, that they can apply to the purchase of their drugs. This subsidy in conjunction with the discount card will give our most vulnerable seniors immediate assistance in purchasing drugs that they otherwise might not be able to afford.

In addition to the prescription drug benefit, there are other significant features in this bill that I strongly support. For example, the bill takes major steps to make Medicare payments more equitable. This is an issue I have been working on since my first year in the Senate. The bill tracks very closely legislation that Senator FEINGOLD and I introduced earlier this year.

Medicare's reimbursement systems have historically tended to favor large urban areas and failed to take into account the special needs of rural States. This simply is not fair. Ironically, in Maine the low payment rates are also the result of the State's long history of providing high-quality, cost-effective care.

In the early 1980s, Maine's lower than average costs were used to justify lower payment rates to doctors and hospitals. Since then, Medicare's payment policies have only served to widen the gap between low-cost and high-cost States. I am, therefore, particularly pleased that the chairman of the Finance Committee worked so hard to include in the conference report significant steps to strengthen the health care safety net by increasing Medicare payments to physicians and hospitals in rural States such as Maine.

According to the American Hospital Association, these provisions will increase Medicare payments to Maine's rural hospitals by more than $125 million in the next 10 years.

Moreover, they will increase payments to physicians in Maine by an estimated $7 million a year.

I can't tell you how important these rural provisions are to my State. Maine ranks near the bottom in the rate of Medicare reimbursement despite the cost of survival care in my State and despite the fact that the providers in Maine give very high quality care. This inequity has only worsened as additional payments under the Medicare system have gone to large urban hospitals.

I am very pleased that the rural health care package will help relieve some of the stress on our rural hospitals which are so important to rural States such as Maine. It will help ensure that there is more equity in the Medicare reimbursement system.

I also include a special thanks to the conferees for including a provision at my request that will ensure continued Medicare graduate medical education funding for Maine's family residency programs. These family practice residency programs are absolutely essential in training physicians who tend to stay in Maine and serve. They practice in underserved areas of the State.

I am also pleased that the legislation restores the rural add-on; that is, the enhanced reimbursement for Medicare home health payments that is vital to sustaining home health care in the rural areas of our country.

The Presiding Officer, the Senator from Missouri, and I have worked very hard over the years to sustain and revitalize home health care. We are well aware that many of our elderly citizens would prefer to receive the health care they need in the privacy and security of their own home. But Medicare reimbursement rates, particularly in rural areas, have been so lacking that that home health care has been in jeopardy. I wish the bill went further. I think we should have had a 10-percent rural add-on in order to compensate for the additional costs in terms of travel time, long distances between patients, and other factors that come into play when home health care is provided to seniors and disabled citizens in rural areas.

In fact, surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly. But certainly the extension of a 5-percent rural add-on is a major step in the right direction.

I am also very relieved that the conferees rejected an ill-advised proposal to have our seniors have a copay for the cost of home health care. I am convinced that had that been included in this package and signed into law, it would have discouraged many of our most vulnerable sick seniors from getting the home health care they need. The conferees made a wise decision, indeed, in dropping that provision which was included in the House version of this bill.

The conference report will also make prescription drugs more affordable for all consumers by closing loopholes in our patent laws that some of the large brand name pharmaceutical companies have exploited in order to delay consumers access to lower priced generic drugs. According to the Congressional Budget Office, these provisions will help to reduce our Nation's drug costs by some $60 billion over the next decade.

I am very pleased to have played a role in drafting this legislation with leaders on the bill—Senator SCHUMER, Senator MCCAIN, Senator EDWARDS, and Senator GREGG. All of us worked very hard to bring this about. This is a really significant provision. It is going to help reduce the cost of drugs in State Medicaid programs. It will help to control the cost of drugs in the Medicare Program as we are adding this benefit. It will help uninsured individuals because it will lower the cost of drugs for them. It will help employers who are providing prescription drug coverage as part of a health insurance plan. This is a very important provision and one I advocated very strongly to be included in this conference report.

In addition, the conference report includes the provision which I offered, and which the Presiding Officer cosponsored, to the Senate bill to establish a pilot program to help modernize the outdated ''homebound'' definition that has impeded access to needed home health services for many of our elderly and disabled Medicare beneficiaries.

I know that when we start talking about the definition of ''homebound'' in the Medicare Act it may sound esoteric, but in fact it is vitally important for so many disabled and elderly citizens who, because of the interpretation of the law by some of the fiscal intermediaries in the Medicare Program, have literally become prisoners in their own homes fearful of leaving in that they will jeopardize their ability to continue to receive essential home health care.

I particularly thank David Jayne, the courageous advocate who inspired this legislation, a truly heroic individual, and also Senator Bob Dole who has been such an outstanding advocate for disabled Americans for so many years. They worked very hard to ensure that this provision was retained in the final version of the bill.

Overlooked in much of the discussion of this Medicare bill are other very important provisions that will provide better coordinated care for seniors with chronic conditions such as diabetes. As the cochair, along with Senator BREAUX and the founder of the Senate Diabetes Caucus, I believe these provisions will greatly improve the quality of care for individuals suffering from diabetes. I am very pleased that these provisions have been included in this bill.

I have talked now at some length about the many provisions in this conference report that I strongly support. I do, however, have reservations about other provisions.

The House bill included provisions based on a premium support model that would have called for direct competition between private plans and traditional Medicare. I have serious concerns about the implications of this proposal, particularly that it could result in driving up premiums in the traditional Medicare Program. That would be particularly problematic in a rural State such as Maine where seniors are not likely to have a host of insurance companies competing for their business because of the small size of the market.

Moreover, the House bill could have resulted in sharply different premiums for seniors in different parts of the country and even within a single State. Those health provisions really troubled me because I did not think that a senior living in Fort Kent, ME, should be paying a different rate for the same coverage as a senior who is living in San Francisco, CA. I therefore joined a number of my colleagues in sending a letter to the majority leader expressing concern about the inclusion of this controversial policy in the Medicare bill.

The final bill, while it still causes me a lot of concerns in this area, is different from what was in the original House proposal. The original proposal was significantly downsized to a limited pilot project that would not begin until the year 2010 and that would provide significant protections for those seniors who are remaining in the traditional Medicare Program.

While I continue to have reservations about even the demonstration project, I urge my colleagues to look at the package as a whole. I agree with the AARP and the National Council on the Aging that its strengths clearly outweigh its weaknesses. When I hear some say that somehow this legislation spells the end of the traditional Medicare Program, I know that is not true. I know it is not true because I have carefully studied this bill. I also am convinced it is not true because the AARP, the Nation's largest seniors organization, would never endorse a bill that spelled the end of the Medicare Program. That is just not conceivable.

This conference report represents the last real hope of getting an affordable Medicare prescription drug benefit anytime in the foreseeable future. Our seniors have already waited too long for this benefit. We cannot delay; we cannot continue to push this issue off to the future. Since the cost of providing a meaningful drug benefit will only increase as time passes, it is imperative we act now. Our seniors have waited too long for this coverage. We cannot push this off another year, another month, another week. Let's act now. Let's not let the perfect be the enemy of the good.

This package is worth supporting despite its flaws. I urge my colleagues to join me in voting yes on the conference agreement.

I yield the floor.

The PRESIDING OFFICER (Mr. GRASSLEY). The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent that Senator BARBARA BOXER be the next Democrat to speak after Senator HARKIN, who I believe is the last person at the moment we have unanimous consent for in terms of speaking order.

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

Ms. STABENOW. Mr. President, it is interesting to listen to the debate with colleagues today on both sides of the aisle concerning this legislation. To hear the discussion from the other side of the aisle, there would be no reason at all to oppose the bill; there would be no reason at all, last night, to have to hold the voting boards open for 3 hours to twist arms to be able to change votes, to be able to get the votes to actually pass the bill; there would be no reason that overwhelmingly Members on the Democratic side of the House and the Senate who crafted and led the creation of Medicare would be opposed to this bill.

On its surface, what is happening makes no sense if, in fact, this is a good bill for seniors. There is no way, if this were a good bill for seniors and for the disabled in this country, that I would be standing here opposing it. There is no way my colleagues in the House of Representatives—some of whom were there when Medicare was passed, some of whom have championed health care and senior citizen services for decades—would have stood on the House floor and voted no if it was good for seniors and for the disabled.

On its face, that makes no sense.

For those who have worked for years on this issue, Mr. President, I actually came into public service over 25 years ago; I often joke that I was 5 at the time—I came into public service over the issue of senior health care in Michigan. That is what brought me into public service. Since that time, I have worked very hard to continue to improve services, access to care, expand home health care, to be able to modernize health care as we have changed with new technology, new medicines, and new opportunities. I was very pleased that the first bill I introduced coming to the Senate was a bill to lower prescription drug prices by allowing our local pharmacist to do business across the border in Canada and other States to lower prices. So I care very deeply about this issue.

Nothing would please me more than to be able to stand here today and declare a victory for our seniors and a victory for all Members because we have finally done the right thing. Seniors have waited too long, there is no question. They have waited way too long.

Unfortunately, under this plan, they are still waiting. Not only will an awful lot of people continue to wait, some of them will find instead of a step

forward—which we all would like this to be—a step forward that I supported with the Senate bill, even though it was not all that I wanted it to be, but it was a bipartisan bill. It was truly a step forward. I supported it as something we could build on. Instead of this being a step forward for seniors, for too many it is a step off the cliff.

Let's look at what we are talking about, just the facts. For someone who is putting out $5,100 worth of prescription drugs in a year—which, unfortunately, is not a high amount given what people are having to pay for prescription drugs—if they are paying $5,100 for prescription drugs, they would have to have out of pocket under this bill $4,020 of that $5,100. They would still pay $4,020 for that $5,100.

Some would say—and I respect that—Well, at least it is something. It may not be much, but at least it is something. The question is, What are you giving up to get that less than $1,100 in help when you have a $5,100 drug bill? The first thing, you may be giving up your coverage altogether to get that benefit. Estimates are that 2.7 million retirees will lose their coverage as a result of this bill. That is about one out of four people in Michigan.

Some would say: Well, 75 percent will not lose coverage. That is great, if you are one of the 75 percent. But what if you are one of the 25 percent of folks who worked all their life, probably along the way gave up some pay raises to get a good health care benefit, may have made a number of tradeoffs to make sure in your retirement you and your family had quality health care?

To get a very meager amount of money for prescription drug help, one out of four folks will lose their benefits. We do not have to do that under a bill we passed when there was a Democratic majority in this Senate. That bill was brought forward under Senator BOB GRAHAM's leadership and sponsorship. I was pleased to be a cosponsor. We had a bill where nobody lost their coverage. We do not have to write a bill where 25 percent of the retirees lose their private insurance coverage. It is all in how it is designed.

This is designed in a way to give incentives, unfortunately, for some employers to drop their coverage—not everyone, but if you are that fourth person when it is one out of four, that is 100 percent of you, 100 percent of your coverage and your family's coverage. So for those folks, this is not a good deal.

Well, let's look at some more. Who else isn't it a good deal for? Well, we are told that about 6.4 million people are low-income seniors who will have less access to the drugs they need, and possibly pay more. These are folks who are the poorest of the poor seniors. These are the folks who really are sitting down tonight at the kitchen table and deciding, do they eat or do they get their medicine?

This is not some platitude, some rhetoric. This is real for people where a dollar or two-dollar or five-dollar copay on a prescription makes the difference between eating, paying their electric bill, or having a roof over their head.

We understand from the Center on Budget and Policy Priorities that many of these 6.4 million low-income and disabled Medicare beneficiaries would pay more for their prescription drugs, possibly much more because they would be moved from Medicaid for low-income seniors—where many only have a one-dollar copay for their prescriptions—to a system where they would be paying more. In addition to that, there are certain drugs now that seniors need or the disabled need that they receive under Medicaid that may not be available under the private insurance plans.

So when they move this system to private plans, which is the intent as much as possible—where there is one or more private insurance plans, plus an HMO or PPO—when they move in that direction, they possibly limit the prescription drug choices of our seniors.

So under this bill, if you have folks who have a bill of $5,100, they still pay $4,020 of it. On top of that, they may be one of the folks who loses all of their benefits. And they may be one of the folks who actually ends up paying more and having less choice about the prescriptions they will receive.

On top of that, what do folks get? Well, they get the pleasure of knowing there is no new competition put in this bill to lower prices. There, in fact, is language which is stunning to me, absolutely stunning, that prohibits Medicare from bulk purchasing, group purchasing, and negotiating on behalf of all Medicare beneficiaries to lower prices.

So no wonder the pharmaceutical lobbyists are thrilled. I have spent a lot of time on this floor talking about how there are at least six drug company lobbyists for every one Member of the Senate. They earned their pay in this bill, that is for sure. I am sure they are high-fiving it all the way to the bank because what has been done in this bill is lock in a whole new group of customers, millions—39 million customers potentially—locked in at the highest possible prices. That is what we get.

So on top of continuing to get very little prescription drug benefit—and you could pay more; you could lose your coverage, but you might get some; you might get $1,000 out of about a $5,000 drug bill—but you are hooked into the highest prices because of the inability to negotiate as broadly as possible to lower prices, the inability to go to Canada.

For Michigan that is a pretty big deal. That is 5 minutes across the bridge and the tunnel, and you can drop the prices in half—or 60 percent or 70 percent. We have, for years, been saying: Let the local pharmacists be able to do business to bring back safe FDA-approved drugs, with a closed supply chain so all the safety is there, to bring them back to the local pharmacies just as the drug companies do every single day. We are not talking about mail order. We are not talking about the Internet. We are talking about licensed pharmacists bringing back lower priced drugs, many of which we have helped to pay to make, to the local drugstores to lower prices.

So we are not seeing that. We are not going to see that in this bill. The prohibition continues. We are not going to see a strong bill to close patent loopholes, to be able to allow more generic drugs on the market to increase competition. There is some language, but it has been weakened. We actually have in the bill a prohibition on Medicare using their clout to lower prices.

The VA uses its clout for our veterans, and we do not pay retail for our veterans for prescription drugs. We get a 30- to 40-percent discount because, on behalf of the veterans, we use our clout, through the VA and the Federal Government, to negotiate a group price.

Well, the drug companies do not want that. I understand that. Their sole mission is to make sure their profits and their prices stay as high as possible, that they stop any competition and keep the prices high. I understand that. That is not our job. That is not our job. The seniors in this country, the families, the workers, the businesses that would benefit by more competition to lower prices—the taxpayers expect us to be fighting for them. When I look at this bill, it is shocking the extent to which that is not the case.

So we have a situation where one out of four people could lose their coverage. In a State such as mine, where we have a lot of retirees who have good benefits, this is a big deal. We have very low-income seniors, the poorest of the poor, living on Social Security, with no pension, trying to make it. They could pay more. Many of them will pay more. And we have everybody locking in to these high prices so that more and more we will see the Medicare dollars—the precious dollars we have—going for those high prices rather than helping more people on Medicare.

Then, to add insult to injury, in 2010—which is not that far away, much as we would like to think it is; basically, 6 years away or so, 7 years—this plan opens up a Pandora's box. It allows the beginning to experiment with privatizing Medicare.

It says—even though when folks, who had a choice between picking a private plan and traditional Medicare, 89 percent of them said, I like my Medicare, I am going to stay right where I am, only 11 percent picked private plans—even though that is the case, this bill now moves to put more people in the 11 percent.

This bill even says: We are going to take precious money from Medicare and give it to HMOs and insurance companies and we are going to actually

pay them so they can compete with traditional Medicare. We are going to pay them more. We are going to spend more over here to get people over here.

Now, that would not seem to make sense if you are trying to look at the fact, as many have lamented, that we have a financial crisis with Medicare. We have a concern about not enough dollars under Medicare. Why would we set up a system that would cost more rather than less? Why would we set up a system that people have said they do not want? That does not make any sense, either.

This, starting in 2010, begins the process. It is called a pilot, but it begins a process where—instead of being in this column, where you can pick your own doctor and you know what you are going to pay, and you know what the copay is, and you know what the premium is; it does not matter where you live, you can have access to Medicare; in Michigan you can be up in Iron Mountain or Marquette or Houghton or Escanaba or Sault Sainte Marie in the upper peninsula or in northern Michigan or Detroit or Three Rivers or Lansing or Grand Rapids; you know you have Medicare; you know you can go to the doctor of your choice, the hospital of your choice; and you have health care coverage—now what they are putting in place, starting in 2010, is a system where the folks who look at analyzing this have said, for those who go into this privatizing process, you would be given, essentially, a defined contribution instead of a defined benefit.

You would be given what some call a voucher, some call it a contribution, X amount of money that you could then purchase between a private plan, an HMO, or traditional Medicare. It would begin to diffuse and pull people out into different kinds of plans. Some people have asked: What is wrong with that?

Unfortunately, what happens is that if you are healthy, you are a younger senior, you are going to get a better rate going to a private insurance company or into an HMO. So you may go in that direction. And gradually what happens is that they all have different rates, different costs, cover different things, cover different doctors. In some, you have your own doctor; in some, you can't have your own doctor.

What happens with traditional Medicare? Those who are the sickest, the most elderly, the most disabled, who can't get a good rate outside of traditional Medicare, will stay. The experts tell us the cost of Medicare will go up; because there are sicker, older, more disabled people here, and we are going to see increases. It has been estimated there will be a 25-percent increase over time in those costs.

What happens in the long run in that system? Gradually Medicare will have more and more costs, fewer and fewer people, and we will have what Newt Gingrich said he was hoping would happen or he expected to happen; that is, Medicare will wither on the vine.

It will take a few years. We can say: We are not going to be around then. It doesn't matter to me.

But what we vote on in the next couple days will begin a process that will unravel what has been one of the greatest American success stories ever—Medicare. That is what we are seeing happen here. Someone like myself, who cares so deeply about Medicare, who cares so deeply about providing prescription drug coverage and lowering prices, has to say, no way, no way will I support this.

I understand that there is a major philosophical difference—I respect that—between those who never supported Medicare, who view it as a big government program. I know that. I know that when Medicare originally passed, there were only 12 Republicans who supported it. There is a big philosophical difference.

I say Medicare is a big success story, so is Social Security. Other colleagues say: Big government program, it needs to be privatized or eliminated. Let folks go to the private sector. Let them buy insurance.

Prior to Medicare, half the seniors couldn't find or afford health insurance. They couldn't find it or afford it. Ask folks today, ask a small business person who is trying to find or afford health care, ask somebody who is a single entrepreneur or in a small nonprofit or single business person in their own private consulting business how easy it is to find and afford health insurance. We need to be addressing those issues.

I find it ironic that when we need to be addressing that and creating bigger insurance pools so that we can actually lower prices and create more access to health care and work with the business community to do so, this bill does exactly the opposite. It unravels the only piece we have had that has worked because it takes 39 million people, puts them in one plan—the sick, the healthy, the older, the younger. Because it spreads the costs and the risks in such a large pool, they have been able to keep the administration down, keep the growth in the program down. It has worked.

On the face of it, we would say: Why in the world would we want to change that? Why in the world would we want to create a system where it costs 2 percent right now to administer Medicare; private HMOs, it costs 15 percent? And we would set up a way to begin to move to this?

If we have a financial crisis with Medicare, I would argue it is because of a self-inflicted set of decisions. The tax cuts passed 2½ years ago were paid for by Medicare and Social Security. We would have dollars to be able to take care of everything we want to do with Medicare right now, and Social Security, if it were not for a decision that was more important—to give to those who already have great opportunity and have done well with it. It was decided it was better to give to them and hope it would trickle down to everybody else rather than keeping our promises to Medicare and Social Security.

So now folks say: We have to change it because the resources are gone. Well, the resources are a problem because of decisions made by this Congress and this President.

Even with that, if you say, well, we can't sustain Medicare as we know it, why would you then say, I have an idea: because Medicare is in crisis and because there is going to be a problem down the road funding it, let's make it more expensive? That doesn't make any sense. It doesn't make any sense at all.

It only makes sense in two ways: One, if you just consider Medicare a big government program and you believe everything should be done in the private sector, then from your standpoint, paying 15 percent instead of 2 percent is OK. But I think there is a broader issue at stake. The underlying focus, unfortunately, is that the folks who want to move us away from Medicare are the folks who benefit by this system. And even more than the insurance companies and the HMOs, that are going to have to be paid more to entice them into this, the folks who are benefiting are in the pharmaceutical industry.

What this battle has always been about is making sure that if we are going to provide prescription drug coverage, we are not doing it under one plan where all 39 million seniors are in one plan and they can get together and have the clout to force a group discount.

That is what all this is about. All of it is about the pharmaceutical industry that fought for years to try to make sure we would not have a prescription drug benefit because we could then get a group discount.

But then a couple years ago they changed their strategy. They said: OK, well, if we are going to have a benefit—because it is clear that seniors need help and we are not going to be able to stop it because seniors need help, something is going to happen—let's change our strategy and make sure that this is a plan that is putting seniors in a lot of different pots, lot of different insurance and HMO pots, so they can group purchase a little bit but they won't have the clout of 39 million people, they will have the clout of just a few, a little bit here, a little bit here, a little bit here; and let's make sure we don't allow any new competition; and if we were really good, we would even write in the bill that Medicare can't negotiate on behalf of everyone for a group discount.

I am sure that was their big wish list. And, lo and behold, in this great big bill, most of which has nothing to do with prescription drug coverage, they got it. They got it.

Because they got it, someone like me, who wants more than anything to see seniors helped in paying for their

medicine, has to stand up and say, no, no way, no way is this thing a good deal for the seniors of this country.

(Mr. BOND assumed the Chair.)

Ms. STABENOW. Mr. President, I want to speak briefly to one thing that I believe in the bill is a good deal. There are positive things. I don't think it is all a negative bill. I think there are positive things in it. I know there are people who have worked hard, including our occupant of the chair, who led efforts to work in a bipartisan way and tried hard to get the right thing done.

On balance, there is no way I can support this bill, but there are some good provisions in it. I believe there are provisions in this bill that, right now, we could pass overwhelmingly, on a bipartisan basis, if we were to pull them out, take away all the bad provisions, and start over on prescription drugs.

I would simply say that to have no bill is better than to have a bad bill. Let's go back to work and get it right for our seniors. Absolutely, they have waited too long. They have waited so long to get this, and they are saying, I waited so long and this is what I got? So let's go back to the drawing board. We can do it quickly if we want to and get it right—lower prices, real prescription drug coverage.

But there is one section I believe we have a tremendous sense of urgency on right now. I know that my distinguished colleague in the chair has been a leader in this effort, and that is our rural providers and what happened with our hospitals, home health agencies, and doctors, and the cuts they have had to take. I want to speak to the fact that I am frustrated that we have not, before now, been able to help our providers.

I was in the House of Representatives in 1997 when we passed the balanced budget agreement at that time, putting into place certain reductions for providers. Unfortunately, since that time, they have seen cuts of twice as much as was originally suggested would happen at that time. It is the health care delivery organizations that will lose reimbursement. Frankly, the citizens of Michigan, indeed the citizens of the country, lose care when our providers are not given the assistance—the dollars to cover the care they need to be able to deliver.

I have been working since that balanced budget agreement in 1997 to turn that around. In fact, the very first amendment I offered on the floor of the Senate to the budget bill was to stop the 15 percent cut in home health care that was scheduled to take place. We have known about this latest round of cuts since December of 2000. We knew it was coming. At that time, we enacted a Medicare relief package, but we knew there was going to be another 15 percent cut in home health or a $1,500 cap on physical therapy services.

Unfortunately, there were a number of cuts that were just postponed at that time. We have known for 3 years that these cuts were coming, and there is no question that the portion of the bill that deals with help for our rural and urban hospitals, help for our doctors, nursing homes, home health agencies, physical therapists, all of the other providers of Medicare services need to be addressed. We need to fix that. We need to stop the cuts that are stopping services from being provided.

If health care providers are not able to get reimbursed for their services at a reasonable rate, we know they are going to simply decide not to serve Medicare recipients. Too many of them have made that decision—not because they wanted to but because they felt they had to. We know patients cannot simply decide not to seek care. It is our responsibility to make sure that providers are available in every community, every rural community, urban, or suburban area.

In the past 5 years, the numbers of physicians accepting Medicare patients has declined by 10 percent. I know there is a sense of desperation now as we look at this package. I have physicians saying to me: We know in the long run that this is not a good deal for seniors, not even a good deal for us; but we are so desperate for something that we feel we have to say yes to this package and then come back and fix it.

Of course, I say to them, I don't know if we can fix it. If we cannot get it right now, I have no confidence that we can come back and get the votes to fix this later and stop the bad things that I talked about earlier.

But I know that there is a sense of desperation. I know the annual increases in Medicare payment rates from my State of Michigan are less than the rate of inflation. In 2000, more than half of Michigan hospitals lost money helping Medicare patients. One of the things that happens when Medicare is cut and not covering the costs, as well as Medicaid, is that those costs—what it takes to care for people—is shifted to people who have insurance. So the providers are private sector providers now, and they are saying now that they have a stake in making sure that hospitals and doctors and other providers are reimbursed at a fair rate, covering their costs, so that those costs don't shift over onto our large businesses, small businesses, and so on. So we all have a stake in making sure that Medicare is paying a fair rate. Certainly our small businesses, which have seen their insurance rates at least double in the last 5 years, have a stake in this.

In my State, our big three automakers and other manufacturers struggle with issues of health care. So I am deeply concerned that the provisions in the bill that deal with our providers be passed.

This next round of cuts in 2004 to Michigan providers would be about $69 million to our hospitals; $53 million to teaching hospitals; $70 million to nursing homes; $120 million to physicians; and for independent home health care agencies, $16 million. Altogether, it is about a $329 million cost.

My concern is that these desperately needed funds are being held hostage in this bill. If we were addressing this package independently, I believe we would have overwhelming bipartisan support, if not unanimous support, for these provisions. They are long overdue. Many of us have been saying now for 3 years that this needs to get fixed. Our hospitals desperately need help, as do doctors, home health agencies, nursing homes, et cetera. And we need to do this now. But I am concerned that it is put in the middle of a bill that is not in the long-term best interest of these same providers.

I spoke a minute ago about how the highest possible pharmaceutical prices are locked into this bill. Because the highest possible prices are locked into this Medicare bill, as soon as the increases to providers are done with in this legislation, and because of the increases in pharmaceutical prices every year—we are seeing 12, 13, 14, 18 percent increases every year—I believe our providers will be in great jeopardy of being cut significantly once again, because an explosion in prescription drug prices will not have any accountability. There will be nowhere to go but back to the doctor to cut, back to the hospital, back to the home health agency, back to the nursing home, the physical therapist, the cancer services. There will be no place else to go. So even though my good friends, who are desperate, feel they have to support this package, which they know is not good for them a few years down the road, I believe we can do better by pulling that language out and today making it clear that we are not going to hold those who provide health care to seniors and the disabled hostage in this legislation.

We are not going to hold them hostage to a broader bill where there is such disagreement and controversy. I believe it is up to us to pass this legislation today.

UNANIMOUS CONSENT REQUEST—S. 1926

Mr. President, I ask unanimous consent that the Finance Committee be discharged from further consideration of S. 1926, which is cosponsored not only by myself but Senators GRAHAM, CLINTON, MURRAY, LEAHY, DASCHLE, PRYOR, LEVIN, CANTWELL, and SCHUMER—this is a bill to restore Medicare cuts to providers—that the Senate proceed to its immediate consideration; that the bill be read a third time and passed; and that the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Mr. President, as chairman of the Senate Finance Committee that has jurisdiction over the legislation, and I want to take a good look at it, I object.

The PRESIDING OFFICER. Objection is heard.

Ms. STABENOW. Mr. President, if I may take another moment, that is

very disappointing to me. I believe our providers need help now. We can do this in a bipartisan way. My legislation would allow that to happen immediately. I will continue to work to make sure that happens.

In conclusion, I say to all of my colleagues, we can do better for our seniors than what is in this bill. I would like very much if we would all vote no and go back to work and get it done right. I thank the Chair.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. BENNETT. Mr. President, as this debate goes forward, it is beginning to take on somewhat of a formulae pattern with one side saying, There are some good things in this bill, but it is so bad that we must do nothing, and the other saying, We have problems; there may be some bad things in this bill, but we have to move forward. Both sides agree the bill is not what individual Senators might prefer, but the way the argument comes down on one side or the other as to the balance.

I am reminded of the statement my father used to make when he served in this body. He said: We legislate at the highest level at which we can obtain a majority. With the Senate as equally divided as this one, with only a one-vote margin between the parties, obtaining a majority is very difficult. I pay tribute not only to the chairman of the Finance Committee, but to the ranking member of the Finance Committee who, in a bipartisan fashion, obtained a majority within that committee and brought a bill that has now obtained a majority in the House of Representatives, however close that was, and is on its way to obtaining a majority in the Senate.

As the debate has gone on, those who are saying, No, this bill is more bad than it is good, seem to have another mantra that I have heard over and over again. That mantra is this: This bill will destroy Medicare. Indeed, there are some who have gone so far as to say that it is the motive and purpose of the Republicans in this matter to destroy Medicare. I have had some say the Republicans have hated Medicare ever since it was established, and they want to kill it, and this bill is somehow a Trojan horse aimed at killing Medicare from the inside.

I reject the notion that the Republicans are trying to kill Medicare. I think that is ridiculous. I don't think there is any indication that is the case, never has been, but it is part of the political mantra that we hear over and over again.

More importantly, I want to address the question of the present health of Medicare absent this bill. We hear over and over again: Medicare is wonderful; we can't tinker with it in any way. The best thing we could do is just take a prescription drug program and put it into the present Medicare mix. Some of the provisions that are in this bill are innovative. Some of the provisions that are in this bill tinker with this wonderful program that everybody loves.

I would suggest to those who have that particular point of view that they should go out and spend some time dealing with Medicare as it presently is constituted, not in the theory of a committee hearing, but on the firing line with providers. Let me give you a few anecdotes out of the real world that have convinced me that while I believe the Federal Government should have the responsibility that it has adopted with respect to Medicare, I do not believe that the present Medicare system is so wonderful that it should not be tinkered with.

Example No. 1: As I have held town meetings around my State, people come to me and talk about their problems. I am sure every Senator has the same experience. Very often, the problems they talk about have to do with Medicare.

A woman came to me and said: I have finally figured out how to deal with Medicare.

It struck me as a little bit strange that she should be talking about Medicare because she didn't strike me as being old enough to worry about Medicare. Then she made it clear; she handles her mother's financial affairs.

So she said: On behalf of my 85-year-old mother, I handle all of her relationships with Medicare. She said: Again, I finally figured out how to handle it: I throw away everything unopened, and then once a month, I call the Salt Lake Clinic and say: How much do I owe you? She said: I am a professional. I am a college graduate. I am an educated woman. I am probably at the top of my powers in terms of my career. I cannot understand anything that comes from Medicare. I open these envelopes, and I try to read what it has to say. It is absolutely impenetrable, and I spent time trying to figure it out; I spent time trying to work it through and finally I adopted my present strategy. Once again, I throw away everything unopened. I don't even bother to look at it, and then at the end of every month, I call the Salt Lake Clinic—which is where her mother gets her health care provided—and I say: How much do I owe you? They give me a number, I write out a check, and life is simple.

She said: I may be overpaying, I may be underpaying, but who knows? Indeed, I don't think there is anybody on the planet who knows how much the bill really should be. She said: I decided that the peace of mind that comes from being able to handle this in this kind of fashion is worth whatever financial discrepancies there might be.

That does not sound to me like a program that is working so well that we can't do a little tinkering with it or a program that is going so smoothly that we can't try some innovation.

Our friends on the other side of the aisle are so horrified that this bill calls for some health savings accounts. I say to them: What are they afraid of? That they will work? Are they afraid the health savings accounts might demonstrate that there is a different way to deal with this, a way that is a little more straightforward, a way that does not involve the mountains of paperwork and the tremendous bureaucracy connected with it?

Example No. 2: I have a daughter of whom I am enormously proud who has a master's degree in speech therapy. After she graduated with that degree from George Washington University, she went to work in a nursing home. This daughter is a very enthusiastic young lady. Some might even suggest she is a little bit excitable. I would not, as her father, make that kind of a charge, but I have heard some who have suggested she gets excited.

She had been on the job, I imagine, a week, maybe a week and a half. She called me. The call came in as calls from my children usually do: Just as I am getting ready to go to bed.

I am so delighted to hear from my children that I do not resent the fact that they prevent me from getting the amount of sleep I would normally like. They can call any time. When she called and I answered, she said: Dad, you are a Senator. You have got to fix Medicare.

I said: OK. Calm down. Tell me what you are talking about.

Then she described the details of the difficulty she was having in her first job in this nursing home trying to provide therapy for seniors who were having serious problems with respect to Medicare. She made this fascinating statement to me. She said: Dad, do you know who the highest paid person in this facility is?

Well, I would have assumed it would be the administrator.

No.

Well, if it is not the administrator, then the most skilled doctor. I can see that a doctor might be paid more than an administrator.

She said: No. The highest paid person in this facility is the woman who is in charge of handling Medicare regulations.

I stopped to think about that for a minute. That means the skill required to understand all of the regulations relating to Medicare is in shorter supply and therefore can command a higher salary than the skill necessary to administer an entire facility or the skill necessary to provide medical services from a skilled physician.

She gave me an example. She said there was a senior in that facility who was having some problems swallowing. The doctor looked at it. The doctor said, I do not understand what the problems are, and called the speech therapist. My daughter, the speech therapist, came in and said: Yes, I understand the problems connected with this. It is fairly straightforward. It is fairly normal among seniors. Here is the way you deal with it. She needs this kind of therapy to deal with her swallowing problems. They are not just minor problems. They could affect her ability to eat and ultimately her ability to live because she needs the nourishment.

So my daughter said: This is what needs to be done.

Well, the relatives of the woman who had the swallowing difficulties said: Absolutely not, until we are sure Medicare will pay for it. We cannot have this kind of procedure and therapy prescribed unless we are sure it is covered by Medicare. If Medicare will pay for it, then grandma can have it, but if Medicare will not pay for it, we are not paying for it, no.

My daughter, in her innocence, first time on the job, said: Let me find out. So she made the inquiry, Will Medicare cover this particular treatment? Three days later, she gets an answer. It took that long to wade through all of the regulations, and all of the rest of it, by this person who was the highest paid person in the nursing home, to figure it out.

My daughter has had the tragic experience of having patients die on her, patients whom she believed she could have helped but was unable to help because of the delays built into dealing with all of the complexities connected with Medicare.

She said, again: Dad, you are a Senator. Fix it.

I said: Well, it takes a little more than one Senator to fix this.

Then she made a very interesting statement. She said: I cannot admit to any of my coworkers in this facility that my father is a Senator because they will be so outraged that my father is a Senator and is not doing anything about fixing Medicare.

So I suggest to those who say Medicare is so sacrosanct that we cannot try anything new, they ought to spend a little time dealing with patients and providers to discover that Medicare has become a bureaucracy of incredible impenetrability and needs to be addressed.

This bill addresses some of those problems. The most significant one, of course, is the fact that Medicare as it currently stands does not provide reimbursement for prescription drugs. Now that is a scandal. Every other health program in this country immediately recognized, as it came along, the shift in the way medicine is practiced in this country, but because Medicare is written by the Congress, it is not flexible enough to make that kind of shift.

We now have prescription drugs that prevent hospitalization, that prevent the necessity for operations and surgical procedures, but Medicare will not reimburse for that even though ultimately it would save tremendous amounts of money. The reason: Medicare is the best Blue Cross/Blue Shield fee-for-service indemnity plan of 1965 frozen in time.

It is almost like a bad movie, a Woody Allen movie where he sleeps for awhile and comes back 40 years later. Medicare has not kept up with the changes in the way medicine is practiced. It has not kept up with all of the things that happen outside of Medicare, in the private world, that happened just because the administrators of the plan look at what is happening in the practice of medicine and say we need to change the plan to adapt to the way medicine is practiced.

Medicare cannot because it has to be changed by Congress, and every time Congress comes along and says we need to try to make some of these changes, we run smack into the political reality that there can be some political hay made by standing up to defend Medicare, by saying the other side is trying to destroy Medicare. The scare tactics of this kind of campaign are something with which we are all familiar.

One of my colleagues on this side described a conversation she had during the 2000 election with her aunt who was in her nineties. Her aunt said: I am not sure I can vote for George W. Bush.

The Senator said: Why not?

She said: Well, he is going to destroy my Social Security.

Wait a minute, said the Senator. Governor Bush has not talked in any sense about your Social Security. He is talking about the future. He is talking about the teenagers. He is talking about the 20-somethings who are just coming into Social Security.

Oh, no, said the woman in her nineties, he is going to destroy Social Security and Medicare. Because she had seen television ads that suggested that any attempt to try to improve, modernize, change, or help either Social Security and Medicare meant destroy, meant we are against it.

We are hearing those same kinds of arguments today. Any attempt on the part of the Finance Committee to improve, change, innovate, experiment, or move in any direction other than the 1965 model is somehow an attempt to destroy.

Well, it is not. I think we all understand that. But that makes for a great bumper sticker. It makes for a great television 30-second sound bite to attack anybody who wants to try anything new as being against the old and, therefore, trying to destroy the whole program.

I have problems with this bill, as does every other Member of this body one way or the other. There are lots of things in it that I do not like and lots of things in it that I think will make the problem I have just described worse, make Medicare even more impenetrable than it is now, but I intend to vote for it. I intend to vote for it with enthusiasm, and I ask my colleagues to do the same thing, because for the first time since 1965, it is at least willing to break down some of the walls that have been built around this program. For the first time since 1965, it is at least willing to try and see if we can get a little experience with a few things that can move us into the 21st century.

I am sure I will be attacked in my election this November as being one who voted to destroy Medicare by virtue of this vote, by those who will want to continue to raise the specter that any kind of innovation or change is an attack at the fundamental program.

But let us understand the most important thing we are faced with here. Let us understand if we do nothing, if we preserve this program as it currently exists, it will destroy itself. This is not a partisan statement, this is not some conclusion Republicans have come to and Democrats dispute. The demographics are irresistible. What is happening in our country as we become older and older, as the good health care that we are receiving makes us live longer and longer, that demonstrates a financial situation that is unsustainable.

If we do nothing with Medicare in the name of preserving Medicare, we watch Medicare self-destruct. That is inexorable. There is no way around it.

I would have suggestions that would go far beyond what this bill does in moving us away from the present paradigm of Medicare into a world of innovation, change, and experimentation, not because I want to destroy Medicare but because I want it to survive. If you leave it on its present course, it is not going to survive.

There are a few halting steps in the right direction in this bill. We need more of them. We cannot stop with this bill. The Congresses of the future will have to deal with this problem, and it will only get worse the longer we delay taking those steps.

So I say let's take those steps now. Let's start with this bill with the full understanding, and with eyes wide open, that the future is going to bring us back to this issue again and again. The demographics are inexorable. They are going to require changes in the next Congress and in the Congress after that and in the Congress after that. They are going to force us to get out of the mindset that we have had since the 1960s, and that has nothing to do with who is in the White House or who controls the Senate in a partisan fashion. Those demographics are there. They are bearing down on us. The quicker we can understand that and begin to think in new ways, begin to experiment with new methods, the sooner we will solve the problem, not only for our existing seniors but, perhaps more important, for the baby boomers who are becoming seniors. We have to think in a new fashion or they will run into a demographic brick wall that will see this program self-destruct regardless of what we do.

So, as I say, for that reason, with all the problems I see in the bill, I am going to vote for it, and I am going to hope that future Finance Committees and Ways and Means Committees will move us in the direction of innovation and experimentation so we can boldly begin to find solutions to the problems that we face.

The PRESIDING OFFICER. The assistant minority leader.

Mr. REID. Mr. President, it is my understanding, on the Democratic side, the speaking order has been set for the next few speakers. Is that true?

The PRESIDING OFFICER. The Senator is correct.

Mr. REID. Who would they be?

The PRESIDING OFFICER. Senators HARKIN and BOXER.

Mr. REID. Following Senator BOXER, I ask that Senator CLINTON be recognized.

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

Mr. REID. I believe that is all we have at this stage, Mr. President.

For tomorrow, whatever time we come in, I ask on our side the Democratic leader be recognized first, I be recognized second, that Senator GRAHAM of Florida be recognized third, and Senator KERRY of Massachusetts be recognized fourth—that is for Sunday.

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

Mr. GRASSLEY. I reserve the right to object.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Was the request just in the order on the Democrat side?

Mr. REID. Unless there is some change by the leadership, I assume we will do the same thing tomorrow we are doing today.

The PRESIDING OFFICER. Without objection, the order will be that stated by the Democratic whip.

The PRESIDING OFFICER (Mr. WARNER). The Senator from Iowa.

Mr. HARKIN. Mr. President, I do have quite a lengthy statement. I had estimated it might take me upwards of about 45 minutes. I know others want to speak. I am going to try to collapse it as much as I can, but I had a number of things I wanted to say. Hopefully, I can get them said within a certain amount of time. I don't mean to drag it out, but I did have a number of things I wanted to point out about this bill.

We are debating an issue of utmost importance—the health and security of this Nation's elderly and disabled. To repeat what has been said, Medicare was created 40 years ago with the purpose of providing this Nation's aged and disabled with a safety net to protect them from debt and destitution. For years, seniors have counted on health security in their golden years thanks to Medicare. This program stands as a social contract between the American Government and the American people, a social contract between one generation and the next.

The contract is simply this: After a lifetime of work, when you turn 65 you are promised health insurance covering doctors visits, hospitals, and many other health costs. But there has been one exemption from this social contract—no coverage for prescription drugs.

It is not possible to overstate what Medicare means to a citizen of modest means who has worked hard for a lifetime, who doesn't want to be a burden on the rest of his or her family. It is really kind of hard to overstate what it means. Medicare has been a rock-solid, reliable, guaranteed lifeline for a great number of America's senior citizens.

I think back to my father's own experience, my own family's experience in the days before Medicare. In 1958—I just pick that year because I was a senior in high school at that time—my father at that time was 74 years old. He had worked most of his life in coal mines, in Iowa. A lot of people don't know it, but we had a lot of coal mines in Iowa. He had a number of accidents in those mines and elsewhere. He suffered from what was then called miner's lung. That is what they called it at that time, miner's lung. Today we call it black lung disease.

As I said, he had several chronic injuries as well and he was in pretty tough shape. Keep in mind, my father only had an eighth grade education, and all of his work life basically had been prior to Social Security coming into existence.

My father's total income in retirement was less than $1,500. Again, thank goodness during World War II, even though he had been old then, he had worked for a while and was covered under Social Security. Other than that, he had no assets, he had no money, no stocks, no bonds. He did own a small house in Cumming, IA. Oh, yes, he had a model A Ford that was 30 years old. That was the only car he ever owned.

Of course, in 1958 he had no Medicare because the program didn't exist. This meant that my father couldn't afford the luxury of seeing a doctor. But every year, like clockwork, my father would get sick in the middle of wintertime. He had this terrible chronic lung problem, black lung, miner's lung. My mother had passed away 8 years prior to 1958. He was on his own and basically taking care of us. As I said, I was a senior in high school at the time.

Every year he would catch a cold, he couldn't get over it, he would come down with pneumonia, and a neighbor of ours who had a car would rush him to the hospital in Des Moines.

He would arrive at the hospital in Des Moines. They would take care of my father. They would put him in an oxygen tent. They would give him his antibiotics and send him home in a week or two.

How could he afford to do that if we were so poor and had no income? My father was 74 years old. Did we have a rich uncle? No. So what happened? I will tell you how we afforded it. We thanked Sisters of Mercy at the Mercy Hospital in Des Moines who gave us charity care because our family didn't have any money. That is the only way that my father got health care.

We forget. Those of us who are young perhaps forget that 45 years ago that was the status of elderly health care in America. My father was not unique. Our family was not unique. In my little town of 150 people, it was all the same. All my father's brothers, his sisters, our family—of all who were that age, none of them had any health care. None of them had any money. If it wasn't for the charity of the Catholic Church and the Sisters of Mercy, my father would have had no health care whatsoever.

Had my father had any money or health insurance, he could have seen a doctor. He could have had annual checkups. He could have prevented long stays in the hospital. But in the absence of anything like Medicare, he ended up in a dire situation, in effect, in the emergency room. For many uninsured in this Nation, things are still that way. But fortunately, Medicare has offered a better alternative for our Nation's elderly and disabled.

I can remember as though it were yesterday. After I left high school, I went to Iowa State University. I had a Navy ROTC scholarship. I was in the Navy. I was flying planes. And I can remember coming home on leave once. It was Christmas of 1966. I came home, and my father, who was nearing his 81st birthday, still with his bad lung problems—I remember coming home and I remember when he proudly showed me his Medicare card. He said: Now I can go to see a doctor. I can go to the hospital, if I have to. But I can see a doctor. We don't have to take charity anymore.

I think of the impact that Medicare card had on my father, and the impact it had on my family and what it meant to my father to be able to get health care without accepting charity. What a tremendous difference. I often think about what my father's later life would have been like had he had Medicare. I think about how much healthier he could have been with good preventive care, and how much more he could have enjoyed his later years if he had had decent health care.

Today, seniors rely on Medicare. It means everything to them. If you do not have your health in your older years, you just do not have much of anything.

Unfortunately, back in 1966, we weren't nearly as sophisticated about medicine and health care as we are now. Surely, if we were creating the Medicare Program today we would include coverage of prescription drugs. We know that drug breakthroughs and innovations have made it possible to prevent illness, control illness, and keep people out of the hospital. For many in this society, modern prescription drugs have been a lifesaver and a life sustainer. Here we are today debating a proposal that was originally supposed to accomplish one simple goal: To fill in the gap that was left in Medicare—to right the wrong in Medicare by providing coverage of prescription drugs and simply to make medicine more affordable to seniors.

That is what we started out to do.

I deeply regret that in writing this bill Congress has strayed from that straightforward objective. This bill got hijacked, and it got hijacked by the corporate special interests, insurance and HMOs, and it got hijacked by the pharmaceutical industry.

We have forgotten who we are supposed to be helping—our Nation's seniors. Instead of a straightforward drug benefit, we now have a Medicare privatization proposal that threatens to undo the entire Medicare Program that seniors and the disabled rely on each and every day—seniors like my father who relied upon the stability and the affordability of Medicare in his later years, and seniors like him back in my home State of Iowa who simply want and need affordable medical care. That is all they want.

But what they are offered in this bill is something else entirely. This bill totally violates the spirit and substance of the original Medicare Program. I call it the ''Big Medicare Gamble.'' It is a roulette wheel. If you know anything about odds in roulette—I don't. I just learned this: The odds are tremendous against you. Roulette—that is what they are playing with Medicare. This bill threatens to unravel Medicare as we know it. Seniors are being told to head to the back of the line because the special interest drug companies and HMOs are more important than they are.

Seniors are being told there isn't enough money for a full drug benefit. That is because we have already squandered our surpluses in tax cuts worth trillions of dollars for the wealthy.

I heard someone the other day say: Look, we can't do any more in Medicare than we are doing now because we are limited by the $400 billion that was put in the budget. So all of you people want all of this stuff, but we can't do that, you see. We can't do it. We simply don't have the money. The very same person saying that voted for the tax cuts in 2001 and in 2003.

I am saying: Well, fine. If you vote for the tax cut, fine. But then don't say we don't have enough money to have a good meaningful prescription drug benefit under Medicare. What you are saying is you had different priorities. Your priority was to give tax breaks to the wealthy. That is your priority, and the seniors and elderly who need prescription drugs, they can go to the back of the line someplace else.

We had the amount of money—I will continue to say this because it is true—that we gave up in the tax breaks. If you spread that out over 75 years, that money is three times more than what we need to make Social Security and Medicare whole for 75 years—three times. So don't tell me we don't have the money. People just have different priorities on how to spend the money.

Once again, the well heeled on Wall Street are more important to this administration and to the supporters of this bill than the elderly and the disabled on Main Street.

What we have before us today is a bill drafted behind closed doors in the dark of night that amounts to a bonanza for special interests. Don't take my word for it. Look at what others are saying. Here is the Los Angeles Times: ''Deal Would Alter the Essence of Medicare.''

As Congress prepares to vote on the final $400 billion Medicare prescription drug bill, there is one thing on which most lawmakers agree. The legislation would over time change the essence of the 38-year-old health insurance program for the elderly and disabled.

We are doing that and we are told that we have 2 days to debate it—2 days, Saturday, today, and tomorrow—and we are going to vote on Monday. My prescription for this bill is to put it out in the countryside, send it out across America, let us get out of here, go back home for Christmas, go back to our constituents, get it out among the elderly, let us see what they say about it, and come back here as we are going to do on January 20 and take it up in February. Let's hear what the American public has to say about it before we pass it. It does not go into effect until 2006, so what is the rush? If it does not go into effect until 2006, why not take a couple, 3 months to put it out there and let people think about it? No, no, we have to debate this Saturday, Sunday, and vote on it Monday.

Here is my own Des Moines Register editorial:

This legislation is a big, sloppy kiss to the pharmaceutical and insurance industries.

From the Albany Times Union:

This is not only an imperfect bill. It may also be a disastrous one.

That is what others are saying about it.

Another one, from the New York Times, on the 19th:

. . . gift to pharmaceutical companies and insurers and a threat to elderly Americans.

From the Los Angeles Times:

Deal would alter Medicare's core.

Continuing:

If a comprehensive bill on prescription drugs passes, the government program will become a massive subsidized insurance market.

That is what we are doing. It is not just the media. Here is what conservative organizations are saying. Here is the Cato Institute, a more libertarian institute, perhaps, than conservative. I am not certain if it is conservative or libertarian:

The Medicare prescription drug bill to be voted on by Congress is a terrible mistake that will dearly cost our children and grandchildren. This is not a Medicare reform bill. This is barely a Medicare prescription drug bill. This is a bill for politicians and special interests. Sometimes the better part of valor is recognizing when you have made a mistake. Congress should recognize this bill as a mistake and go back to the drawing board.

That is Cato director of health and welfare studies Michael Tanner.

From the Heritage Foundation:

The agreement contains an unworkable and potentially unpopular drug benefit with millions of Americans losing part of their existing coverage.

That is not just me, a Democrat, saying that. It is the Heritage Foundation. They go on to say:

More than four million seniors with existing private coverage are bound to lose it or have it scaled back. Meanwhile, the politically engineered premiums and deductibles coupled with their odd combination of ''doughnut holes'' or gaps in coverage are likely to be unpopular with seniors.

That was November 17, 2003, Heritage Foundation.

From the American Conservative Union:

The Medicare prescription drug benefit bills that have passed the House and Senate would drive up costs for millions of senior citizens.

They go on:

Millions more would lose their current coverage under private medigap insurance and employer-provided plans. The House-Senate conference committee should reject the current bill and start over with a bill that includes real Medicare reform.

That was the American Conservative Union, August 21, 2003.

It probably seems odd for this progressive Democrat to be agreeing with conservatives, but sometimes they get it right, and they are right on this.

This bill would provide billions of dollars in subsidies—make that bribes; they say subsidies, it is bribes; call it to what it is, bribes—to private plans and HMOs. It would ensure billions of dollars in profits, a projected $139 billion in profits to pharmaceutical companies.

It speaks volumes that on Wall Street this week, drug and health industry stocks have surged up on the news of this big money, special interest bonanza. I often pointed out that during the deliberations on this so-called prescription drug bill, you never saw any pharmaceutical companies around here. I can tell you one thing. I have been here 29 years, and I have seen times in the past whenever we had bills dealing with drugs or pharmaceutical companies, if it is something that is going to cost the pharmaceutical companies one penny, they are here. They are in the halls. Their private jets are parked out at the airport. They are calling; they are phoning; they are in our offices. If there is any legislation that is going to take a nick out of the pharmaceutical companies, believe me, you see them up here.

I never saw a one, not one during this entire debate and development of this bill, which indicates to me they love it. Why wouldn't they, with a projected $139 billion in profits?

Now, I don't mind pharmaceutical companies making profits. They have a right to it. They provide good drugs. They do good research. But what I mind is that the $139 billion in profits they are getting are coming out of taxpayers' pockets—not to buy drugs, just as a subsidy, a blatant subsidy. It is not something they are making in the marketplace; it is a funnel from taxpayers to the taxing power of the Government and giving it right back out to the pharmaceutical companies.

One of the oldest statements in medicine goes back to Hippocrates: The first thing in medicine is ''do no harm.'' That is the oath that each doctor takes in this country: First do no harm.

We have to look at this bill. It does tremendous harm. Most egregiously, this legislation seeks to privatize Medicare, despite the fact that 89 percent of seniors are in traditional Medicare, and that is what they have chosen.

I listened to the Senator from Michigan, Ms. STABENOW. She pointed out we offered seniors a choice in this country in 1997. It is called Medicare+Choice. They could stay with traditional Medicare or they could join an HMO. Guess what, 89 percent of the seniors in this country stuck with Medicare and 11 percent went with HMOs. It seems to me they have already stated what they want.

Despite the fact that traditional Medicare is less expensive to administer—this is something else that a lot of people do not understand—they say private industry can do it cheaper than Medicare. The fact is, since we have had Medicare for over 40 years, we have good data. We know. We can look at the figures. This is not something on which you have to guess. So we look at the figures, and what do we find? We find that the average administrative expense in Medicare is 2 to 3 percent. In other words, for every $1 that goes to a Medicare recipient, 2 to 3 pennies are used in administration. In private plans, it is 15 percent. For every $1 that goes through a private plan in health care, 15 cents is used in administration; only 2 to 3 pennies in Medicare.

Why is that? With traditional Medicare, we do not have to spend millions on corporate CEO salaries or give them the private jets in which they fly all over the country. How about all the big page ads they take out in USA Today, New York Times, and Newsweek magazine? Those cost a lot of money. Medicare does not do that. So we have very cheap administrative expenses.

Despite the fact that administrative costs are 2 to 3 percent in Medicare and 15 percent in the private sector, they want to privatize Medicare. Despite the fact that under Medicare+Choice, which I just mentioned—they came in a few years ago in the late 1990s. HMOs have a history of dumping seniors. They get signed up, they are not making enough money, they leave town, and they dump them. But, still, we want to privatize it. They want to privatize it despite the fact that Medicare expenditures are growing at a slower rate than private plans. This is fact. This is not something we are guessing at. We have the data, how much Medicare has grown expenditures percentage-wise compared to private plans. We have the data. No one on that side will ever dispute it because it is factual. Medicare expenditures are growing at about 9.6 percent a year; private plans, 11.1 percent. Their expenditures are growing faster than Medicare.

They want to privatize Medicare despite the fact that private plans are concerned first with what? Profits. I do not say that as a bad word. That is their business. They are in business to make money for themselves and their shareholders. So their first concern is profit.

Senior citizens and the sickest are not profitable. The elderly are not profitable. The sickest and the disabled are not profitable for insurance companies.

Despite the clear wishes of senior citizens in this country, they want to privatize Medicare. The conferees have chosen to ignore all of these facts. Instead, they have concocted a witch's brew—a witch's brew—of seemingly appealing schemes which are designed to let Medicare wither on the vine, and to set the stage, next year and beyond, for attacking Social Security. Make no mistake about it; that is what this is designed to do. And I will have more to say about that in a minute because of what Newt Gingrich stood for.

The ideological experiment that we have confronting us is the result of what I call private sector worship. It is sort of a faith-based notion among some of our colleagues and administration officials that the private sector will take care of everything. It is a blind faith that free markets solve every problem. But this private sector worship flies in the face of past experience.

The entire reason we have Medicare today is because there is no private sector market for health insurance for sick seniors—none, zero, zip, nada—no private sector market because there is no money to be made in insuring the sick, the elderly.

The free market works just fine when you are talking about automobiles and airplanes and TVs, and widgets, et cetera. But the free market is not stupid. It cares about profit, not people. So by its very nature the free market shuts out people with disabilities, people with mental illnesses, people in the last years of their lives—in short, people who are not profitable.

So I have news for my colleagues who believe the free market is the answer to everything. The free market did not break down barriers to people with disabilities in our country.

When the Americans with Disabilities Act was passed in 1990 and signed into law, it was not the free market that did that. It was Government. It was us, the elected officials here in the Congress, working with the President, who did that. It was our free Government that had to step in to ensure that opportunities and openness in our country was there for people with disabilities. In the survival-of-the-fittest free market, these folks are just simply left behind.

Another example: We have been fighting in this Congress for years now to pass a bill ensuring mental health parity. But people with mental illnesses are not a profitable group. So the free market, left to its own devices, will have nothing to do with mental health parity in insurance. That is why I hope, as soon as we get back in our session next year, we can get to work passing the Paul Wellstone mental health parity bill because when we leave it up to the free market, folks with mental illness simply get left behind.

Another prime example of those left behind is simply the elderly. The elderly are not a profitable group of people to include in an insurance risk pool. They are sick. They are older. They have chronic illnesses. They are expensive to treat. On this score, the proof is all around us.

It is impossible to imagine private insurers fighting and competing with one another for the privilege of covering the elderly. That is why this bill has to bribe these companies with billions of dollars in subsidies to participate in this wrong-headed scheme we have before us.

As I said in my opening comments today, I have seen this proof firsthand. Now, back in 1958, when my father, as I said, was then 74, getting sick every year, going to the hospital, relying upon the charity of the Sisters of Mercy, we had insurance companies. There were a lot of insurance companies in those days.

Why weren't those insurance companies rushing out to Cumming, IA, with a population of 150 people, knocking on our door and competing with one another to cover my father with health insurance? Because they would never make any money off my dad. He got sick all the time. And he did not have any money.

Where was the free market? Where was the free market to cover my father in his time of need when he was elderly? The only market that was there was the charity market. Somehow I get the uneasy feeling that those promoting this bill see that as, once again, sort of the last kind of stopgap to helping our elderly, relying on charity once again, relying upon your kids, relying upon your families.

So do not tell me the private sector will solve every problem. I have lived through its failures firsthand. And I know that many elderly in my State of Iowa and around the country are in the same situation. They do not want to be let to not-so-tender mercies and whims of HMOs.

Now, it may sound like I have a real case against insurance companies. I do not. In fact, in my State of Iowa I think we are proud that we are the second largest domiciliary of insurance companies in the Nation, next to Connecticut, I believe. We are proud of our insurance companies in Iowa. They employ a lot of people. They are good corporate citizens. And they provide a very valuable commodity: insurance.

What the heck, I have a lot of insurance. I have life insurance, health insurance, car insurance. I probably have more insurance than I know what to do with, but it is a good tool, and I can afford it.

Insurance has been good for us ever since the first insurance scheme started about, I think it was, 3,000 years ago, in China, when Chinese farmers

were sending their barges down the Yangtze River, down to the ports, down to the cities. They found the storms would come up, and they would lose some of the barges, so a few of them got together and they decided to pool—to pool—their risks so that if one barge went down, that one person would not be totally wiped out. They found out by doing that, they could cover one another. Thus began the whole idea of insurance—risk pool, sharing the risk, spreading the risk around.

So, no, I have a great deal of respect for insurance. I think it provides a very valuable, meaningful commodity for all of us. But it is not adaptable here in health care for the elderly. It is just not adaptable.

Many of my colleagues prefer the free market over Government intervention. In many cases this is a wise preference. But in other instances it is a misplaced faith that the free market can do anything. There is a time and a place for the Government to step in where the private sector either fears to tread or fails to tread because it is not profitable. No question, this is the case when it comes to helping people with disabilities, people with mental illnesses, and seniors with serious health problems.

We hear the claim that private sector competition will drive down costs and save Medicare.

Come on, let's get real about this. The only competition in this bill will be the competition for healthy seniors. That is where the competition will come.

It says right here in the Washington Post: ''Medicare Deal Likely To Spark More Health Care Competition.'' When you read that, you say that is good, that is what you want. Except when you read in here, it says:

''This could be like the wild west out there,'' Hayes said. ''If suddenly there are five or six or seven plans out there, the insurance companies will be pricing their product to make a profit, as they are obligated to do. If the consumer is kind of shooting in the dark because of the complexity of this—and the darkness is deepened by age or disability—you'll have a customer primed for exploitation. We're real concerned that people could get ripped off.''

If you are sick and you are a senior, you are going to be shunned. If you are a senior and you are healthy, you are going to have people fighting for you. Why? Not on a free-market basis, but that is where the subsidies go. We are going to give them subsidies to do this.

We hear the claim that Medicare should compete with the private sector, but they don't want an even playing field. This bill will give billions of extra dollars to the private plans so they can compete and make profits. That is not competition, that is simply another excuse to shovel taxpayers' dollars to the special interests. In fact, this bill will pay private plans 9 percent more than traditional fee-for-service Medicare.

But that is not the end of it. On top of that, the conferees have come up with what they call a stabilization fund, which amounts to a $12 billion slush fund for private plans.

Once again, the writing is on the wall. Privatization costs everyone more money. So understand this: They say they will pay the private plans 9 percent more, but when you add the $12 billion in this stabilization fund, it is more like 26 percent more. In other words, taxpayers of this country are going to pay, out of our tax dollars, 26 percent more to the private plans so they can compete with Medicare. What a sweetheart deal that is; what a sweetheart deal. And then they say that is competition, that is fair competition. It is nothing more than a scheme to give money to special interests.

We hear the claim that seniors should have a choice. Many people have said seniors should have a choice as we Members of Congress have. I can tell you this: When they find out what is in this bill, they are going to be disappointed to find out their options are nothing like our options.

Yes, I believe the seniors of this country ought to have what we Members of the Senate and Congress have. But they aren't going to get it under this bill.

Many seniors could actually end up with reduced choice with this legislation. Under this plan, if there are two private health plans, say an HMO and a PDP—I know, aside from a few people probably around here, no one has ever heard of a PDP. And why not? Because they don't exist. They have just been conjured up out of this witch's brew. It is called a prescription drug plan. There is no such animal out there now. In a particular area, if a senior wants drug coverage, that senior will be forced to get their drug coverage through one of those private plans, not Medicare. That senior will not be allowed to get their drugs through traditional Medicare. So they can go to the PDP or the HMO.

Well, they don't want to go to an HMO. Eighty-nine percent of seniors have already said they don't want to join an HMO. They want their choice of doctor. They want fee-for-service. So they can join a PDP, but we don't know what they are like because no one has ever built one. But once the senior goes in this private plan, they could face restrictions on what doctors they can see. The plan can change the drugs that are available to them. You could be on one drug and they could say: Well, we aren't going to cover that drug; we are going to cover another drug.

Now, why would they switch from one drug to another? Well, maybe they are getting a kickback from the pharmaceutical manufacturer that is making the drug. Maybe they get a bigger kickback on one drug than they do another. So they tell you: We are not going to cover that drug. So seniors could be forced to change drugs in midstream.

This is not competition. This is another excuse to shovel money to the special interests. I don't call that choice. That is not choice at all.

There is a lot of rhetoric surrounding this bill that doesn't match reality. This administration has said many times that seniors deserve choice, that seniors deserve what Members of Congress have. I am all for that. But let's put our money where our mouths are.

Right now, as a Senator, I pay about 25 percent of my drug costs, period—a heck of a deal. But the prescription drug plan put before seniors today won't even come close to this. Instead, it is a confusing, convoluted maze that—mark my words—will leave our seniors feeling betrayed and bewildered once they find out about it.

I say to my colleagues, if you like our seniors' reaction to the catastrophic health insurance plan of 1987, you are going to love their reaction to this grossly inadequate prescription drug plan.

In 1987, I was here. We all voted for a catastrophic health plan for the elderly. The AARP supported it and said it was wonderful. Guess what. We came back a year later and had our heads handed to us by seniors in our States. I know I had mine handed to me. We came back a year later and undid it.

I can barely lift the bill that we have before us. It got delivered to us sometime this morning or last night. I didn't see it last night when I went home so it must have been sometime during the night or this morning this was handed to us. I am not going to kid anybody. I haven't read this. I have been here all day. I haven't read this. I am not about to. I will have my staff look it over, and we will try to get through it. But no one is going to read this prior to the vote on Monday.

How many seniors in the country will go through this before Monday and be able to tell us what they think about it? Yet we are given 2 days—today and tomorrow—and we vote on Monday. A bill such as this, that is this big, that could have disastrous effects, is a bill that ought to be out there, around the countryside. Let's go home for Christmas and Thanksgiving. Let's let it out there. Let's get people looking at it, talking about it. See what the effect is going to be in your State and mine, urban and rural, wealthy, poor. Come back in February and let's take it up and see how we feel about it then. To me, that is the way democracy works.

This President wants to bring democracy to Iraq. I sure hope they are not watching this. I sure hope they are not watching this exercise. They might think democracy may be something they may not want if they watch this.

Look at what our seniors are going to be faced with. Once a year, we in our plan, the Federal Employees Health Benefits Program, get an open season in which we can leave the plan we are in and pick another one. Here are all the books I get once a year to look through to decide which plan I want.

I get 30 days, or something like that, to look through them and decide which

one. Here is MD Individual Practice Association; here is GEHA; here is NALC; here is the Mail Handlers Benefit Plan; here is BPP and PPP—never heard of that; here is Kaiser Foundation; here is APWU—on and on and on. You get my point.

So we are now going to say to the seniors that every year you get a change and you will get all these wonderful books, like we do, to read, and you go through them and decide which plan you now want to be in. Give me a break. Maybe a person out there is sick and just hanging on, and they are supposed to decide by looking at these books. I suppose maybe they will have to go out and hire somebody to look at them. They will have to give a subsidy to somebody else. Maybe we will give a subsidy to the trial lawyers to help them decide which one to choose. Every single year. Who knows what drugs will be covered or what doctors? It is convoluted, bewildering. Every year they can bounce them around; you can be in a different plan.

At the end of the year, the plan can say: I am not making enough money, so I am out of town. Nothing in this bill stops them. Nothing in the bill says: We don't care if you don't make any money, you have to stay. If you are not making money, you can get out of there, and the senior is dropped, period.

Let's talk about what Senators are going to pay with this. They are going to find out, to their dismay, what they are going to have to pay. Aside from being confused and bewildered, being able to be dropped every year, let's see what they have to pay. Seniors who have an annual income above $13,470 per year—that is right, $13,470 a year—that is not a lot of money. If they have an income above that, they pay a yearly deductible of $250 before their coverage kicks in. They will pay $35 a month in premiums. Can I tell you also that this $35 is not fixed in law; it is estimated. It could go up every year. It could be $40, $42, $45, or who knows? There is no guarantee it is going to be $35. So now you have about $420 a year. As I said, the number could change every year. When a private plan is not making enough profits, they can increase the premiums every year. So seniors end up paying more.

So after seniors put at least $670 upfront into the program, they can start receiving some benefits. You might say, well, $670 is not a lot of money. If you are making $14,000 a year, or $13,470 a year, that is a lot of money. That is asking a lot. Then, after they pony up the $670, they pay 25 percent of their drug costs up to $2,250. At $2,250, the senior hits the gap—what we call the donut hole—at which point they pay 100 percent of their drug costs until they hit the catastrophic amount, even though they are still paying monthly premiums into the program.

So during the course of the year, a senior could have coverage one day, and the next day they could go to the pharmacy and be charged the full sticker price for the prescription drugs. That is the donut hole. It is not fair. It is outrageous.

Look at what they are paying now: Part A premium, zero. Part A deductible, for hospitalization, $876 per benefit period; Part B premium for doctors, $66.60 a month. The deductible is $100 a year with doctor visits. The cost share for doctor visits is 20 percent. That is straightforward, simple, and easy to understand. There are not income limits, asset tests, or anything else. It is just very straightforward. Seniors who have annual drug costs of $500 actually pay more into the program than what they receive. They would pay $500 for drugs, but they would pay $751.25 into the program. Tell me how fair that is. A senior with $1,000 in drug costs would pay $876.25. At the higher end, a senior with $5,000 in drug costs would pay nearly $4,000 for his or her drugs. What a deal. And for that, they get to read all these books every year. They get all these, I say to my friend from California, every year. And they have to try to decide. They can get bounced every year from one plan to another. For that, they pay $5,000, or they pay 4,000. It should not come as a surprise.

It is estimated that seniors, over the next 10 years, will have $1.8 trillion for prescription drugs costs, but we are allocating $400 billion to pay for it. Where did that money go? Well, it went to tax cuts. Hopefully, the people who voted for the tax cuts now will not bemoan the fact that we don't have the money. They voted to blow the money on tax breaks for the wealthy.

Now, let's look at one other thing. To make things even messier, this program would create several tiers of class under Medicare. Right now, you have one class. Everybody knows what he or she has to pay. Under the new program, we are going to classify you and have a lot of different strata here. There are different low-income benefits for those under 135 percent of the poverty level—$12,123, single—and another set of benefits for those under 150 percent of poverty—$13,470.

On top of that, to receive the low-income benefits, a senior has to undergo an asset test. Again, hang on here, folks. We will see if we can understand this. We will have a little test afterward. For those at 135 percent of the poverty level and below, the asset test is $6,000 for a single person, $9,000 for a couple. For the group at 150 percent of poverty and below, the asset test is different. In this group, a person cannot have more than $10,000 in assets, or $20,000 for a couple. Follow me?

So what you are going to have is this. I predict this is exactly what is going to happen. You are going to have seniors at the senior citizen center, or at the local McDonald's having a cup of coffee; and old Bob is going to say: You know, this thing they passed is a pretty good deal. I am getting all my free drugs and stuff like that. His friend, Sue, is sitting there and she might say: What are you talking about? I just took a job at the local supermarket bagging groceries or stocking shelves; I am retired and have Social Security, but I need to make ends meet and pay for my drugs. Because I took that extra job to help make ends meet, to pay for heating bills, to meet my drug costs—I took this job that doesn't pay a heck of a lot—minimum wage—but because I got bumped up a little, I don't get the same benefits you get, Bob. And Margaret, who is sitting there, thought she was going to get the low-income benefits, but she filled out her forms and found out she had too much life insurance, over $10,000 in life insurance. She cannot afford her medicine, but her life insurance is considered an asset.

If you are going to go to McDonald's in the morning and you are sitting and having coffee, they are going to talk about this. But for the spread of $25 a year—maybe $50 a year—one person will get great benefits and the other person won't. You tell me if this is not a formula for an uprising among the elderly. It is not rich and poor. I am talking about people who make $13,470 a year, or they make a little less than that.

Or $12,123 versus $12,150. That is the kind of difference you are going to have, and that is going to decide what you get. Then they are going to say: You know, old John over there is getting those low-income benefits, but, by gosh, he is cheating because I know he owns something else. He owns a better car than what he said or he has a little something stashed away someplace. How do we get those low-income benefits? We know he has more than that.

It is going to arouse suspicion among the elderly: Why do you get a better benefit than I get? We are both in the same boat, and you make 50 bucks more a year than I do and you get all these benefits and I don't.

Hang on to your hats. It is going to happen.

How are they going to know where they fit in? You will have several people who make nearly the same amount of money each year and they receive drastically different benefits. This is a formula for confusion and confrontation among the elderly.

Right now, there is only one group. When you have Part A deductible, you all pay. When you have a Part B premium of $66.60, everybody pays it. When you have deductible of $100, everybody pays it. When you have a Part B cost share of 20 percent, everybody pays it.

When they sit around McDonald's having their coffee in the morning, Bob isn't suspecting that Joe is getting away with something or that Sue maybe has a little something extra, and Margaret who took that job at the supermarket to have a little extra money doesn't feel as if she is discriminated against because she has a little extra pocket change. They all pay the same.

Wait until this program heads south. You just wait. You just wait and see what happens.

I don't know, did the authors of this bill deliberately design a system that is going to fail, that does more harm than good? There were a thousand pages delivered to us on Thursday. The drug and health industries are spending millions to ram this bill through immediately, even though seniors across the Nation don't know what is in it.

What is the rush, I ask again? It doesn't go into effect until 2006. What is the rush? Why must we pass this bill before seniors have had a chance to examine the provisions and voice their views?

I saw this cartoon in a newspaper from Newark, NJ. This is the cartoon. Here is the pharmacy and the pharmacist. This, obviously, is a senior citizen who has come in. She has a prescription to fill out. The pharmacist represents Congress. He is saying to her: Have a seat. It'll be ready in 2½ years.

That is what we are saying: Have a seat; in 2½ years, this will be ready. Why do we have to rush it through right now? Why do we have to fill the prescription now if she doesn't get it for 2½ years? Maybe we ought to write the prescription later on, next year after we have had a chance to really look at it.

I think seniors in this country deserve more. They deserve to be put first in the process. They have been given short shrift in this process by the corporate special interests who have a very different view about the direction of Medicare. As I said earlier this week, the stocks of pharmaceutical companies and health insurance stocks have gone up.

Maybe a lot of seniors assume that AARP would stand up for their interests; that AARP would come in here and stick up for them. But AARP, the American Association for Retired Persons, has brazenly betrayed the wishes of its members on this issue. Seniors with whom I have spoken from all across Iowa do not like this bill.

AARP came to Iowa late this summer and had three big town meetings on this drug bill. Several hundred people showed up. I was told when AARP presented it, they presented the House version and the Senate version, as we passed them, in a straightforward manner without editorializing whether one was better or worse or good or bad.

After presenting this to several hundred Iowans in three different locations, at every meeting, they asked the 200 to 250 people who showed up, all senior citizens: How many of you would sign up for this plan? Do you know how many hands were raised? Zero. Not one hand went up. Not one hand. Now AARP is saying this is a great bill. I don't know with whom they talked. When they talked to the elderly in Iowa, they didn't get any takers.

My constituents want an affordable, reliable benefit under the traditional Medicare Program. Seniors across the country agree. A poll released this week found that almost two-thirds of seniors view this bill unfavorably. Most of them identify themselves as AARP members. Among those, only 18 percent said Congress should pass the bill; 65 percent said Congress should go back to work on this bill. They need to know the direction Medicare is taking and whose side AARP is on.

It says everything about this bill that Newt Gingrich is urging Republicans to vote in favor of it. For those of you who have forgotten who Newt Gingrich is, he was Speaker of the House and was the one who uttered the famous phrase: It was his desire to let Medicare ''wither on the vine.''

Mr. Gingrich is one of those ideologs who insists the private marketplace will solve all the problems. It would make his day to see Medicare dismantled through privatization, and that is exactly why he is pulling out the stops in lobbying for this bill—because under this bill, Medicare not only withers on the vine, it is cut away from the vine.

This bill is a realization of Newt Gingrich's fondest dream: to end Medicare as we know it. I might also say that Newt Gingrich made no bones about it. He wanted to privatize Social Security—privatize it, put it out on the stock market. That is next. But he sees this as the first step to that privatization.

The newspapers have been full of accounts of Mr. Gingrich's ''pull out the stops'' lobbying for this bill. He says:

> Every conservative Member of Congress should vote for this Medicare bill.

I submit, if Newt Gingrich is for this bill, that is a serious red flag. That ought to raise a lot of questions because, as I said, Mr. Gingrich has made no bones about it—I give him marks for honesty—he has said time and time again that Medicare ought to wither on the vine; we ought to privatize Social Security. Not only does it privatize Medicare, it is a bonanza for Mr. Gingrich's corporate friends, the big money corporate interests.

This bill is like Christmas in November for Mr. Gingrich's corporate friends. It allows people to sock away thousands of dollars a year in tax-free medical savings accounts. Of course, the people from where I come don't have money for tax-tree accounts. It will be used mostly by the wealthy, not low-income seniors. Newt Gingrich is ecstatic. This Medicare bill is yet another tax cut bill with the benefits flowing overwhelmingly to the wealthy.

Here is more of what Mr. Gingrich has to say about this Medicare bill:

> I think this is one of the great historic moments in moving the Nation in a conservative direction.

He said—get this—this is Newt Gingrich:

> If you are a fiscal conservative who cares about balancing the Federal budget, there may be no more important vote in your career than one in support of this bill.

I guess as a supply-side zealot, he believes that the tax-cut provisions in this bill will help us balance the budget. That is bizarre. That is just bizarre. They just want to privatize Medicare. That is all they want to do.

They want to privatize Social Security. Mr. Gingrich claims that the shift towards medical savings accounts would be ''the largest change in health policy in 60 years.''

He made this claim to a gathering of his right-wing anti-tax enthusiasts at the Americans for Tax Reform headquarters in Washington. Of course, the head of Americans for Tax Reform, Mr. Grover Norquist, is famous for saying, ''My goal is to cut government in half, to get it down to the size where we can drag it in the bathroom and drown it in the bathtub.''

That includes Medicare and Social Security. That is part of his government. That is what he wants to drown in the bathtub.

So it is no wonder that Mr. Gingrich and his right-wing friends love this bill. Not only does it undermine a Government program that they despise; even better, it serves up another fat tax cut for the rich. Only the wealthy and healthy will benefit from this bill.

Mr. Gingrich is outspoken in his belief that pharmaceutical companies are getting unfair treatment and they are punished by their success. Well, Mr. Gingrich, that is wrong. This bill does not ask one penny from the pharmaceutical companies. In fact, it protects drug companies from Government efforts to negotiate lower costs. I am the first to support drug research and development, but the Medicare burden should not be taken solely out of the pockets of seniors and taxpayers.

In closing, I would have to ask: Exactly why are Newt Gingrich and AARP in the same bed? That seems odd. What are they up to? AARP's slogan is ''the power to make it better.'' They claim to represent American seniors. However, millions of seniors are furious that AARP has endorsed this lousy bill. As I said earlier, a Peter Hart poll found almost two-thirds of seniors viewed the bill unfavorably, and most of those were AARP members. Among AARP members, only 18 percent said we should pass this bill, while 65 percent said we had to go back to work on it.

Yesterday, AARP members from Maryland, New York, and Pennsylvania tore up their membership cards in front of their organization's Washington headquarters. AARP's Web site community message board is filled with outraged comments. Members are accusing William Novelli, CEO of AARP, of selling out to conservatives and Newt Gingrich.

Now, where, I wonder did they get that idea? In fact, the relationship between Newt Gingrich and the bigwigs at AARP goes way back. William Novelli, executive director of AARP, wrote the preface to Newt Gingrich's book, ''Saving Lives, Saving Money.''

In that preface, Mr. Novelli states that: Newt's ideas are influencing how we at AARP are thinking about our national role in health promotion and disease prevention and in our advocating for systems change. That is Mr. Novelli's preface in Newt Gingrich's book.

Well, I have to ask: Which of Newt's ideas are ''influencing how we at AARP are thinking''? Is it Newt's fond wish that Medicare ''wither on the vine''?

No wonder members of AARP feel so betrayed. I too feel betrayed that AARP's leaders have chosen to endorse the right-wing principles of this Medicare bill and endorse Newt Gingrich's ideas of how to undermine and privatize our Nation's health care system.

AARP's endorsement is disturbing for another reason. They have a flagrant conflict of interest in this matter. Bear in mind AARP receives vast revenues from the sale of insurance to seniors. Royalties from such arrangements include deals with United Health Care Insurance Company, Metropolitan Life Insurance Company, and Advanced PSC Pharmacy Benefit Management, accounted for more than one-third of AARP's $636 million in revenues last year, according to AARP's 2002 annual report. There we have it. AARP is looking at the insurance end of it, of course.

American seniors deserve better from the AARP and from Congress. They deserve a bill that includes an affordable prescription drug plan, that strengthens Medicare, that does not penalize the sickest and the poorest in our Nation.

This bill reflects the priorities of this Republican administration and of Newt Gingrich who have been hostile to Medicare since its inception. This bill needs to be written by individuals and groups that believe in Medicare, not those who want to undermine it. Seniors know that this bill is a betrayal. They know who the winners and losers are with this bill.

Under premium support, HMOs, PPOs, and pharmaceutical companies, they win; seniors and the disabled lose. Under cost containment, the private companies win; the seniors and disabled lose. Under drug coverage, pharmaceutical companies win; seniors lose. Under health savings accounts, the wealthy HMOs win; seniors and disabled lose. Under the so-called stabilization fund, this slush fund, HMOs, PPOs, and pharmaceutical companies win; seniors and the disabled lose. Under so-called competition—boy, there is a misnomer if I have ever heard it—HMOs, PPOs, and pharmaceutical companies win; seniors and disabled lose.

The seniors know this. Again, it is a question of priorities. This administration rammed through this Congress $1.6 trillion in tax cuts. Now they say they cannot take care of the elderly who have worked their entire lives, contributed to their communities and served this country. Once again, the administration has made a clear choice. They have chosen the folks on Wall Street over the folks on Main Street.

It is a big deal. I got to thinking the other day. I talked about how my father, during the Depression—I was born November 19, 1939. I just had my birthday this week. In 1939, my father was out of work. He had a wife, five kids, and one on the way. I was the sixth one. He had no money. He had an eighth grade education. My mother was an immigrant who had no formal education. They lived in a small house in a small town in rural Iowa, and my father had no hope. He was already 54 years old, had worked in the coal mines most of his life, and the only thing they had was this tiny little house in this small town.

As I walk out of my door every day, I have on my wall a little framed orange piece of paper. It is dated July 19, 1939, 4 months to the day before I was born. On that orange piece of paper, it is printed and it says: You, Patrick F. Harkin—that is my father—are to report to work at once as a laborer on a project, $48.30 a month. It was signed by somebody, and then my father signed it—4 months to the day before I was born. It was his WPA form when my father went to work on a WPA project.

Now, I look at that because I remember once George Bush, when he was a candidate for President, said: Government cannot give hope to people. Every day when I walk out of my office and I look at that piece of paper, I say: Mr. Bush, you are wrong. If it had not been for Franklin Roosevelt and the New Deal, I do not know what would have happened to my family and my father. They gave him a job. They gave him hope.

Years later, when I was in high school, my father took me to some of those projects he built. One of them was at Lake Okoboji. It is still in use as a recreational facility in Iowa; a high school in Indianola is still being used today built by WPA. Why do I say that? Because I got to thinking about the new deal and I got to thinking, it was a Government program, Roosevelt's New Deal. Who was the benefactor? The unemployed. To my father, who had no hope, it gave him hope and it gave him a job.

Then we had Truman's Fair Deal, and who benefited from that? The uninsured and low-wage workers.

Today we have a new Government program that they are trying to push on us, Bush's Big Deal. Not the New Deal, not the Fair Deal, but the Big Deal. Who wins? The HMOs, big pharmaceutical companies and private health plans. I call it the Big Deal because the bigger you are, the better the deal. Compare that to Franklin Roosevelt's New Deal and Harry Truman's Fair Deal, that reached down and helped bring people up. No, today we have the Big Deal: the bigger you are the better the deal.

This is a radical departure for Medicare. It changes the nature of this program as an entitlement. The conferees set an arbitrary cap on how much Medicare money can be spent. Instead of a cap, we ought to just be spending the money more wisely. We ought to be spending less on HMO subsidies, less on subsidies to the pharmaceutical companies, and more on preventive health care, keeping our seniors more healthy, getting them better diets and better exercise—more preventive health care to keep them healthy.

This is an article called ''Entitlement Change Is Inevitable, Key Administration Officials Say.'' They went on to say: ''In the long run, Social Security cannot meet its commitments.''

That seems to be the constant refrain we hear from this administration. Social Security cannot meet its commitments. Of course not; we just took the huge surplus that had been built up under the Clinton administration and we squandered it on tax breaks for the wealthy.

I say again, the amount of money going out in tax breaks to the wealthy in our country that was passed in 2001 and 2003, over the next 75 years, is three times more than what is necessary to ''save Social Security and Medicare.'' Don't tell me that the money is not there and that Social Security can't meet its commitments. It can't meet its commitments now because we squandered all the money on tax breaks for the wealthy. Sure, Medicare is headed for a train wreck, but it is a train wreck planned and plotted by this administration.

You can be sure as soon as this bill is out of the road they are going to start on Social Security. Headline: ''Bush Pushes For Expanded Private Role in Medicare.'' That is what it is all about.

''The foundation of this . . . compromise—is a level playing field between Medicare and private plans,'' said Senator Edward Kennedy. ''What conservative Republicans are now trying to do is rig the system in a way that would coerce senior citizens away from Medicare and into private plans.''

Senator KENNEDY said it right.

To be fair it is not just Mr. Gingrich and Mr. Bush who are hostile to the Medicare Program. Many others share their views.

The junior Senator from Pennsylvania and third ranking Republican, Mr. SANTORUM, said—I believe this is a direct quote:

I believe the standard benefit through the traditional Medicare program has to be phased out.

That is the third ranking Republican on that side of the aisle.

The junior Senator from Utah, Mr. BENNETT, has said:

Medicare is a disaster. Medicare will have to be overhauled. Let's create a whole new system.

Tom Scully, head of the Centers for Medicare & Medicaid, the top Medicare official in the Bush administration, said this about Medicare; he called it ''an unbelievable disaster'' and a ''dumb system.''

Medicare is not a disaster or a dumb system in the eyes of millions of seniors who rely on it every single day. As

I said, this is too big an issue to address in a day or 2 days.

We have to act now, we are told.

Nonsense. The provisions in this bill don't kick in until 2006. We received the bill on Thursday, this right here. We received it this morning on our desks. We didn't have time to look at it. We ought to withdraw the bill, get it out to the public, and bring it back for consideration in February. That will allow time for seniors back home to analyze it, discuss it, and share their views with Members of Congress. Then we can take an informed vote on this bill, taking into consideration the views of seniors in our respective States.

This is the Senate, supposedly the world's greatest deliberative body. We can take more time, as we did last week, in going all day and all night and all day and all night, talking about four judges who were held up—we can take more time to do that than we can to debate and discuss this profound change in Medicare in the United States. What does that say about the state of affairs in the Senate today? Oh, yes, we can deliberate over four judges—168 that got approved and 4 that didn't. We can talk about that for days or weeks on end. But, no, to discuss this profound change in Medicare we take Saturday and Sunday and vote on Monday.

The Senate has ceased being the world's most deliberative body. It is now the world's most rushed body: Rush it through, stampede it, and get it done. This is a complex, confusing, bureaucratic nightmare of a bill. It is a bad bill procedurally.

This bill contains untested experimental privatization plans that especially threaten seniors in rural areas. To top it off, it offers yet another big tax break for wealthy Americans.

There is supposedly a fix in this bill for the disparities. There is supposed to be fairness, in terms of addressing the disparity between the States, in reimbursement for Medicare on a per beneficiary basis.

I have taken the floor many times to talk about how Iowa is No. 50 in the Nation in the per beneficiary reimbursement for Medicare. So Iowa has been 50th out of 50 States.

This bill was supposed to have a fix in it to make it more fair. So they put, I think, $25 billion into this bill to make it more fair over the next 10 years. Right now, the per beneficiary reimbursement in Louisiana is $7,336. In Iowa it is $3,053. In Virginia it is $4,611.

I say to the occupant of the chair, the citizens of Virginia pay the same Medicare taxes as anybody else in this country. Yet the seniors in Virginia get back $4,611 per beneficiary, the seniors in New York get $6,924; the seniors in Texas get $6,539; the seniors in Maryland, right next-door, get $6,301, but in Virginia they only get $4,611 per beneficiary. In Iowa it is $3,053. Yet we pay the same Medicare taxes.

So we have been fighting for a long time to try to straighten this system out and make it a little bit more fair.

They put some money in the bill. But guess what they did—they made it worse because what they basically did is they kind of gave a percentage increase. You know how that works.

If you get $100 and I get $10 and we get a 10-percent increase, you get a lot more money than I get. Right now, Iowa, we are 50th. Louisiana is first in terms of how much money they get per beneficiary. Now we are 50th. The disparity in payments for seniors between Iowa and Louisiana is $4,685. In other words, a beneficiary in Iowa gets $4,685 less. We get less in reimbursement per beneficiary than it cost Louisiana. Under this bill, supposedly meant to fix this, Iowa is still last. We are number 50th. The disparity has gone from $4,685 per beneficiary to $5,017 per beneficiary. It is worse. This was supposed to be fairness?

There are some who will say that Iowa, in terms of the beneficiary and the amount of money they got, is 13th. That is all right. It may be 13th. But other States are more.

As you can see, it increases the disparity rather than lessening it. That is what we want to do—lessen the disparity in the States.

Lastly, the Washington Post this morning said it all. ''2 Bills Would Benefit Top Bush Fundraisers.''

At least 24 Rangers and Pioneers could benefit from the Medicare bills as executives of companies or lobbyists working for them, including 8 clients affected by both bills.

Meaning the Energy bill. ''Pioneer'' is someone, I guess, who raises $100,000 for the President, and ''Ranger'' is someone who raises $200,000 for the President.

I ask unanimous consent that the article be printed in the RECORD.

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

2 BILLS WOULD BENEFIT TOP BUSH FUNDRAISERS

(By Thomas B. Edsall)

More than three dozen of President Bush's major fundraisers are affiliated with companies that stand to benefit from the passage of two central pieces of the administration's legislative agenda: the energy and Medicare bills.

The energy bill provides billions of dollars in benefits to companies run by at least 22 executives and their spouses who have qualified as either ''Pioneers'' or ''Rangers,'' as well as to the clients of at least 15 lobbyists and their spouses who have achieved similar status as fundraisers. At least 24 Rangers and Pioneers could benefit from the Medicare bill as executives of companies or lobbyists working for them, including eight who have clients affected by both bills.

By its latest count, Bush's reelection campaign has designated more than 300 supporters as Pioneers or Rangers. The Pioneers were created by the Bush campaign in 2000 to reward supporters who brought in at least $100,000 in contributions. For his reelection campaign, Bush has set a goal of raising as much as $200 million, almost twice what he raised three years ago, and established the designation of Ranger for those who raise at lest $200,000.

With the size of donations limited as a result of the campaign finance law enacted last year, fundraisers who can collect $100,000 or more in contributions of $2,000 or less have become key players this election cycle. The law barred the political parties from collecting large—sometimes reaching $5 million to $10 million—''soft money'' contributions from businesses, unions, trade associations and individuals. This has put a premium on those who can solicit dozens, and sometimes hundreds, of smaller contributions from employees, clients and associates.

The energy and Medicare bills were drafted with the cooperation of representatives from dozens of industries. Power and energy company officials; railroad CEOs' pharmaceutical, hospital association and insurance company executives; and the lobbyists who represent them are among those who have supported the bills and whose companies would benefit from their passage.

The Medicare bill was scheduled to be acted upon by the House late last night. If passed, it will go to the Senate. The first comprehensive revision of energy policy in more than a decade passed the House this week, but in the Senate, the measure ran into a roadblock yesterday when opponents stopped it from coming to a vote. Sponsors promised to make further efforts to get the 60 votes to break the filibuster.

The energy bill provides industry tax breaks worth $23.5 billion over 10 years aimed at increasing domestic oil and gas production, and $5.4 billion in subsidies and loan guarantees. The bill also grants legal protections to gas producers using the additive methyl tertiary-butyl ether (MTBE), whose manufacturers face a wave of lawsuits, and it repeals the Public Utility Holding Company Act (PUHCA), a mainstay of consumer protection that limits mergers of utilities.

The bill has been the focus of a bitter ideological and partisan fight for three years. A leading sponsor, Rep. W.J. ''Billy'' Tauzin (R–La.), chairman of the House Energy and Commerce Committee, praised the legislation, saying, ''All Americans can look forward to cleaner and more affordable energy, reliable electricity and reduced dependence on foreign oil for generations to come.''

Public Citizen, which has tracked the legislation and correlated patterns of contributions to members of Congress and to Bush, denounced the bill as ''a national energy policy developed in secret by corporate executives and a few members of Congress who are showered in special interest money.''

Perhaps the single biggest winner in the energy bill, according to lobbyists and critics, is the Southern Co. One of the Nation's largest electricity producers, it serves 120,000 square miles through subsidiaries Alabama Power, Georgia Power, Gulf Power, Mississippi Power and Savannah Electric, along with a natural gas and nuclear plant subsidiary.

The repeal of PUHCA, for example, would create new opportunities to buy or sell facilities; ''participation'' rules determining how utilities share the costs of new transmission lines that are particularly favorable to Southern; two changes in depreciation schedules for gas pipelines and electricity transmission lines with a 10-year revenue loss to the Treasury of $2.8 billion; and changes in the tax consequences of decommissioning nuclear plants, at a 10-year revenue loss of $1.5 billion, according to the Joint Committee on Taxation.

At least five Bush Pioneers serve as a Southern Co. executive or as its lobbyists: Southern Executive Vice President Dwight H. Evans; Roger Windham Wallace of the lobbying firm Public Strategies; Rob Leebern of

the firm Troutman Sanders; Lanny Griffith of the firm Barbour Griffith and Rogers; and Ray Cole, of the firm Van Scoyoc Associates.

The railroad industry also has a vital interest in the energy bill. For years, it has been fighting for the elimination of a 4.3 cent-a-gallon tax on diesel fuel, and, at a cost to the Treasury of $1.7 billion over 10 years, the measure repeals the tax. Richard Davidson, chairman and CEO of Union Pacific, is a Ranger, and Matthew K. Rose, CEO of Burlington Northern, is a Pioneer.

Among the major lobbying firms in Washington, Akin Gump Strauss Hauer & Feld has been one of the most successful collecting fees for work on the energy and Medicare bills. In the first six months of this year, Akin Gump, which has two partners who are Prioneers—Bill Paxon and James C. Langdon Jr.—received $1.6 million in fees from medical and energy interests.

Mr. HARKIN. Mr. President, I apologize to my fellow Senators. I have taken a long time. I have taken over 1 hour and 15 minutes, I believe. But I believe we ought to take a lot longer than that. I think we ought to get this bill out of here, send it into the countryside, let people see it, and come back in February rather than taking Sunday, Monday, Tuesday. Let us, as I said, take a week or two to get into this bill, debate it, discuss it, and yes; and amend it if we need to, rather than being ramroded through as they are doing.

If the seniors reject it, then we can reject it and go back to the drawing board. We should not at the eleventh hour when people want to go home for Thanksgiving be stampeded to support a bad bill, a bill that will destroy Medicare as we know it.

I yield the floor.

The PRESIDING OFFICER. The distinguished Democratic leader.

Mr. REID. Mr. President, I know the distinguished Senator from Missouri is anxious to speak. He is going to visit his son who is coming home on leave from the Marine Corps.

I will be very quick. Following the Senator from California, Mrs. BOXER, our next speaker will be Senator LINCOLN. Tomorrow, the Democrats, other than those we have already lined up—the last Member we lined up I believe was Senator KERRY—would be Senators WYDEN, LEVIN, KENNEDY, MURRAY, DORGAN, CORZINE, and AKAKA.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Mr. President, reserving the right to object, I want to ask a question. In the process of reserving the right to object, I want to know how much time has been used on the respective sides.

Mr. REID. Mr. President, I have spoken to the Parliamentarian. The opponents of this legislation have approximately 2 hours left tonight before 11 o'clock.

The PRESIDING OFFICER. The proponents have 3 hours 57 minutes remaining, and the Senator from Nevada, the assistant Democratic leader, is correct in his estimate.

Mr. GRASSLEY. I have no objection.

Mr. REID. Mr. President, following Senator AKAKA, we would like to have Senators JOHNSON, DAYTON, BINGAMAN, and Bill Nelson.

The PRESIDING OFFICER. If there is no objection, the Chair is prepared to rule.

Without objection, it is so ordered.

The Senator from Missouri.

Mr. BOND. Mr. President, I ask unanimous consent that I may go out of order to speak for 5 minutes prior to Senator HATCH, and then Senator HATCH may be recognized.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BOND. Mr. President, I am most grateful to my colleagues. I have been here on the floor for 3 scintillating hours, and I have other commitments that I have to make.

Early this morning the House passed historic bipartisan legislation to improve and strengthen the Medicare program and give all seniors access to prescription drug coverage. Seniors will finally receive the prescription drug coverage they need and the health care security they deserve.

This Medicare conference report is a compromise in the truest sense of the word. It is not perfect—some on the far left don't like it and some on the far right don't like it either. But I will tell you who does like it: The AARP—this agreement has been endorsed by the leading voice for older Americans—representing 35 million members nationwide and 743,000 members in my home State of Missouri. As well as the hospitals, doctors, other health care providers and employers.

Why do these groups support this bill? Because in AARP's own words, ''This is about getting vital help to people that need it most.''

Before I talk about some of the strengths on this bill I wanted to take this opportunity to address some of the criticism from my friends on the other side of the aisle. I have heard some Members say that this bill ''keeps drug prices high.''

That is untrue. Seniors will realize significant savings off their current drug bills under this bill. In 2004–2005, senior citizens will receive a Prescription Drug Discount Card that the Department of Health & Human Services—HHS—estimates will cut drug costs by up to 25 percent.

In 2006, the prescription drug benefit is added to Medicare that HHS estimates will help seniors currently without coverage save up to half off what they're paying today. For the typical senior who spends $1,285 a year on prescription drugs, more than $640 they get to keep in their pocket translates into significant savings.

Lastly, the bipartisan Medicare plan also ensures generic drugs, less expensive than brand-name pharmaceuticals, are moved to market much faster to help hold down costs.

I have heard some members say that this bill will ''cause two to three million retirees to lose drug coverage.'' This bill contains $88 billion worth of employer incentives to help protect retirees' private coverage. This bill will actually strengthen the safety net for seniors by providing financial incentives for employers to continue offering prescription drug coverage for their retirees.

This marks the first time that Medicare will provide a federal subsidy of 28 percent of beneficiaries' drug costs between $250 to $5,000—up to $1,330 per beneficiary. This subsidy is excluded from taxation, providing another incentive for employers to offer coverage.

Lastly, qualified retiree plans have maximum flexibility on plan design, formularies and networks, and allows employers to wrap-around Medicare coverage options. That is why the AARP and major employer groups, such as the National Association of Manufacturers, Employers' Coalition on Medicare, Chamber of Commerce and Business Roundtable, endorse the bipartisan Medicare plan. Some Members have said this bill is ''bad for seniors'' and cited a recent Consumers Union report.

Truth is this Medicare bill provides help to the two groups that need it most—low income seniors, and seniors with high drug costs. Even Consumers Union acknowledges that low-income seniors ''will be eligible for substantial subsidies for their prescription drugs.'' Consumers Union also acknowledges that seniors with catastrophic drug expenditures get ''measurable relief'' under the bill, which will cover 95 percent of a senior's drug costs over $3,600. In other words, the Medicare bill provides help to the two groups that need it most—low income seniors, and seniors with high drug costs.

And finally some have claimed that this Medicare bill will destroys Medicare as we know it and privatize the whole program. That is one of my personal favorites. Bottom line is the AARP would never endorse a bill that privatizes or in any way destroys the Medicare program period.

I will support this bill because it is the first major upgrade to Medicare in 38 years, providing help to the two groups that need it most—low income seniors, and seniors with high drug costs.

For nearly four decades, Medicare has provided peace of mind and health care security for millions of seniors. Yet, increasingly this cherished program is no longer meeting the security needs of our seniors. Medicine has advanced exponentially since 1965, but the Medicare Program has not kept pace. When Medicare was launched 38 years ago, modern medicine meant surgery and hospitalization—and that is what Medicare covers.

Today, doctors routinely treat their patients with prescription drugs, preventive care and groundbreaking medical devices—but Medicare has not kept pace with these changes.

For example, today Medicare covers only about half of the typical seniors'

health care costs. Medicare lacks good preventive coverage, wellness care, and chronic disease management. It doesn't even cover the costs of an annual physical. It does not protect against large, catastrophic health costs should serious illness strike. And we all know that it does not cover outpatient prescription drugs.

Additionally, the program faces serious financial and demographic pressures in the coming years. Between now and 2030 the number of seniors will nearly double from 40 million to 77 million. The program's costs will more than double to nearly $450 billion annually, even before we add prescription drug coverage or improve other benefits. And the number of taxpayers paying into the system to finance health coverage for seniors will drop from 4 today to 2.4 by 2030. This underscores the need to act and the need to act responsibly. We need to improve the program for today's seniors but we also need to put in place a more stable structure that will provide health care security for generations to come.

My goal is and has always been to give seniors the best, most innovative care. This will require a strong, up-to-date Medicare system that relies on innovation and competition, not bureaucratic rules, price controls and regulation.

The bill before us takes a bold new step and is an important achievement in the effort to strengthen and improve Medicare and provide meaningful prescription drug benefits to seniors. This bill offers beneficiaries a meaningful and reliable drug benefit through the private sector, with reasonable and fair cost-sharing. Beneficiaries will have the ability to receive the drugs of their choice without government interference and with better coverage options.

Most importantly, it will provide prescription drug coverage at little costs to those who need it most—people with low incomes. It will provide substantial relief to those with very high drug costs and relief to millions more. In a country as prosperous as ours, we can no longer tolerate situations where seniors have to split their pills in half or cannot fill necessary prescriptions because they can't afford the vital drugs they need.

This bill ensures access to drug benefits for beneficiaries who live in rural areas. Reliable coverage will be available everywhere in Missouri—wherever there is Medicare coverage, there will be prescription drug coverage.

As we work to implement this new Medicare benefit, this bill will provide immediate prescription drug assistance for beneficiaries through a temporary drug discount card available to seniors 6 months after the bill is signed into law.

This discount card is expected to yield a savings of between 10 and 25 percent. Some of our most vulnerable seniors would receive an additional $600 subsidy annually to assist with the purchase of prescription drugs. This drug card would be available until the Medicare prescription drug benefit is fully implemented in 2006. Adding vital prescription drug coverage is not the only thing that we are doing to improve Medicare coverage for seniors.

Medical experts long ago learned that preventive care extends and improves quality of life. The bill before us today adds vital preventive care, wellness services, and chronic care management. This long overdue step will keep seniors healthy and will save money and most importantly save lives.

This bill also includes $25 billion in new assistance to ensure patient access to hospitals, doctors and other health care providers, especially in rural areas. The Medicare bill corrects existing rural inequities by infusing billions of dollars over the next decade into rural and small towns as well as small hospitals everywhere.

Admittedly I remain concerned about the magnitude of the reductions in payments for cancer care included in the bill. I hope to work with the Senate leadership as well as Chairman GRASSLEY and Senator BAUCUS moving forward to ensure that these cuts do not threaten access to cancer care for patients in Missouri and across the country.

We must bring Medicare into the 21st century: add a prescription drug benefit, expand coverage, improve services, and give seniors more control over the health care they receive.

This week we are poised to make historic changes with bipartisan support to improve the Medicare Program, to strengthen it for seniors and to preserve and protect it for future generations.

I want to say why I am in favor of this Medicare conference report. I think that Senator GRASSLEY and Senator BAUCUS, in a bipartisan coalition, came up with a great compromise. Nobody should be surprised that it makes enemies left and right. That is what a compromise or a moderate proposal does.

I will tell you one group that is for it. That is the AARP, with 35 million members nationwide. There are 743,000 seniors in my State who have been deeply involved in the preparations of this legislation. They say it is a good deal because it is about getting the vital help to people who need it most.

I was a little amused hearing some of the folks on the other side of the aisle condemning AARP. Generally, AARP may side with the Democrats, but in this instance we have worked with them and on a bipartisan basis. It isn't just Republicans. Now that they endorse a bipartisan compromise, rather than going with the Democrats, they condemn them.

Let me just talk about a few of the misconceptions I have heard in the last 3½ hours: Drug prices will be high. There will be a senior citizen discount card with a 15 to 25 percent reduction; $600 for low-income seniors the next couple of years. HHS estimates in 2006 the typical senior will save approximately half of what he is paying today. This plan also ensures the less expensive generic drugs will get the market faster, helping to hold down the cost.

Some have said this is bad for seniors. The truth is that the Consumers Union acknowledges it will help the two most needy groups—the low-income seniors and those seniors with high drug costs. These are the people who really need the help.

Finally, this is the favorite charge: Some have said this is going to destroy Medicare; that it is going to privatize it. That is really one of my personal favorites.

I think the Senator from Utah, Mr. BENNETT, did a wonderful job of pointing out some of the demagoguery we hear when people talk about destroying Medicare.

There are problems in Medicare with the way it is administered. Senator BENNETT outlined quite a few of those. We can tell you about a lot of problems. I have staff people who work all the time helping people sort through Medicare.

To say that the Republicans and the Bush administration want to destroy it is a big, fat, flat lie. No matter how many times you repeat it, it is not true.

The whole purpose of this is to assure that there is a reliable drug benefit and health care benefit for seniors now and in the future. We are asking the next generation to pick up the ball for a $400 billion, 10-year plan that is going to continue to grow, and we owe them the solid viable Medicare program that is still in operation when they reach Medicare-eligible age.

One of the problems that Senator COLLINS of Maine discussed which she and I have been fighting with the former Health Care Financing Administration, HCFA, is they were ordered to save some money in Medicare. They squeezed it down so tightly that instead of saving $16 billion a year, they cut the cost by $64 billion a year, and they threw one-third of the home health care agencies out of business in Missouri.

Seniors could not get the home health care they needed because of HCFA. Somebody said the costs are not going up. The problem with Medicare is fewer and fewer doctors and hospitals can afford to take it because the Federal bureaucracy has ground down the reimbursements.

Then someone said Newt Gingrich wanted to abolish Medicare or have it wither away. That is absolutely flat wrong. Members cannot use that form of demagoguery in this body and expect to get away with it. Former Speaker Gingrich said HCFA is a problem. Frankly, I can show case after case after case where HCFA and the bureaucracy were a problem. He wanted to change the system so that seniors got good health care and you did not have a bureaucracy ratcheting down

and controlling prices so rural hospitals such as a hospital in my home State could not afford to take seniors and doctors had to say: We cannot take any more Medicare patients because we are getting reimbursed from Medicare less than it costs us and we cannot give balanced billing so we have to arbitrarily ration on health care to the elderly because of the way Medicare is implemented.

That is wrong. That is what this bill is going to improve. I hope my colleagues will look at the significant improvements this $400 billion, 10-year bill will bring to improving health care for seniors and giving the seniors now better health care and assuring that seniors in the future—the current generation will be paid for—have the health care when they need it.

I thank my colleagues. I yield the floor.

CLOTURE MOTION

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, I send a cloture motion to the desk and ask unanimous consent that it be in order at this time.

The PRESIDING OFFICER. Without objection, it is so ordered. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the conference report to accompany H.R. 1, the Medicare Prescription Drug and Modernization Act, 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.

Bill Frist, Charles Grassley, John Ensign, Ted Stevens, Susan Collins, Lisa Murkowski, Jon Kyl, John Cornyn, Orrin G. Hatch, Larry Craig, Craig Thomas, Robert F. Bennett, Olympia J. Snowe, Jim Bunning, Christopher Bond, John Warner.

Mr. FRIST. Mr. President, I ask unanimous consent that the live quorum under rule XXII be waived.

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

Mr. FRIST. Mr. President, I regret that it has become necessary to file a cloture motion on this bipartisan legislation being considered on the floor of the Senate. However, it appears that at this juncture we have no option.

I do want to express my deep disappointment that the senior Senator from Massachusetts has stated he intends to filibuster this landmark legislation. I seriously hope he will reconsider these intentions. His decision is particularly disappointing because it is clear to those of us who have followed this debate for the last several months, indeed, over the course of the day, that there is a strong bipartisan majority in this body in favor of this Medicare prescription drug legislation.

I am equally disappointed because it really points to what is going to happen to 40 million seniors in America today.

They have waited 38 years for what we are about to accomplish, and that is access, affordable access to prescription drugs. Prescription drugs are not a part of Medicare today for those 40 million Americans, and they will be once this legislation is passed. They are just moments away from what they desperately need, desperately have asked us for, and what we have a responsibility to deliver.

Senator KENNEDY has said that he intends to block the vote or do everything within his power to block an up-or-down vote; that he will obstruct a bipartisan Senate majority, and that he will stand in the way of health care security for these millions of seniors and individuals with disabilities.

In my own State of Tennessee, there are nearly a quarter million seniors who have no prescription drug coverage. There are millions all across the United States for whom this legislation means the difference between life and death. They simply cannot afford to wait any longer.

This generation that will be served by this legislation has survived the Depression, has fought in World War II, has helped make the United States into the prosperous Nation that we have. Again and again, they have answered the call. Now is the time for us to fulfill our duty to that generation, many of whom, as we all know, are sick and poor. Now is the time for us to answer their call. That is what this legislation does.

Those who would support a filibuster of this bill would hold our parents and grandparents, 40 million seniors, hostage to Washington politics. Our seniors simply deserve better.

In 1965, when President Johnson signed that Medicare bill into law, he said:

No longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this . . . country.

Let us not stay that hand of justice now. Let us not turn our back on America's seniors and individuals with disabilities.

Once again, I regret this cloture motion is necessary, but we do need to protect our seniors. As I have said, for many this is a life-or-death issue. They simply cannot wait for help. I hope that, working with the minority leader, we can move toward vitiating this cloture motion at the appropriate time and, working together, schedule an up-or-down vote on this vital measure.

I implore the senior Senator from Massachusetts to listen to his own words of November 5 this year when he said:

Senior citizens want help and they want it now. They don't want a partisan deadlock.

I think he was right then. I believe he is wrong now.

Mr. REID. Mr. President, I apologize to the Senator from Utah. If the Senator will allow me to ask a couple questions, through the Chair, I appreciate the majority leader coming in an hour earlier tomorrow. We have 15 speakers lined up on our side for tomorrow. We are going to try to work out some kind of time arrangement. I say to the staff listening, what we would like to do on our side is limit the time to a half hour each. If anybody has any objection to that, they should call here as soon as they can. Otherwise, it is unfair to people who are at the bottom of the list.

I also say to the majority leader, we have gotten a number of calls today about this being the last item of business before we go home until January. I know the majority leader is working on that. I hope that is the case. Some of our folks are willing to give up time and do various things as a result of family obligations they have at home. If they have to come back again after Thanksgiving, I think their family obligations will become so paramount that they may not be as cooperative as we would like them to be.

Mr. FRIST. Mr. President, the Democratic leader and the leadership on both sides of the aisle have been in conversation throughout the day. Our intention is to continue to address Medicare aggressively and I have a feeling we will be here for a while tonight to give people an opportunity to speak.

Tomorrow, we are going to start earlier, and we will run as late as necessary to give people the opportunity to speak.

Regarding Monday, I want to warn people a little bit because people who want to speak, I encourage them to come tonight, tomorrow, or tomorrow night. Monday, I have a feeling everybody is going to come back in and say: I want to speak.

In order to complete Medicare on Monday and to address the appropriations bills we are working together on, we can address that on Monday and Tuesday—to finish business and be gone for good, which is what we are working toward, so we don't have to come back after Thanksgiving. That is the objective of both sides of the aisle. It means we have to continue doing what we have done all day today, tomorrow, and Monday. We need to stay focused, keep our remarks short enough so everybody can participate. With that, I intend not to have to come back after the Thanksgiving holiday.

Mr. REID. Mr. President, briefly, I appreciate very much the majority leader mentioning that. We have had people say they want to speak Monday. What I have said is that we can have 90 minutes per side on Monday. That is my understanding, having spoken to the two leaders. People will only have very short periods of time because the managers will need to make the paramount arguments on Monday. You are absolutely right. For people wanting to come back, the time is going to be very minimal. I appreciate that from the majority leader.

Mr. FRIST. I thank the Senator.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. GRASSLEY). The Senator from Utah.

Mr. HATCH. Mr. President, I have sat here for hours now and listened to some of the comments by our colleagues on the other side. They must not have paid any attention to what this bill is all about or any attention to what the conferees, who worked day and night, did to put this bill together in a bipartisan way. They must not have paid any attention to the words in the bill or paid any attention to their respective caucus meetings where we discussed the aspects of it.

When a Senator said this bill is being ramrodded through, I want to make it clear that we have been trying to improve Medicare for 40 years, especially in the last 10, 15 years. That is hardly ramrodding it through.

This is it. This is the last chance to have prescription drug benefits for our seniors. It is amazing to me how many on the other side just want to say no to anything: No to judges. No to prescription drug benefits unless they are way out of sight as far as expenses go. No to any possible private sector improvements that might possibly work. No to all the ideas that Democrats and Republicans have worked on, 7 o'clock in the morning meetings, 3 o'clock to midnight, in the afternoons, day after day after day, week after week. We were not doing that for our fun. We were not doing that for political reasons. We were not doing that to try to hurt one side or the other or to make political points on one side or the other.

We were doing it the best we could to try to come up with a bill that would improve Medicare and get prescription drugs to our seniors who need them, who do not have drug coverage right now, or who do not have access to drugs because they cannot afford to pay for them.

We take care of beneficiaries from 150 percent of poverty or less. If I had my way, the whole $400 billion would have gone to those at 200 percent or 250 percent or less and we would not have made any benefits for people such as Bill Gates and Warren Buffett, billionaires who can afford their own prescription drugs. But no, there is a desire by some on the other side to have what is called ''universal'' health care. That is, the Federal Government controls everything, pays for everything, and we have socialized medicine. Not many people who think it through want to go to that extent. That is why they are not getting their way so they will continue to moan and groan. One of the most offensive things of all is the people whom AARP basically have supported through all these year, the Democrats, and some of these Democrats condemning AARP for supporting this legislation.

I have seen Democrats stand on the floor and put the AARP's number up and tell people to call AARP and tell AARP they are wrong.

We are here to make decisions as to what should be done. The decisions cannot always be no, no, no.

I have to admit I was irritated with my party in times past because we seemed to say no to everything the Democrats wanted. I will state what is really behind this. Many of our colleagues who are against this on the other side just plain do not want President George Bush to get any credit for this Medicare reform bill. They cannot tolerate that this President has called for this, has fought for this, has provided a climate for this, has a bureaucracy working for this, has his staff working for this, has helped us every step of the way. Health and Human Services Secretary Thompson, as tough as it was to sit in those meetings, said virtually every one of these meetings was tough on him. There were a lot of tough discussions.

They are so afraid President Bush might get some credit for enacting a prescription drug law. President Bush will probably be the last one to take credit for it, although he deserves credit for it because he has been a leader who has helped to bring this about. And he would deserve the credit. But so would every Democrat who votes for this. Above all, Senators Baucus and Breaux, who sat through every one of those meetings. They deserve a lot of credit for not letting politics distort their worldview of what should be done and for standing up for this bill. It is one of the reasons the AARP is for this bill.

Another reason happens to be our two leaders: Speaker of the House DENNY HASTERT, and of course our majority leader in the Senate, Dr. FRIST, who has worked with these problems his whole professional lifetime. He has wanted to get this done as much as, if not more than, anyone else. And Senator GRASSLEY worked day and night on this with his staff. We could not have a better person.

Then we have cheap politics because they know former House Speaker Newt Gingrich has not always been the most followed person in this world even though he is one of the brightest people with one of the brightest political minds in America today. So what do they do? They distort what former House Speaker Newt Gingrich said—not only distort it, they do it downright offensively. I am frustrated by the continued references to the alleged comments by the former Speaker of the House about the ''Medicare Program,'' and those who insist that the former Speaker wanted Medicare to wither on the vine. We have heard it all day long by these people who are against everything. They are sadly mistaken. They are misrepresenting his remarks.

What the former Speaker said was that the agency that controlled Medicare, HCFA, the Health Care Financing Administration, which has evolved into CMS, said that HCFA should wither on the vine because that bureaucracy was so filled with command-and-control bureaucrats who were more concerned about redtape than seniors' health.

That is a far cry from condemning Medicare, which is the way they would present it. I personally resent that kind of distortion of what the former Speaker of the House had to say. Gingrich believed these bureaucracies were strangling Medicare. If anything, he was standing up for Medicare. He was arguing against large bureaucracies and for seniors to have more individual control over their health care dollars.

So do not believe this gibberish coming from some on the other side. That is exactly what it is.

I have heard Democrats who were opposed to everything with regard to Medicare, unless it is an $800 billion to $1 trillion program, and even then would be opposed to some of the approaches here.

They argue that 25 percent of seniors will be worse off than they are today because of this bill. That is pure, unmitigated bunk, and they know it. It is not true.

First of all, we are adding $400 billion to the Medicare Program in new spending for drug benefits and Medicare improvements—$400 billion. That is not chickenfeed. So how can anybody say they are going to be worse off?

Secondly, we take care of those who are in lower income brackets and those who have high drug costs. That is what this bill ought to do, and it does, and they are better off.

Very important to me, to Senator GRASSLEY, to Senator BAUCUS, and virtually all of us who have rural States, is that we improve access to quality care in rural areas—something that just has not happened under the old Medicare system, under traditional Medicare. We improved it. This bill does a lot towards helping those in rural America who have been shortchanged for years.

I do not see how anybody standing up from a rural State, with lots of farmers, can have the gall to come on this floor and say they are going to be worse off with this bill when we put very strong language in with regard to rural health care. Yet we have had some Senators from the other side doing that.

Unlike the 1988 catastrophic bill, which I virtually argued against at the time—it was a mandatory bill—but unlike that bill, this is a bill where you have a choice of whether you go into this program or not. You do not have to do it. You can stay right where you are in traditional Medicare if that is what you want. I do not think most people are going to do that, but who knows? But they have a right to do so. It is not like the 1988 catastrophic bill which was mandatory. And when the people found out they had to pay for it, yes, they rebelled because they did not want us telling them they had to pay for the benefit. Today, we are not telling them they have to participate. In fact, the two bills are quite different.

The Government is going to pay 75 percent of the cost of drugs for Medicare beneficiaries over 150 percent of poverty. Now, tell me that is not better than the current system.

The Democrats do not seem to understand the fact that a lot of corporations are dropping health care coverage because they cannot afford it anymore or they do not want to pay for it anymore.

I will never forget, I had a conversation with the head of IBM a few years back. He said: We are paying $7,000 per employee for health care. If it goes up any more, we are just going to turn around and give them the $7,000 and say, go get your own health care. He said: We just can't afford to keep going in this direction.

Well, before this bill, it was estimated that the corporations were going to drop the health care of 37 percent of retirees. Now it is estimated that the drop out number will be below 20 percent, probably closer to 15 percent. We have made some strides in trying to solve that problem.

This bill contains Hatch-Waxman reforms. For those who do not understand this, let me explain it as the author of the Hatch-Waxman bill in 1984.

Hatch-Waxman created the modern generic drug industry that is in competition with the pioneering companies and has brought drug prices down $10 billion in consumer savings every year since 1984. It is called, even by my friends on the other side, one of the greatest pieces of consumer legislation in the last century, and rightly so, because it has saved billions and billions of dollars for consumers.

But there was a gaming of Hatch-Waxman by some companies, and we have corrected that in this bill, which is a pretty important thing. These reforms will prevent gaming of the system, and they will provide seniors with less expensive generic drugs more quickly.

I get so tired of the demagoguery against the pioneering companies; that is, the PhRMA companies; that is, the large pharmaceutical companies. The generic companies know that if the large pharmaceutical companies do not spend their $30 to $35 billion every year in research and development, there will not be any drugs for them to take off into generic form. If these large companies spend that kind of money, then they have to find a way of recouping that money. Because of our current FDA system, it takes up to 15 years of patent life.

If you develop a gizmo, you have 20 years of patent life, or what you call market exclusivity, to sell your gizmo. In the case of prescription drugs, you might only have 5 years to recoup the moneys you have put in. And just for people's understanding, it takes up to 6,000 scientific misses, in other words, experiments—up to 6,000 of them—to arrive at a marketable drug, at a cost of around $1 billion per drug.

You wonder why companies have to charge as much as they do to get their money back? If they do not get their money back, they cannot conduct more research and development on future pharmaceutical products which are really saving our seniors and causing them to be able to live longer lives today.

I will talk a little bit more about drug reimportation in a few minutes. But in all honesty, that is an overblown, demagogued position, too. Our pharmaceutical industry in this country is one of our great industries. It is one of the reasons we have a balance of trade surplus. The pharmaceutical industry and the entertainment industry are about the only two that provide balance of trade surpluses.

What I hear from the other side that we have to have price controls, which is what Canada has; it is important to remember that Canada no longer has a pharmaceutical industry. The reason is that you cannot afford to do what it takes to get these drugs developed when you have price controls. Now, these are things that just are demagogued here on the floor, and I am personally getting tired of it.

There is so much I would like to say that would refute the demagoguery I have heard from some on the other side. Let me just take a second on AARP because it is amazing to me. The AARP has basically sided with the Democratic Party on almost everything with regard to seniors, and with the more liberal Republicans. They have been involved in this intimately for years. And here we have Democrats trashing the organization that has been one of their mainstays of support because all of a sudden the AARP is thinking for itself and doing what is right for seniors, and not keeping seniors under the thumb of Government regulation. So AARP has to be trashed here on the floor of the Senate by some of our friends on the other side.

I find it ironic that my friends on the other side of the aisle are criticizing the AARP for supporting legislation that will provide Americans access to drug coverage through Medicare. It is the first time this is going to happen, and they are trashing AARP?

What a difference a year makes. Last year, AARP could do no wrong as far as the Democrats were concerned. This year, it seems the AARP can do nothing right. That is because the more liberal Democrats, who are opposed to this bill because it is not socialized medicine, are up in arms that the AARP has finally decided to do what really is a bipartisan approach.

AARP made a courageous decision by endorsing our drug plan, a bill that I predict will soon be signed into law. And maybe my friends are just upset because they are on the losing side on this issue for a change, and they just do not want President Bush to get any credit for it.

Well, I also want to stress that the so-called slush fund I have heard mentioned on the other side, that my friend from Iowa raised, is no slush fund at all. This is a stabilization fund that is important for rural States such as Utah and Iowa. It is crucial to our States. Utah did not benefit from Medicare+Choice because it just did not work in my state. Health plans told me that the payments were too low.

So this stabilization fund provides assistance to those States, such as Iowa and Utah, that may not have regional PPOs, preferred provider organizations, or local plans that provide coverage they would offer to these beneficiaries living in rural areas.

Of course, look at what happened to Medicare+Choice. In Utah, the Medicare+Choice plans left the State, leaving my beneficiaries with nothing because Medicare+Choice plans could not survive in rural Utah. This bill will help to solve that problem. The stability fund will be used to encourage plans to enter rural States such as Utah and Iowa and stay there once and for all. It is not a slush fund.

This is a fund designed to help give rural beneficiaries choice and coverage through the HMOs, PPOs, and standalone drug plans. It helps seniors in rural areas. I find it disconcerting that someone from Iowa would criticize that aspect of this program. That shows he has not read the bill, does not understand the bill, has not listened to Senator GRASSLEY, who has read the bill, does understand it, and helped to implement it, and who is probably rural America's strongest advocate in the Congress. This is no exception.

Let me tell you what this legislation does for my folks in Utah. I think you can extrapolate this into every State in the Union, but let me talk about my State because I want my folks in Utah to realize this is a good bill.

The bipartisan agreement provides all of my 219,973 beneficiaries in Utah with access to a Medicare prescription drug benefit for the first time in the history of the Medicare Program, beginning in January of 2006. Beginning in 2006, the bipartisan agreement will give 55,538 Medicare beneficiaries in Utah access to drug coverage they would not otherwise have and will improve coverage for many more.

Within 6 months after this bill is signed, Utah residents will be eligible for Medicare approved prescription drug discount cards which will provide them with savings of between 10 and 25 percent off the retail price of prescription drugs, of most drugs. That is something they do not have now but they will have.

Beneficiaries with incomes of less than $12,123 or $16,362 for couples who lack prescription drug coverage, including drug coverage under Medicaid, will get up to $600 in annual assistance to help them afford their medicines along with a discount card. That is a total of $53,619,525 in additional help for 44,638 Utah residents in the years 2004 and 2005.

Mr. President, beginning in 2006, all 219,973 Medicare beneficiaries living in

Utah will be eligible to get prescription drug coverage through a Medicare approved plan in exchange for a monthly premium of approximately $35. Seniors who are now paying the full retail price for prescription drugs will be able to cut drug costs roughly in half. In many cases, they will save more than 50 percent of what they pay for prescription medicines, and those at less than 150 percent of poverty basically will have their drugs for free.

Mr. President, 63,560 beneficiaries in Utah, who have limited savings and low incomes, generally below $12,123 for individuals and $16,232 for couples, will qualify for even more generous coverage, as I have said. They will pay no premium for prescription drug coverage, and they will be responsible only for a nominal copayment, no more than $2 for each generic drug or $5 for brand name drugs. Now, 17,613 additional low-income beneficiaries in Utah, with limited savings and incomes below $13,470 for individuals and $18,180 for couples, will qualify for reduced premiums, lower deductible, and coinsurance, and no gaps in coverage.

Additionally, Medicare, instead of Medicaid, will now assume the prescription drug costs of 17,739 Utah beneficiaries who are eligible for both Medicare and Medicaid. This will save Utah $51 million over 8 years on prescription drug coverage for its Medicaid population.

This is a bill that will help every State. I cite Utah just to show that in a State the size of mine, which is smaller in population than many other States but fairly substantial, there are substantial benefits that will come from this bill.

I want to make it clear that this is the last train out of town. We have been trying to do this for years and years. I listened to at least four of my colleagues on the other side who, in my opinion, were demagoguing this issue all day long. Frankly, they are wrong in most of their assertions, and they act as if all we have to do is take this back to committee and work it through again. If people had sat through those meetings we held in the conference committee, they would realize we went through every word, every aspect of this legislation. We had a heck of a time putting together a total bipartisan package such as this as it was. If you look at it, it barely passed the House—but it did pass the House. I hope it will pass the Senate because our seniors will be better off with the choices this bill gives them than with current law.

Yes, I wish we could have done more to reform Medicare; I wish we could have done more to put more private sector capability in this bill. I think over the long run that would really pay off. I wish we could have done more in a wide variety of areas that would have cost a lot more money. But I have to say, under the circumstances, the conference committee members really worked hard, and I think we did a good job.

So I rise to express my strong support for the final conference agreement on H.R. 1, the Medicare Prescription Drug Improvement and Modernization Act. Over the years, countless Medicare beneficiaries in Utah have written to me to express their desperation over the fact that Congress has not added a prescription drug benefit to the Medicare Program. Time after time, session after session, in Congress after Congress, we have tried to answer their pleas. Fifteen years ago, we almost made it. The plan was so flawed that it had to be repealed. Last year, I thought we might make it with the tripartisan initiative. I was one of the five tripartisan Senators, as was Senator GRASSLEY who is sitting in the chair now, and Senators SNOWE, JEFFORDS, and BREAUX. The five of us have come up short each and every time we have tried—except this year. I think if we had not had Presidential support this year, we probably would have come up short again.

We cannot afford to fail America's seniors. We cannot afford to fail America's disabled. I am dismayed to hear many colleagues preparing for us to fail again. Not if this Senator can help it. To me, it is unconscionable to let this opportunity pass us by out of a concern that this is not a perfect bill. I spent years working on this issue. Unlike some on the other side, who have been complaining about the issue, I have worked on every health care program in the last 27 years, and a number of them have my name on them. I believe I know the issues as well as anybody in this body. I worked hard on the conference committee as well.

Let me tell you, in all the experience of 27 years, I can tell you something I know is categorically true: We cannot have a perfect bill.

The intersection of Medicare, Medicaid, and responsible public policy is about the most complex pathway Congress has ever negotiated. On the one hand, we want to provide as many seniors and disabled with as comprehensive and affordable coverage as possible. On the other hand, we want to minimize Government and its attendant bureaucracy and cost. The two are in inherent conflict. So we do the best we can—and we did.

Since Congress first enacted Medicare nearly 40 years ago, we have seen miraculous breakthroughs in medicines that have allowed for diseases, conditions, to be treated by innovative prescription drugs. As seniors and the disabled have gained access to many treatments, many are faced with the choice of splitting pills or missing meals in order to afford their vital prescription drugs.

This is simply unconscionable. Providing access to these vital treatments is the right thing to do for our seniors and the right thing to do for our children. It will make our society more healthy, and it will save countless medical expenses. Seniors will live longer, as they are doing now, because of these inroads we have made.

Is there anyone who doubts that greater access to preventive medicine will save our Medicare system in the long run perhaps by tens of billions of dollars?

My constituents have been waiting for close to 40 years for this day to come. The time is here; the time is now. We are about to pass historic legislation that will make the most significant changes to the Medicare Program since it was created in 1965.

I say to my colleagues, Monday will be a momentous day in the Senate, and I hope we will invoke cloture so we can proceed with this bill. If we invoke cloture, we will pass this bill and millions and millions—40 million—of our senior citizens in this country will benefit. The whole country will benefit. Medicare beneficiaries will finally be offered a prescription drug benefit plan.

Medicare will offer beneficiaries more choice in coverage, and Medicare's fiscal solvency will be preserved for our children and grandchildren.

This bill has countless extra benefits. We have made improvements in the way health care is delivered to rural America, as I mentioned. Beneficiaries, like so many in the State of Utah, will receive quality health care. Providers in these areas will be reimbursed appropriately and have incentives to give good care.

Overall, we cannot escape the conclusion that this is a good bill. Whenever I go back home to Utah, the Medicare Program is the one topic that comes up in almost every conversation I have with constituents. No matter where I go—Salt Lake City, St. George, Beaver, Ogden, Cedar City, you name it, from the north to south, from east to west, the question is still the same: When will drugs be covered by Medicare? I have looked forward to this day for a long time—the day when I will be able to answer: Now.

I would like to read a letter, one of many I have received, from a different kind of constituent. For the past several years, Medicare providers, especially those in rural Utah, have complained about their insufficient Medicare reimbursement in Utah. As a result, many have threatened to leave the State if Medicare payments are not increased. Let me give you a quote from Dr. Beth Hanlon, a Utah physician, who is complaining about unfair reimbursement rates. Here is what she had to say:

> My patient population is 30 to 40 percent Medicare. I cannot continue to see our senior patients if rates drop further. My overhead costs continue to increase; I cannot provide the same services I did a year ago because of lower reimbursements. I will have to refer patients to consultants and the emergency room for problems I could previously have managed in my office. This is so distressing, as our population ages and we see more doctors planning retirement.

Dr. Hanlon, we have good news for you. We took your concerns seriously, and this bill takes the necessary steps to increase your Medicare reimbursement rates.

Let me talk a little bit about the process and how we got to this historic place in the annals of the Senate. As I said, I was privileged to serve as a member of the House-Senate Medicare conference committee. I served on many conferences during my 27 years in the Senate, but this was probably the most complex and technical conference I have ever encountered, and it was a difficult conference to be on.

Every Senate and House conferee—especially conference Chairman BILL THOMAS, chairman of the Ways and Means Committee, and Cochairman BILLY TAUZIN of the Energy and Commerce Committee, and conference Vice Chairman CHUCK GRASSLEY, chairman of the Finance Committee—did a great job, a fine job of guiding members to this final agreement. It was no easy task, and it took several months and many long hours to complete our work.

Other conference members made significant contributions to this historic conference report, and I would like to take the opportunity to recognize all of these members for their diligence and commitment to the process.

They certainly include Senate majority leader, BILL FRIST; Senate minority leader, TOM DASCHLE; Senate Finance Committee ranking member, MAX BAUCUS; Senator DON NICKLES; Senator JAY ROCKEFELLER; Senator JON KYL; and Senator JOHN BREAUX; House majority leader, TOM DELAY; the Speaker of the House, DENNY HASTERT; Ways and Means Committee ranking member, CHARLIE RANGEL; Energy and Commerce Committee ranking member, JOHN DINGELL; Ways and Means Health Subcommittee chairwoman, NANCY JOHNSON; and Energy and Commerce Health Subcommittee chairman, MIKE BILIRAKIS.

These are all the people who were concerned about this bill. Most of them worked to try to work out the differences between the House and Senate bills. Some of them did not, and some of them are complaining to this day.

I also wish to take this opportunity to recognize the staff who worked literally around the clock on this conference agreement for several months. They are: Dr. Mark Carlson, who was my legislative fellow this year; Colin Rosky; Leah Kegler; Jennifer Bell; Ted Totman; Alicia Ziemiecki; Liz Fowler; Bill Dauster; Russ Sullivan; Judy Miller; Jon Blum; Pat Bousliman; Andy Cohen; Danial Stein; Diana Birkett; Joelle Oishi; Jenny Wolff; Allison Giles; Julie Hasler; Patrick Morrisey; Chuck Clapton; Patrick Rowan; Jeremy Allen; Dean Rosen; Liz Scanlon; Eric Ueland; Sarah Walter; Michelle Easton; Paige Jennings; Lauren Fuller; Stacey Hughes; Don Dempsey; Diane Major; Lisa Wolski; Jane Lowenstein; Kate Leone; Susan Christianson; Bridgett Taylor; Amy Hall; John Ford; Cybele Bjorklund; and Terry Shaw.

Mr. President, I would like, though, to recognize the hard work of our Senate Finance Committee staff, especially Linda Fishman, Mark Hayes, Liz Fowler, and Jon Blum; and the staff of the Ways and Means Committee, John McManus, Deb Williams, Madeleine Smith, and Joel White; and staff of the House Energy and Commerce Committee, especially Patrick Morrissey and Chuck Clapton.

I also wish to acknowledge the work of my own staff: Pattie DeLoatche, Trish Knight, Bruce Artim, and others who worked very hard in this area.

I wish to acknowledge the work of the Senate and House legislative counsel staff, Jim Scott, John Goetcheus, Ruth Ernst, Ed Grossman, Pierre Poisson, and Pete Goodloe.

They have been the unsung heroes in this process and have given up significant time with their family in order to draft this legislation.

Another organization that deserves special recognition is the Congressional Budget Office. The staff of Steve Lieberman worked tirelessly for us, and it was a continuous process.

Finally, the Department of Health and Human Services, especially the Centers for Medicare & Medicaid Services staff, led by Administrator Tom Scully and Rob Foreman, worked around the clock to provide us with detailed information on questions we had about the Medicare legislation.

I thank all of these fine people for a job well done.

I have been involved in this issue for more than a decade, as I mentioned—actually for most of my Senate career. I worked closely with my Finance Committee colleagues to get this bill through the Finance Committee and the Senate earlier this year. I was also one of the authors of the Senate tripartisan Medicare bill which was considered last Congress and shot down because of nothing more than politics, something that appears to be rearing its ugly head right now.

In addition, I was lead sponsor with our colleague, Senator BILL ROTH, of the legislation establishing the Bipartisan Medicare Commission, which was included in the Balanced Budget Act of 1997.

Both the Medicare tripartisan bill and the Bipartisan Medicare Commission, which was chaired by my friend and colleague, JOHN BREAUX, laid the groundwork for the agreement we are currently considering.

We have learned from those efforts, and that has only improved the legislative effort that is before us today. That is why this bill presents the best opportunity that we will ever have to provide our seniors with the drugs they need so desperately.

Of course, the bill is not perfect. No compromise ever is to any one person. But after all these years, considering all the policy differences and all the differing views on entitlement programs and how a drug benefits should be delivered, we now have a bill that can pass.

With all of those differences, we finally have a bill that represents the best possible compromise. There will most certainly never be another opportunity like we have when we vote this Monday.

There is a lot of misunderstanding about what is in this bill. There is a lot of misinformation. I have mentioned some of it in my earlier remarks, but I would like to take a few more moments to clear up some of this.

First, I would like to explain one of the most important components of this legislation to my colleagues at this time, which is the drug benefit. Many Utahns are under the mistaken impression that they will be forced to participate in this new drug program, and that is simply not true. So I want all of you out there who are listening and watching and those who will read comments in the papers to note these comments by some of my colleagues, such as ''you don't have any choice,'' are wrong. You have a choice whether you want to be in this program or not. No one will be forced into the new drug plan. No one is going to be forced into an HMO. No one will be forced to leave traditional Medicare on which they have come to depend.

I simply cannot stress enough that this is a voluntary benefit. If Medicare beneficiaries do not want drug coverage, they do not have to participate. I hope that point is clear to everyone across the country listening to this debate, especially senior citizens.

Second, in one word, this bill provides choice. Seniors will be able to choose the drug benefit that best suits their needs rather than be forced into a one-size-fits-all Government handout.

(Mr. ALLARD assumed the Chair.)

Mr. HATCH. Everyone will be offered a Medicare-endorsed drug discount card in April 2004. This will cost no more than $30 per year.

These drug discount cards will immediately provide our seniors with drug savings ranging from 10 to 25 percent. Right off, that's a benefit you don't have now.

In addition, this is a fair bill and a fair provision.

We have targeted the lion's share of this benefit to those seniors who have the greatest need. Those under 135 percent of the federal poverty level will receive $600 per year to buy their prescription drugs and will not be required to pay enrollment fees. That's a total of $53.6 million in additional help for 45,000 Utah residents in 2004 and 2005.These low-income beneficiaries would only be required to pay coinsurance between 5 and 10 percent for each prescription drug. That is a tremendous change from today.

The prescription drug card program concludes when the larger benefit kicks in on January 1, 2006.

Beginning in 2006, 220,000 Medicare beneficiaries will be offered access to the new standard prescription drug program. Standard coverage includes a $35 monthly premium, a $250 annual deductible, beneficiary coinsurance of 25 percent up to $2,250, and protections against high drug cost once out-of-pocket spending reaches $3,600.

While individual drug plan sponsors may change some of the specifications, every beneficiary who participates will be guaranteed a drug benefit that is at least equal in value to the standard benefit.

Those wishing to remain in traditional Medicare will have access to a stand-alone prescription drug plan.

Beneficiaries who want private, integrated health coverage may receive their drug benefits through local or regional Medicare Advantage plans. No one—not one senior or person with a disability—would be forced to give up the coverage that they receive from traditional Medicare. And this bill will provide 56,000 Medicare beneficiaries in Utah with access to drug coverage that they would not otherwise have.

This bill also has additional coverage for 63,000 Utahns with low-incomes.

For the dual-eligibles 18,000 in Utah—who are below 100 percent of the Federal poverty level, there would be no monthly premium, annual deductible, or gap in coverage. These individuals will merely have copayments of $1 for generic drugs and $3 for brand name drugs. Once the catastrophic limit is reached, there would be no beneficiary coinsurance for these individuals.

But there's even more help for our low-income beneficiaries. Those below 135 percent of poverty, there will be no monthly premium, annual deductible or gap in coverage. These individuals would have copayments of $2 for generic drugs and $5 for brand name drugs. Once the catastrophic limit is reached, there will be no beneficiary coinsurance for these individuals.

For those below 150 percent of poverty, there will be a sliding scale for monthly premiums, a $50 annual deductible, and up to 15 percent beneficiary coinsurance on the out-of-pocket spending. Once the catastrophic spending limit is reached, there will be beneficiary copayments of $2 for generic drugs and $5 for brand name drugs.

Let me illustrate how this would work.

Evelyn, a widow from Sandy, Utah makes $35,000 annually. She has diabetes, high blood pressure and arthritis and her annual drug expenditures are close to $5000. Evelyn decides to join the Medicare prescription drug plan. It's her choice.

Under the bipartisan Medicare agreement, her out-of-pocket spending on drugs will be reduced from $4800 per year to approximately $2400 cutting her prescription drug expenditures significantly. Factoring in her monthly premiums, she will save almost $2000 per year.

I continue to hear arguments on the floor about seniors being in worse shape if this bill becomes law.

Would Evelyn think saving $2000 puts her in worse shape? Not on your life.

This conference agreement provides additional assistance to the poorest and the sickest beneficiaries—that has always been my goal—to provide assistance to those beneficiaries who need the most help.

Who can argue against that?

It gives beneficiaries something that they have wanted for 40 years—prescription drug coverage—and it is strictly voluntary.

H.R. 1 also improves the traditional Medicare program by enhancing preventive services offered to beneficiaries.

The conference agreement includes a Welcome to Medicare preventive physical examination, cardiovascular and diabetes screening, and improved payments for mammography.

The new benefits will be used to screen Medicare beneficiaries for many illnesses, and in most cases, if these illnesses are caught early they may be treated. Conditions like diabetes, heart disease and asthma will be treated far more effectively due to this one-time physical examination. Would patients think they are worse off because their conditions are detected earlier and treated more effectively? Not on your life.

This conference agreement also establishes Health Savings Accounts, better known as HSAs. HSAs are tax-advantaged savings accounts which may be used to pay for medical expenses, and they have worked in numerous other forms in the private sector. They are open to everyone with a high deductible health insurance plan; however, the annual deductible must be at least $1,000 for individual coverage and at least $2,000 for family coverage, and the out-of-pocket expense limit must be no more than $5,000 for individual coverage and $10,000 for family coverage.

Employee HSA contributions are not included in the individual's taxable income. In addition, contributions by an individual are tax deductible. Also, the accounts are allowed to grow tax free and there is no tax on withdrawals for qualified medical expenses. Boy, does that make sense. But that is sticking in the craw of a number of those who want Government to pay for everything and don't want people to have to save for their own health care. I mean, that is in my view.

HSAs are portable, like an individual retirement account (IRA), the HSA is owned by the individual, not the employer. If the individual changes jobs, the HSA travels with them. In addition, individuals over age 55 may make extra contributions to their accounts and still enjoy the same tax advantages. In 2004, an additional $500 can be added to the HSA. By 2009, an additional $1,000 can be added to the HSA.

The inclusion of these new accounts is a significant part of the agreement that made this conference report possible. Yet some on the other side, because it is giving people a choice to save on their own, tax free, and pay for their own health care tax free, don't want this. It is easy to see why, if what you want is socialized medicine. The inclusion of these new accounts is a significant part of the agreement that made this conference report possible. Allowing individuals to take charge of their own savings for future health care expenses is an important and necessary change in the direction of our health care policy, and is one I support strongly.

In my opinion, the conference agreement made great strides in perfecting the Senate-passed language sponsored by Senators GREGG, SCHUMER, and KENNEDY pertaining to the Drug Price Competition and Patent Term Restoration Act of 1984, better known as the Hatch-Waxman Act.

The intent of the 1994 law is to provide incentives to develop valuable new drug treatments through patent and exclusivity protection, and also to facilitate access to generic versions of the drug after the innovator's patent or exclusivity expires. The CBO estimated that the Hatch-Waxman Act saves consumers $8 billion to $10 billion each year. I was pleased to be the prime sponsor and to work out every word in that Act.

In recent years, however, access to generic drugs has sometimes been delayed by litigation. The Judiciary Committee, which I chair, highlighted these problems in a hearing held in May of 2001 and two hearings this year.

The HELP Committee reported legislation on these matters both last year and this year. The Senate adopted these amendments by wide margins both last year and this year.

Although I opposed the specific provisions in these bills, I recognize the sustained efforts of Senators MCCAIN, SCHUMER, KENNEDY, COLLINS, EDWARDS, and FRIST. I want to especially commend Senator GREGG for his leadership in bringing this year's vehicle more in line with the policies that I have long advocated.

I also want to commend the leadership of President Bush who took regulatory action earlier this year to close a significant loophole in the 1984 law, which will save all Americans an estimated $35 billion over 10 years. Secretary Thompson and the Commissioner of Food and Drugs, Dr. Mark McClennan, deserve a lot of credit for completing this important rulemaking in less than one year. The expert advice given by the Chief Counsel for Food and Drugs, Dan Troy, must also be acknowldged.

Medicare legislation that passed the House and Senate earlier this year included the codification of the new FDA rule modifying the 30-month-stay provisions of Hatch-Waxman. Enactment of these provisions as part of the bipartisan agreement will lower prescription drug costs for millions of Americans by improving access to generic drugs, which are safe and effective and can be much less costly alternatives to brand-name prescription drugs.

A key component of the bipartisan agreement codify the recent regulation that limits drug manufacturers to one and only one 30-month automatic stay

in patent infringement litigation involving a generic drug application. This is the policy that I advocated in May 2002 testimony before the HELP Committee and on the Senate floor during the debate of 2002.

Although the McCain-Schumer bill in the 107th Congress, S. 812, contained a very different provision with respect to the 30-month stay, in time the wisdom of my position on the 30-month stay took hold.

Last July, the Federal Trade Commission issued a report that recommended the policy I advocated and became a central feature of the FDA rule and the legislation contained in the conference report.

I want to commend the sustained effort and considerable expertise of FTC Chairman Muris in this area.

As well, I would be remiss not to single out such dedicated and thoughtful public servants as Mike Wroblenski at FTC and Jarilyn DuPont, Amit Sachdev, and Liz Dickinson at FDA, and many others.

One of the key provisions of the Greater Access to Affordable Pharmaceutical Act amendments are those pertaining to declaratory judgments. It was this provision that was discussed at our two most recent Judiciary Committee hearings on this legislation in June and August of this year. The Department of Justice, ably represented by a fellow Utahn, Deputy Assistant Attorney General Sheldon Bradshaw, understandably took the position that the Senate declaratory judgment provision was unconstitutional.

I am pleased that the conferees fixed the constitutional defect in the Gregg-Schumer-Kennedy language that passed the Senate.

The problem with the language, adopted by the Senate by, as I recall, a 94–1 margin, is that it tried to legislate directly counter to the ''case or controversy'' requirement of Article III of the Constitution.

Before reaching the merits of a case, including declaratory judgment actions, a Federal judge must first determine that there exists an actual dispute between the parties. Courts are not permitted by our Constitution to hear hypothetical cases or cases in which there is only a possibility of future litigation.

As both of the hearings of the Judiciary Committee documented, the law is settled with respect to the standards that must be met before a declaratory judgment may be heard in patent litigation. A court may only take a declaratory judgment case if and only if it finds that a ''reasonable apprehension'' of being sued by the patentee is present at the time the action is brought.

This is only common sense because it would be imprudent to allow the courts to be flooded with speculative, time consuming and costly patent suits. As the erudite statements of Mr. Boyden Gray fully documented, the Senate-passed language essentially stood the Constitution on its head by defining the absence of a lawsuit as a statutory basis for satisfying the ''case or controversy'' requirement.

I certainly enjoyed reading the several intriguing missives written on this topic by my former Judiciary Committee General Counsel, Professor John Yoo.

But neither his statements nor his surprise visit and testimony at our committee hearing have convinced me of either the constitutionality or policy wisdom of the declaratory judgment provisions contained in S.1. If we only knew Professor Yoo was coming to testify, we would have given Mr. Gray equal time.

In any event, in the provision the Senate considers today, the settled case law of the ''reasonable apprehension'' test remains undisturbed and the Constitutional requirements are observed.

In adopting this language it is important to note that the presence of the two factors referred to in the statute, the filing of an ANDA application with a Paragraph IV patent challenge certification and the absence of a suit filed by the patent-holding innovator firm, do not alone satisfy the reasonable apprehension test.

Certainly courts should, and in fact, must under the new language consider these two important factors but that should neither be the start nor the end of the inquiry.

For example, the result in the case of Dr. Reddy v. Pfizer, commented upon by many, including my friend from New York, Senator SCHUMER, does not appear to be affected by the language in this bill. In that case, which involved a challenge to patents set to expire three and one-half years later, the court found that the reasonable apprehension test was not satisfied.

Refiling the suit more proximate to the patent expiration date may yield a different result. That will be a matter for the courts to decide applying the new statute and the existing standards of the ''reasonable apprehension'' test.

I also want to make explicit, the implicit—that nothing in this new language pertaining to pharmaceutical patent-related declaratory judgments creates a new cause of action separate from the existing authority under title 28.

On balance, I believe that the conferees arrived at a fair resolution on the declaratory judgment provision that is a marked improvement over the Senate language.

I want to commend my colleagues in the Senate for recognizing the serious flaws in the language of S.1. I want to commend my colleagues in the House for recognizing the importance of retaining a strong declaratory judgment provision so that generic drug firms will be able to determine the status of their patent challenge in an appropriate fashion.

I plan to monitor closely the history of litigation of these new rules pertaining to pharmaceutical patent litigation and hope that the FTC and other governmental agencies and outside groups will also provide us with their analysis of how well the new provisions work in practice.

We need to be vigilant in assessing whether we have the proper balance between the interests of patent holders and patent challengers. I will expect and request an FTC report, similar to the agency's extremely helpful 2002 study, at an appropriate time.

There are also additional important provisions in this bill that affect Hatch-Waxman, but I would like to reserve my comments for this coming Monday.

One other important issue that we have addressed in this legislation is the preservation of retiree health coverage. My office has been flooded with calls from seniors worried about losing their retiree benefits.

And we have seen published reports indicating that rising drug and health care costs are pushing more and more employers and unions to drop their retiree health coverage.

We took these concerns very seriously as we negotiated this conference agreement.

That is why we have dedicated nearly one-quarter of the spending in this bill to protect retiree health benefits.

For the first time, Medicare will provide funding and incentives so employers and union officials will continue retiree health coverage. Under this bill, no beneficiary will be forced to drop retiree health coverage and participate in the new prescription drug program.

However, if employers drop health coverage in the future, those losing coverage will be allowed to enroll in the Medicare drug program without being penalized.

In addition, this legislation contains a 28 percent non-taxable employer subsidy for each retiree's annual drug spending between $250 and $5000—as high as $1,330 per beneficiary. To qualify, employer coverage must be as generous as, or more generous than, the Medicare Part D drug benefit.

We have made a lot of progress on this provision—protecting retiree health benefits was one of the primary goals of the Medicare conference committee. Let me tell you how much progress we have made—when we considered S.1 in the Senate this summer, CBO told us that the employer drop-out rate was 37 percent. The last CBO estimate on the conference report's employer drop-out rate is below 20 percent. This is a remarkable achievement.

The conference agreement is good for rural America. We want to ensure that Medicare beneficiaries will have access to quality health care—no matter where they live—and especially that rural providers, who provide these important health services to beneficiaries, will be properly reimbursed for their services.

Si Hutt, the CEO of Ashley Valley Medical Center in Vernal, Utah wrote to me asking:

Please vote for the Prescription Drug Bill that came out of the conference committee. It not only assists Medicare beneficiaries with escalating drug costs, but it has key provisions which are important to rural hospitals and physicians.

The last data that I looked at actually showed a negative margin for our Medicare business. At the same time, over 50 percent of our patients are Medicare, Medicaid, or self-pay.

As you know, Medicare payment is very complicated and has some inequities that are improved with this bill. The bill stops a reduction of physicians' reimbursements—which is crucial in today's horrible malpractice premium situation and rising costs.

It also gives a full market basket increase to hospitals for the next couple of years if hospitals participate in the American Health Association's (AHA's) national quality effort. We were among the first to sign up for this initiative.

Please vote yes for this bill. Thank you.

Hospitals across America will receive a full market-basket update as long as they submit appropriate quality data to CMS. Medicare payments to hospitals providing services to a disproportionate share of low-income and uninsured patients, typically rural and small urban hospitals, were increased from 5.25 percent to 12 percent. It was an increase that was overdue.

There also is an increase in Medicaid DSH payments.

In addition, the legislation redistributes unused hospital residency positions and rural hospitals will be given top priority for receiving these redistributed resident positions.

The conference report does several things to assist critical access hospitals: namely, it increases payments for these hospitals and eases several burdensome requirements that have been imposed upon them.

Rural physicians benefit greatly under this conference report. We included legislation I helped develop that relieves Medicare providers from burdensome regulations and requirements.

Physicians will no longer be subjected to a 4.5 percent reduction; instead they will be receiving a slight increase in Medicare reimbursement for the next two years. We also modify the geographic adjustment for physician Medicare payments, which is extremely important to my Utah physicians back home.

And we reward physicians who are willing to provide care to Medicare beneficiaries who live in scarcity areas—areas that have medical shortages.

Home health care, skilled nursing facilities and hospice facilities in rural areas also receive an increase in Medicare payment. In addition, there are no home health care co-payments for beneficiaries.

As one of the authors of the home health care bill many years ago, I am proud to be able to say we were able to get that done in this bill. Finally, ambulance services in rural areas will be rewarded through increased payments.

Another issue that is extremely important to me is the reimportation of prescription drugs. I mentioned I would talk about this for a few minutes. My Utah constituents are deeply concerned about the high price of pharmaceutical products. But allowing drugs to be reimported from other countries is not the solution. In fact, it makes the problem worse because the safety of these drugs cannot be guaranteed by the Department of Health and Human Services. The recent Government sting operation in one U.S. port discovered that 85 percent of the reimported drugs seized were found to be counterfeit, outdated, or improperly packaged, knock-off packages.

This is very disturbing to me and an example of why I simply cannot support the reimportation of prescription drugs. The possibility of mistake and deception is just plain too great. People could die. Already the FDA has documented many cases of what appeared to be FDA-approved imported drugs that were, in fact, contaminated or counterfeit, contained the wrong product or incorrect dose, were accompanied by inadequate distributions, or had outlived their expiration date. These drugs would be, at a minimum, ineffective and would actually be harmful, if not fatal.

Those safety concerns are real and those in Congress who advocate reimportation ignore them not at their own risk but at the risk of the lives of millions of Americans. If we truly care about our seniors and others who depend on prescription drugs, we should not expose them to what amounts to pharmaceutical Russian roulette.

I might add that I will come up with an amendment that will give tort liability for local and State governments that encourage reimportation.

In addition to these safety concerns, reimported drugs are a threat to the innovation that Americans and the rest of the world have come to expect from our pharmaceutical industry. I am author of the FDA Revitalization Act that now is providing for, after 10 years, finally building the White Oak FDA Central Laboratories with the finest equipment and facilities in the world. It will take us another 10 years to do it. It should have been done 10 years ago. That should move this drug price problem forward because it would, hopefully, give them the facilities to acquire even better people to work there, tough scientists, whom they have not been able to attract for years, who basically will move these drugs through in a more safe and expeditious fashion, thus saving costs to those who develop the drugs, and thus bring prices down.

Canada and other countries with lower drug prices generally import superior American products but they impose price controls to keep costs down. However, it can cost up to $1 billion, as I have said, to produce a new drug, test it, win FDA approval, educate doctors, and make the drug available to patients. No pharmaceutical company could go through this without a chance to recover some of its costs, which will not be possible if we impose in America, however indirectly, Canadian-style price controls. They do not have a pharmaceutical industry in Canada anymore because they basically have thrown their business right out of the country. I don't want to see that happen in our country where we have the greatest pharmaceutical companies in the world. We should be proud.

I do not believe sacrificing the safety supply of our drugs by reimportation is the right answer to the high cost of prescription drugs. The conference committee reimportation provision is similar to what we passed earlier this year. The Secretary of HHS is directed to establish a program that would allow for the reimportation of drugs from Canada by pharmacists, wholesalers, and individuals. However, the Secretary has the authority to suspend such a program if public safety is compromised.

The conference agreement directs the Secretary to conduct an extensive study that identifies the barriers for implementing a drug reimportation program and the potential problems associated with it. I believe it is imperative that such a study be conducted by implementing a program that can pose such a serious public health risk.

Before I close, I take this opportunity to refute some of the arguments I have heard from the other side of the aisle. In fact, I will repeat some of the things I have said before but, hopefully, make them more clear.

My colleagues have said that 25 percent of seniors will be worse off when this bill passes than they are today. That is simply not true. It is false. And it is wrong for them to make these statements. This conference agreement provides Medicare beneficiaries with the benefit they have been demanding for close to 40 years, prescription drug coverage and quality health coverage. This week, we are finally going to give them what they want. We spend almost $400 billion in new money to accomplish that goal.

I also heard some say that this is catastrophic all over again and we will be back a year later repealing this legislation just like we repealed the Medicare Catastrophic Coverage Act of 1988. There is one fundamental difference between the current Medicare conference agreement and the Medicare Catastrophic Coverage Act of 1988—although there are other differences as well. Our Medicare benefit is voluntary. The Medicare catastrophic coverage law was mandatory. That is a major difference. No one is forced to participate in this program. But I think virtually everyone will want to.

In addition, this legislation offers drug coverage to the 33 percent of Medicare beneficiaries who do not have coverage today. I have mentioned how that benefits folks in my State. The Hatch-Waxman reforms on generic system drugs get less expensive drugs to the market faster, providing everyone with less expensive drugs.

This bill makes significant health care improvements for Medicare beneficiaries in rural America and the health care workers who care for these beneficiaries.

Before I close, I make an observation about the endorsement of this legislation from the AARP. Regarding the American Association of Retired People, I have not always been in agreement throughout the years, but I have a new regard for that organization because it made a courageous decision by putting seniors first. I respect the AARP for taking such a positive stand on this legislation. I personally resent some of the irresponsible attacks that have been made against them. If we are going to attack AARP, make sure we are right in doing so and do not use phony arguments because you are losing in the Senate.

In conclusion, passage of this Medicare conference agreement is the right thing to do for our seniors, especially those who currently do not have prescription drug coverage because they cannot afford it. I am pleased I have had an opportunity to play an important role in making this dream a reality for 41 million Medicare beneficiaries across the country. I am pleased I was able to work with such fine members of the conference committee, every one of them. Every one of them worked well. Every one of them deserves credit. Every one of them played a specific role. There were hardrock conservatives who made this bill passable in the House. There were those who were more liberal who made this bill acceptable to many in the Senate, if not the vast majority. There were many in the middle who were trying to make sure we got this thing done right and did the very best we could to do achieve that goal.

Again, I have mentioned the people who basically deserve most of the credit for working on this bill. Everyone on those conference committees worked long, hard hours.

So I resent some of the comments that were made by those who did not participate or, if they would have participated, would have done nothing but complain throughout the process and would have stalled the process. They are complaining because they did not have their way and we will not go towards a socialized medicine approach. They want Government to handle all these problems. We think Government can do a good job if it has some competitive aspects with the private sector as well. The vast majority of this is government, but in a reformed way, with new programs that do a lot of good for every senior citizen who wants to participate in them. It will be a sea change advantage to all as we go forward.

I hope my colleagues will pass this bill. This is a historic opportunity for to us do what is in the best interests of our senior citizens in this country. It is the only opportunity that has been brought to both floors of Congress and the only opportunity for us to pass legislation. This bill is important. This bill should not be subject to petty partisan politics, a superabundance of which I have seen through this process, but particularly yesterday and today. I hope all of our colleagues will vote for this bill.

I yield the floor.

Mrs. BOXER addressed the Chair.

Mr. HATCH. Mr. President, could I do just a little bit of wrap-up?

Mrs. BOXER. Of course.

Mr. HATCH. I thank my colleague from California. I thank her for her graciousness throughout this process with regard to my speech.

RECOGNIZING THE IMPORTANCE OF RALPH BUNCHE AS ONE OF THE GREAT LEADERS OF THE UNITED STATES

Mr. HATCH. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged from further consideration of S. Con. Res. 82 and that the Senate proceed to its immediate consideration.

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

The clerk will report the concurrent resolution by title.

The assistant legislative clerk read as follows:

A concurrent resolution (S. Con. Res. 82) recognizing the importance of Ralph Bunche as one of the great leaders of the United States, the first African-American Nobel Peace Prize winner, an accomplished scholar, a distinguished diplomat, and a tireless campaigner of civil rights for people throughout the world.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. HATCH. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to this concurrent resolution be printed in the RECORD.

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

The concurrent resolution (S. Con. Res. 82) was agreed to.

The preamble was agreed to.

The concurrent resolution, with its preamble, reads as follows:

S. CON. RES. 82

Whereas Ralph Bunche's life of achievement made him one of the 20th century's foremost figures and a role model for youth;

Whereas Ralph Bunche graduated valedictorian, summa cum laude, and Phi Beta Kappa from the University of California at Los Angeles in 1927 with a degree in International Relations;

Whereas Ralph Bunche was the first African-American to receive a Ph.D. in Government and International Relations at Harvard University in 1934;

Whereas Ralph Bunche served as a professor and established and chaired the Political Science Department at Howard University from 1928 to 1941;

Whereas, in 1941, Ralph Bunche served as an analyst for the Office of Strategic Services;

Whereas Ralph Bunche joined the Department of State in 1944 as an advisor;

Whereas Ralph Bunche served as an advisor to the United States delegation to the 1945 San Francisco conference charged with establishing the United Nations and drafting the Charter of the organization;

Whereas Ralph Bunche was instrumental in drafting Chapters XI and XII of the United Nations Charter, dealing with non-self-governing territories and the International Trusteeship System, which helped African countries achieve their independence and assisted in their transition to self-governing, sovereign states;

Whereas, in 1946, Ralph Bunche was appointed Director of the Trusteeship Division of the United Nations;

Whereas, in 1948, Ralph Bunche was named acting Chief Mediator in Palestine for the United Nations, and, in 1949, successfully brokered an armistice agreement between Israel, Egypt, Jordan, Lebanon, and Syria;

Whereas Ralph Bunche was deeply committed to ending colonialism and restoring individual State sovereignty through peaceful means;

Whereas the National Association for the Advancement of Colored People awarded its highest honor, the Spingarn Medal, to Ralph Bunche in 1949;

Whereas for his many significant contributions and efforts toward achieving a peaceful resolution to seemingly intractable national and international disputes, Ralph Bunche was awarded the Nobel Peace Prize in 1950, the first African-American and the first person of color to be so honored;

Whereas Ralph Bunche was named United Nations Under-Secretary-General in 1955, in charge of directing peacekeeping missions in several countries;

Whereas, in 1963, Ralph Bunche received the United States' highest civilian award, the Medal of Freedom; and

Whereas Ralph Bunche's critical contributions to the attempt to resolve the Arab-Israeli conflict and towards the de-colonization of Africa, and his commitment to and long service in the United Nations and numerous other national and international humanitarian efforts, warrant his commemoration: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) recognizes and honors Ralph Bunche as a pivotal 20th century figure in the struggle for the realization and attainment of human rights on a global scale; and

(2) urges the President to take appropriate measures to encourage the celebration and remembrance of Ralph Bunche's many significant achievements.

RECOGNIZING ALTHEA GIBSON FOR HER GROUND BREAKING ACHIEVEMENTS

Mr. HATCH. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged from further consideration of H. Con. Res. 69 and that the Senate proceed to its immediate consideration.

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

The clerk will report the concurrent resolution by title.

The assistant legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 69) expressing the sense of Congress that Althea Gibson should be recognized for her ground breaking achievements in athletics and her commitment to ending racial discrimination and prejudice within the world of sports.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. HATCH. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to this concurrent resolution be printed in the RECORD.

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

The concurrent resolution (H. Con. Res. 69) was agreed to.

The preamble was agreed to.

RECOGNIZING THE IMPORTANCE OF RALPH BUNCHE AS ONE OF THE GREAT LEADERS OF THE UNITED STATES

Mr. HATCH. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged from further consideration of H. Con. Res. 71 and that the Senate proceed to its immediate consideration.

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

The clerk will report the concurrent resolution by title.

The assistant legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 71) recognizing the importance of Ralph Bunche as one of the great leaders of the United States, the first African-American Nobel Peace Prize winner, an accomplished scholar, a distinguished diplomat, and a tireless campaigner of civil rights for people throughout the world.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. HATCH. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to this concurrent resolution be printed in the RECORD.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 71) was agreed to.

The preamble was agreed to.

EXPRESSING THE SENSE OF CONGRESS SUPPORTING VIGOROUS ENFORCEMENT OF THE FEDERAL OBSCENITY LAWS

Mr. HATCH. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 375, S. Con. Res. 77.

The PRESIDING OFFICER. The clerk will report the concurrent resolution by title.

The assistant legislative clerk read as follows:

A concurrent resolution (S. Con. Res. 77) expressing the sense of Congress supporting vigorous enforcement of the Federal obscenity laws.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. HATCH. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table en bloc, and that any statements relating to the concurrent resolution be printed in the RECORD.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The concurrent resolution (S. Con. Res. 77) was agreed to.

The preamble was agreed to.

The concurrent resolution, with its preamble, reads as follows:

S. CON. RES. 77

Whereas the Supreme Court in Miller v. California, 413 U.S. 15 (1973) held that obscene material is ''unprotected by the first amendment'' (413 U.S. at 23) and that obscenity laws can be enforced against '' 'hard core' pornography'' (413 U.S. at 28);

Whereas the Miller Court stated that ''to equate the free and robust exchange of ideas and political debate with commercial exploitation of obscene material demeans the grand conception of the first amendment and its high purposes in the historic struggle for freedom.'' (413 U.S. at 34);

Whereas the Supreme Court in Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1973) recognized that there are legitimate governmental interests at stake in stemming the tide of obscene materials, which include—

(1) protecting ''the quality of life and total community environment'' (413 U.S. at 58);

(2) protecting ''public safety'' (413 U.S. at 58);

(3) maintaining ''a decent society'' (413 U.S. at 59–60);

(4) protecting ''the social interest in order and morality'' (413 U.S. at 61); and

(5) protecting ''family life'' (413 U.S. at 63);

Whereas Congress, in an effort to protect these same legitimate governmental interests, enacted legislation in 1988 to strengthen federal obscenity laws and in 1996 to clarify that use of an interactive computer service to transport obscene materials in or affecting interstate or foreign commerce is prohibited;

Whereas the 1986 Final Report of the Attorney General's Commission on Pornography found that ''increasingly, the most prevalent forms of pornography'' fit the description of ''sexually violent material'' (p. 323) and that ''an enormous amount of the most sexually explicit material available'' can be categorized as ''degrading'' to people, ''most often women'' (p. 331);

Whereas the Internet has become a conduit for hardcore pornography that now reaches directly into tens of millions of American homes, where even small children can be exposed to Internet obscenity and older children can easily find it;

Whereas a national opinion poll conducted in March 2002 by Wirthlin Worldwide marketing research company found that 81 percent of adult Americans say that ''Federal laws against Internet obscenity should be vigorously enforced'';

Whereas a May 2 report from the National Academies' National Research Council stated that ''aggressive enforcement of existing antiobscenity laws can help reduce children's access to certain kinds of sexually explicit material on the Internet'';

Whereas vigorous enforcement of obscenity laws can help reduce the amount of ''virtual child pornography'' now readily available to sexual predators; and

Whereas it continues to be the desire of the People of the United States of America and their representatives in Congress to recognize and protect the governmental interests recognized as legitimate by the United States Supreme Court in Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1973): Now, therefore be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of Congress that the Federal obscenity laws should be vigorously enforced throughout the United States.

FAIR AND ACCURATE CREDIT TRANSACTIONS ACT, 2003—CONFERENCE REPORT

Mr. HATCH. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of the conference report to accompany H.R. 2622, the Fair and Accurate Credit Transactions Act of 2003.

The PRESIDING OFFICER (Mr. BURNS). The report will be stated.

The assistant legislative clerk read as follows:

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2622) to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes, having met, have agreed that the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, and the Senate agree to the same, signed by a majority of the conferees on the part of both Houses.

The PRESIDING OFFICER. Without objection, the Senate will proceed to the consideration of the conference report.

(The conference report is printed in the House proceedings of the RECORD of November 21, 2003.)

Mr. HATCH. Mr. President, I ask unanimous consent that the conference report be agreed to, the motion to reconsider be laid upon the table, and any statements relating to the conference report be printed in the RECORD.

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

The conference report was agreed to.

HOMETOWN HEROES SURVIVORS BENEFITS ACT OF 2003

Mr. LEAHY: Mr. President, I rise today to express my pleasure with the House passage of the ''Hometown Heroes Survivors Benefits Act of 2003,'' S. 459, at daybreak today. This bill, as amended and passed by unanimous consent in the House, will improve the Department of Justice's Public Safety Officers Benefits program by allowing survivors of public safety officers who suffer fatal heart attacks or strokes while participating in nonroutine stressful or strenous physical activities to qualify for Federal survivor benefits.

I want to pay special thanks to Congressman BOB ETHERIDGE, the author of the House companion bill, and House Judiciary Committee Chairman SENSENBRENNER for their leadership and fortitude while negotiating this legislation. Without their perseverance and willingness to find bipartisan compromise language, passage of this bill in the House would not have happened.

I also commend Congressman COBLE, Congressman BOBBY SCOTT, the Fraternal Order of Police and the Congressional Fire Services Institute for working with us on bipartisan compromise language so that we could pass the Senate bill through the House. I look forward to working with Senate Judiciary Chairman HATCH, Senator LINDSEY GRAHAM, the lead Republican cosponsor of this bill, and Senate leadership to quickly pass the Senate bill, as amended by the House, and send it to the President's desk for enactment into law.

Public safety officers are our most brave and dedicated public servants. I applaud the efforts of all members of fire, law enforcement and EMS providers nationwide who are the first to respond to more than 1.6 million emergency calls annually—whether those calls involve a crime, fire, medical emergency, spill of hazardous materials, natural disaster, act of terrorism, or transportation accident—without reservation. Those men and woman act with an unwavering commitment to the safety and protection of their fellow citizens, and forever willing to selflessly sacrifice their own lives to provide safe and reliable emergency services to their communities.

Sadly, that kind of dedication can result in tragedy, which we all witnessed on September 11 as scores of firefighters, police officers and medics raced into the burning World Trade Center and Pentagon with no other goal than to save lives. Every year, hundreds of public safety officers nationwide lose their lives and thousands more are injured while performing duties that subject them to great physical risks. And while we know that PSOB benefits can never be a substitute for the loss of a loved one, the families of all our fallen heroes deserve to collect these funds.

The PSOB program was established in 1976 to authorize a one-time financial payment to the eligible survivors of Federal, State, and local public safety officers for all line of duty deaths. In 2001, Congress improved the PSOB regulations by streamlining the process for families of public safety officers killed or injured in connection with prevention, investigation, rescue or recovery efforts related to a terrorist attack. We also retroactively increased the total benefits available by $100,000 as part of the USA PATRIOT Act. Survivors of first responders killed in the line of duty now receive $267,494 in PSOB.

Unfortunately, the issue of covering heart attack and stroke victims under PSOB regulations was not addressed at the time.

Service-connected heart, lung, and hypertension conditions are silent killers of public safety officers nationwide. The numerous hidden health dangers dealt with by police officers, fire fighters and EMS personnel are widely recognized, but officers face these dangers in order to serve and protect their fellow citizens.

The intent of the legislation Senator GRAHAM and I introduced earlier this year was to cover officer who suffered a heart attack or stroke as a result of nonroutine stressful or strenuous physical activity. As drafted and passed by the Senate by unanimous consent on May 16, however, members of the House Judiciary Committee felt the bill's language would cover officers who did not engage in any physical activity, but merely happened to suffer a heart attack while at work. Chairman SENSENBRENNER, Congressman ETHERIDGE, Congressman COBLE, Congressman SCOTT, FOP, CFSI and I worked out a substitute amendment to address those concerns.

The substitute amendment to S. 459 will create a presumption that an officer who died as a direct injury sustained in the line of duty if the following is established: That officer participated in a training exercise that involved nonroutine stressful or strenuous physical activity or responded to a situation and such participation or response involved nonroutine stressful or strenuous physical law enforcement, hazardous material response, emergency medical services, prison security, fire suppression, rescue, disaster relief or other emergency response activity; that officer suffered a heart attack or stroke while engaging or within 24 hours of engaging in that physical activity; and such presumption cannot be overcome by competent medical evidence.

For the purposes of this act, the phrase ''nonroutine stressful or strenuous physical'' will exclude actions of a clerical, administrative or non-manual nature. Included in the category of ''actions of a clerical, administrative or non-manual nature'' are such tasks including, but not limited to, the following: sitting at a desk; typing on a computer; talking on the telephone; reading or writing paperwork or other literature; watching a police or corrections facility's monitors of cells or grounds; teaching a class; cleaning or organizing an emergency response vehicle; signing in or out a prisoner; driving a vehicle on routine patrol; and directing traffic at or participating in a local parade.

Such deaths, while tragic, are not to be considered in the lien of duty deaths. The families of officers who died of such causes would therefore not be eligible to receive PSOB.

For the purposes of this Act, the phrase ''nonroutine stressful or strenuous physical'' actions will include, but are not limited to, the following: involvement in a physical struggle with a suspected or convicted criminal; performing a search and rescue mission; performing or assisting with emergency medical treatment; performing or assisting with fire suppression; involvement in a situation that requires either a high speed response or pursuit on foot or in a vehicle; participation in hazardous material response; responding to a riot that broke out at a public event; and physically engaging in the arrest or apprehension of a suspected criminal.

The situations listed above are the types of heart attack and stroke cases that are considered to be in the line of duty. The families of officers who died in such cases are eligible to receive PSOB.

Heart attacks and strokes are a reality of the high-pressure jobs of police officers, firefighers and medics. These are killers that first responders contend with in their jobs, just like speeding bullets and burning buildings. They put their lives on the line for us, and we owe their families our gratitude, our respect and our help. No amount of money can fill the void that is left by these losses, but ending this disparity can help these families keep food on the table and shelter over their heads.

I urge the Senate to take up and pass the Hometown Heroes Survivors Benefits Act, S. 459, as amended and passed this morning by the House, and show its support and appreciation for these extraordinarily brave and heroic public safety officers.

ADDITIONAL STATEMENTS

IN MEMORY OF JUDGE RAYMOND J. PETTINE

● Mr. REED. Mr. President, on Monday, November 17, 2003, Rhode Island, the judicial community and the entire Nation lost a great jurist, a great scholar and a great man. U.S. District Court Judge Raymond J. Pettine passed away leaving a legacy of protecting individual liberties and constitutional rights.

Judge Pettine was born July 6, 1912 on America Street in Federal Hill, one of the original Italian neighborhoods in Providence; a fitting place to be born for someone who would champion the Constitution that distinguishes this country, America, from so many others. His father was a wigmaker in Italy who immigrated to these shores to find a better life for his family and to make a better America through his labors and his sacrifice. Judge Pettine was sustained and inspired by the example of these good people, his mother and father. The hard work, the great patriotism, the unwavering decency and integrity, the deep respect for both family and faith, the gracious manners of a true gentleman were learned in that home on America Street.

Early in his life, Judge Pettine became fascinated with the law. As a

child of eight, he scrawled a note to the Dean of Harvard Law School and asked him, ''What do you have to do to become a lawyer?'' The Dean wrote in reply ''study hard, be a good boy, always have a dream.'' His dream led him to Providence College and Boston University Law School. Soon after graduation, he enlisted in the U.S. Army and served on active duty from 1941 until 1946 rising to the rank of major. He later would be promoted to colonel in the Judge Advocate General Corps as a reservist.

After his discharge from active duty and a brief stint in private practice, Judge Pettine began a 13-year career as a prosecutor in the Rhode Island Attorney General's office. Like every task he undertook, he brought great passion and determination to this endeavor. He understood that our adversarial system of justice requires that both the prosecution and the defense must bring the full weight of the facts and the law before the jury so that they may have the benefit of principled and forceful advocacy to make their decision. He was a tough and uncompromising prosecutor determined to enforce the law.

His reputation and his record as a prosecutor earned him appointment as the Federal Attorney for the District of Rhode Island is 1961. His service as Federal Attorney won him the praise of Attorney General Robert F. Kennedy as one of the nation's top three federal prosecutors. And, this prosecutorial experience would help make him a superb judge upon his appointment to the bench in 1966 by President Johnson. Judge Pettine recognized that the role of a judge was different than that of a prosecutor or defense counsel. He was charged with something greater than simply enforcing the law or arguing for a client. He was charged with seeking justice, that delicate balance that rests on fairness and a keen understanding of the nature of people as well as the tenets of the law. He was also charged in a special way with defending the Constitution and the Bill of Rights. He recognized that our democracy, in his words, ''prizes itself in having a Bill of Rights designed to protect us against despotic abuse of authority by the government.''

There was no more courageous, forceful or principled defender of the Constitution than Raymond Pettine. In 30 years on the Federal bench, and as chief judge from 1971 to 1982, Judge Pettine staunchly guarded the individual rights enshrined in the Constitution. He said the Constitution should be interpreted in ways that ''give meaning to the heart and soul of what it's all about: a kinder, more understanding Constitution that recognizes the disenfranchised, the poor and underprivileged.''

In his rulings, he repeatedly upheld the Bill of Rights' freedom of speech, of religion and of privacy.

Pettine stood by the Constitution and showed courage in the face of controversy when he, a practicing Catholic, ruled that municipalities could not erect Christmas Nativity scenes on public land. As he said, ''I firmly believe this with great conviction: that there has to be a separation between church and State—that one of the saving graces of this country is the fact that we are tolerant of all religions, and even of those who have no religion. And, if we start breaking that down, we are going to be in an awful lot of trouble.''

His wise defense of the Constitution and its protections for individual conscience brought him vicious criticism and personal scorn. But, no amount of criticism or scorn could deter him from his obligation to extend the protections of the Constitution to the poor as well as the powerful, to the maligned as well as the popular.

Judge Pettine embraced his judicial duties with remarkable dedication. He became a scholar of the law and, in order to insulate himself from even the appearance of partiality, he led a life focused on his family and the lonely rigors of his judicial responsibilities. Nevertheless, he cut a dashing figure in Rhode Island. He was a man of great culture and erudition who exuded style and panache.

Judge Raymond J. Pettine has left a remarkable legacy. His wisdom, his integrity and his selfless devotion to the Constitution made him a judge of extraordinary achievement. His love of family and his compassionate regard for all he met made him a man of singular worth. I admire him greatly. He has given us the example and the confidence to carry on. And, his presence will continue to be felt whenever we stand up in defense of the Constitution and in defense of those who are ''disenfranchised, the poor and underprivileged.''

My deepest condolences go out to his family and friends, especially his daughter, Lee Gillespie, his granddaughter, Lauren Gillespie and his son-in-law, Thomas Gillespie.●

MESSAGE FROM THE HOUSE

At 10:01 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.

The message also announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2622) to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes.

The message further announced that the House agrees to the following bills, each with an amendment in which it requests the concurrence of the Senate:

S. 459. An act to ensure that a public safety officer who suffers a fatal heart attack or stroke while on duty shall be presumed to have died in the line of duty for purposes of public safety officer survivor benefits;

S. 877. An act to regulate interstate commerce by imposing limitations and penalties on the transmission of unsolicited commercial electronic mail via the Internet; and

S. 1768. An act to extend the national flood insurance program.

The message also announced that the House has passed the following bill, without amendment:

S. 579. An act to reauthorize the National Transportation Safety Board, and for other purposes.

The message further announced that the House has passed the following bills and joint resolution, in which it requests the concurrence of the Senate.

H.R. 1964. An act to assist the States of Connecticut, New Jersey, New York, and Pennsylvania in conserving priority lands and natural resources in the Highlands region, and for other purposes;

H.R. 2584. An act to provide for the conveyance to the Utrok Atoll local government of a decommissioned National Oceanic and Atmospheric Administration ship, and for other purposes;

H.R. 3181. An act to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to reauthorize the predisaster mitigation program, and for other purposes; and

H.J. Res. 80. Joint resolution appointing the day for the convening of the second session of the One Hundred Eighth Congress.

The message also announced that the House has agreed to the following concurrent resolutions, in which it requests the concurrence of the Senate:

H. Con. Res. 206. Concurrent resolution supporting the National Marrow Donor Program and other bone marrow donor programs and encouraging Americans to learn about the importance of bone marrow donation; and

H. Con. Res. 229. Concurrent resolution providing for the sine die adjournment of the first session of the One Hundred Eight Congress.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Ms. COLLINS, from the Committee on Governmental Affairs, without amendment:

S. 1683. A bill to provide for a report on the parity of pay and benefits among Federal law enforcement officers and to establish an exchange program between Federal law enforcement employees and State and local law enforcement employees (Rept. No . 108-207).

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. BUNNING (for himself, Mr. MILLER, Mr. INHOFE, Mr. NELSON of Nebraska, Mr. CRAIG, Mr. LUGAR, Mr. SANTORUM, Mr. COLEMAN, Mr. SMITH, Mr. HATCH, and Mr. CARPER):

S. 1931. A bill to repeal the sunset of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to the expansion of the adoption credit and adoption assistance programs; to the Committee on Finance.

By Mr. CORNYN (for himself, Mrs. FEINSTEIN, Mr. HATCH, Mr. SMITH, Mr. ALEXANDER, and Mr. GRAHAM of South Carolina):

S. 1932. A bill to provide criminal penalties for unauthorized recording of motion pictures in a motion picture exhibition facility, to provide criminal and civil penalties for unauthorized distribution of commercial prerelease copyrighted works, and for other purposes; to the Committee on the Judiciary.

By Mr. HATCH (for himself, Mrs. FEINSTEIN, and Mr. CORNYN):

S. 1933. A bill to promote effective enforcement of copyrights, and for other purposes; to the Committee on the Judiciary .

ADDITIONAL COSPONSORS

S. 1549

At the request of Mrs. DOLE, the names of the Senator from Maine (Ms. COLLINS) and the Senator from Wisconsin (Mr. KOHL) were added as cosponsors of S. 1549, a bill to amend the Richard B. Russell National School Lunch Act to phase out reduced price lunches and breakfasts by phasing in an increase in the income eligibility guidelines for free lunches and breakfasts.

S. 1926

At the request of Ms. STABENOW, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. 1926, a bill to amend title XVIII of the Social Security Act to restore the medicare program and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BUNNING (for himself, Mr. MILLER, Mr. INHOFE, Mr. NELSON of Nebraska, Mr. CRAIG, Mr. LUGAR, Mr. SANTORUM, Mr. COLEMAN, Mr. SMITH, Mr. HATCH, and Mr. CARPER):

S. 1931. A bill to repeal the sunset of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to the expansion of the adoption credit and adoption assistance programs; to the Committee on Finance.

Mr. BUNNING. Mr. President, I rise today in celebration of National Adoption Day by introducing legislation to repeal the sunset on two current-law tax provisions that make adoption more affordable for American families.

In 2001, this Congress passed and President Bush signed into law the Economic Growth and Tax Relief Reconciliation Act. This act contains many much needed tax relief provisions for the American people. However, because of procedural rules in the Senate, this law sunsets and expires after December 31, 2010.

The legislation I introduce today makes permanent two tax provisions contained in that law, the adoption tax credit and the exclusion for employer-provided adoption assistance benefits. If we do not pass this bill and therefore allow these provisions to sunset, then this tax credit will be cut overnight from a maximum of $10,000 to $5,000. Families who adopt special needs children will no longer receive a flat $10,000 credit, and instead, they will be limited to a maximum of $6,000. As well, families claiming the credit may be pushed into the Alternative Minimum Tax.

Today, National Adoption Day, we celebrate the adoption of over 3,000 children from foster care. There are over 542,000 kids in foster care. Of these, more than 125,000 children are waiting to be adopted permanently. We here in Congress need to continue to help these children to find loving homes. We need to make it easier for families to adopt, not throw up barriers. If the adoption tax credit is cut to the prior law level of $5,000, many families will not be able to afford adoptions. And therefore less children will be welcomed into what they want the most, a permanent family.

Last year, the House of Representative passed this permanent extension of the adoption tax credit by a vote of 391 yeas to 1 nay. We in this Chamber failed to act. I am hopeful that my colleagues in the Senate recognize the importance of moving on this legislation to permanently extend this tax credit. The children and parents deserve to see this adoption tax credit set into law for good. This is not a partisan issue, but something all Americans can agree on. We owe it to them all.

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. 1931

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

SECTION 1. REPEAL OF APPLICABILITY OF SUNSET OF THE ECONOMIC GROWTH AND TAX RELIEF RECONCILIATION ACT OF 2001 WITH RESPECT TO ADOPTION CREDIT AND ADOPTION ASSISTANCE PROGRAMS.

Section 901 of the Economic Growth and Tax Relief Reconciliation Act of 2001 is amended by adding at the end the following new subsection:

''(c) EXCEPTION.—Subsection (a) shall not apply to the amendments made by section 202 (relating to expansion of adoption credit and adoption assistance programs).''.

Mr. INHOFE. Mr. President, I rise today to join my colleagues in introducing this bill to repeal the provisions of the Economic Growth and Tax Relief Act of 2001 that sunset the adoption tax credit and adoption assistance programs.

Under the current legislation, families with adopted children are given a tax credit of up to $10,000 to cover their adoption expenses and families who adopt children with special needs are credited the full $10,000. Providing this type of assistance is important in easing the costs of the adoption process and helping families cover expenses incurred by adopting children with special needs.

Currently, there are around 550,000 children in foster care. Of this number, 126,000 are up for adoption. In order to facilitate and expedite the adoption process, I have worked as a member of the Congressional Coalition on Adoption to encourage and support families who are willing to provide a loving, stable, and permanent home for these children. The Coalition has been active in promoting adoption around the country through a number of programs, including the National Adoption Day, a day set aside to draw attention to expediting and finalizing adoptions. In fact, Oklahoma held 20 adoptions this week in celebration of the day.

I strongly believe that it is critical to repeal the sunset provision of the Economic Growth and Tax Relief Act and continue to support those families who are making it possible for children to grow up in a loving and caring environment. As the grandfather of an adopted granddaughter, I can say through personal experience that providing a home where a child can be nurtured and given opportunities to become a contributing member of society is one of the greatest and most rewarding gifts we can ever give.

By Mr. HATCH (for himself, Mrs. FEINSTEIN, and Mr. CORNYN):

S. 1933. A bill to promote effective enforcement of copyrights, an for other purposes; to the Committee on the Judiciary.

Mr. HATCH. Mr. President, I rise to introduce the Enhancing Federal Obscenity Reporting and Copyright Enforcement Act of 2003, the EnFORCE Act. This bill makes three sets of narrow, but important, changes that will build greater flexibility and accountability into our system of intellectual property laws.

First the EnFORCE Act will expand an existing antitrust exemption to conform the law to market realities. Today, an antitrust exemption in the Copyright Act gives record companies and music publishers the flexibility they need to negotiate mechanical royalty rates in the rapidly evolving market for legal music downloading. These parties now need the same flexibility to ensure that they can negotiate royalties associated with innovative forms of physical phonorecords, like enhanced compact disks and DVD audio disks.

The music industry has sometimes been criticized for being too slow to

adopt its business models to new technologies. The industry is now responding to such concerns by developing new products and new distribution channels. The EnFORCE Act will ensure that Federal law allows the music industry to provide consumers with these innovative products and services.

Second, the EnFORCE Act will also resolve two narrow issues relating to statutory damages in copyright infringement litigation. Some accused infringers have tried to avoid liability for statutory damages by challenging the accuracy of the information in copyright registrations; this bill clarifies that courts should resolve such challenges by applying the existing judicial doctrine of fraud-on-the-Copyright-Office. In other cases, disputes have arisen about how many ''works'' have been infringed for purposes of computing statutory damages. These disputes are important for the music industry, which has received inconsistent adjudications about whether an album consisting of ten songs counts as one or ten works for statutory-damages computation. The bill gives courts discretion to conform the law of statutory damages to changing market realities.

Third, and finally, the EnFORCE Act will also enhance both the enforcement and oversight of federal intellectual property law. The bill authorizes appropriations to ensure that all Department of Justice units that investigate intellectual property crimes have the support of at least one agent specifically trained in the investigation of such crimes. The bill also requires the Department of Justice to report to Congress detailed information about the scope of its efforts to investigate and prosecute crimes involving the sexual exploitation of minors or intellectual property.

For the above reasons, I urge my colleagues to support the Enhancing Federal Obscenity Reporting and Copyright Enforcement Act of 2003. I look forward to working with my colleagues in the Senate and the affected public to ensure that this bill achieves its important objectives.

PRIVILEGES OF THE FLOOR

Mr. HATCH. I ask unanimous consent that Grace Becker, a detailee from the Sentencing Commission, be granted the privilege of the floor for the duration of the 108th Congress.

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

Mr. GRASSLEY. Mr. President, I ask unanimous consent that Grant Menke and Brett Swearingen be granted floor privileges throughout the debate on the conference report on H.R. 1.

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

Mr. HARKIN. Mr. President, I ask unanimous consent that Jenelle Krishramoorthy be granted the privilege of the floor for the remainder of the debate today, and the remainder of the debate on this Medicare conference report.

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

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

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, this debate so far has been very illuminating, in a way fascinating, to see how different Members of the Senate view the bill that is before us. I hope that America's seniors are watching this debate. I hope they are listening. I hope they will make up their own minds.

There are many groups out there who are going to give their opinions, and I respect them all. But I think if you just go to the debate and you listen to all sides of it, seniors will come up with their own conclusions. As a matter of fact, I also hope people in their fifties and forties are watching this debate because many of the changes that will be made, if this bill becomes law, are going to impact people in their fifties, people in their forties.

Let's face it, Medicare is a program that impacts all families because the children of senior citizens oftentimes bear the burden, if there are health problems. Of course, they care deeply about their families.

We know that Medicare is a nationwide health plan for aged and certain disabled Americans, and it was created 40 years ago for seniors to offer them access to good quality health care. There was a huge debate at that time about whether this was the right thing to do. But people looked around and saw that our seniors were in trouble. They were spending their money on health care, didn't have anything left, oftentimes had to move in with their families. Their families had to pick up their health care bills, and it was very difficult.

This program has fulfilled its promise. Is it perfect in every way? Of course not. What program is? What corporation is? What person is? But Medicare has saved many lives and has made the golden years golden for a lot of our seniors. That is why they feel so strongly about it.

I have been listening to some of the call-in shows. I have heard seniors identify themselves as Republicans, Democrats, and Independents. They are worried about the changes that are about to hit the system, and so am I.

The one thing I think everyone agrees on is that there ought to be a prescription drug benefit. At least I think most of us believe that from both sides of the aisle. We know this cost is heavy on our seniors. We know drug prices are skyrocketing because, unfortunately and very sadly, we don't allow drug reimportation from places like Canada and Mexico, although I have to tell you that in my State, people are going to Mexico.

I received a letter from a constituent of mine from San Marcos, CA, earlier this year. She told me that her annual cost for prescription drugs this year will top $10,000. Think about that, $10,000. How do our seniors deal with this when they are retired?

A retired physician from Marina del Rey told me that a pill he takes for his heart disease went up 600 percent, from $15 a month to $85. For seniors who have to take an assortment of medicines to manage their chronic diseases, the costs really start to add up.

Very sad to say, in this bill there is virtually no cost containment. Even though the House version said reimportation from Canada was a good idea, this has not happened. We will continue to pay the highest drug prices in the world. It is very sad, indeed. The provisions on generic drugs were watered down a bit. We have some in there but not what they should be.

For all the reasons that I talked about—the fact that I feel deep compassion for my constituents who have to pay these huge sums for medicines—I voted for the Senate bill. The Senate bill left here. I thought it made some sense. So let's look at what the Senate bill did for our seniors.

It had about six things that it did that I thought were really important.

First, there was a modest benefit for seniors that were hardest hit by the costly prescription drugs. That benefit was a lot better than the benefit that is currently before us. I will go into the differences. The benefit that is before us is so weak, it barely has a pulse. It is barely worth filling out the forms. It is barely worth your time. You could probably do better if you become friendly with your pharmacy down the road. They will probably give you a better deal.

The benefit before us, unlike the benefit we voted on, is this: If you have $5,100 worth of drug costs, you will pay $4,020 for those drugs. In the meanwhile, you will have to figure out what are your deductibles, what are your copays, filling out the forms, being nervous, getting notified that you no longer have the drug benefit because there is a benefit shutdown, which I will get into later. So think about it. You have a $5,000 drug bill, and you are paying $4,000. And you are going through probably bureaucratic hell to get that thousand dollars off.

So the benefit, when we got the bill, we voted it out. I voted for it. I wanted it. It was a modest benefit but a decent benefit. It was much better than this one. We will get into that later.

Secondly, all seniors were guaranteed a Medicare prescription drug benefit if they didn't have two private plans in their area. So you had a good fallback. If you didn't have two private drug plans competing for your business, could you say: Forget this. I can go to Medicare.

Third, Medicare could have bargained for lower prescription drug costs. Now, why is this important? Just look at the

Veterans' Administration. They can get way lower costs for the drug benefits for their veterans because they represent millions of veterans. Therefore, they have bargaining power. It is not like if I walked into a pharmacy myself and said: Hi, I am a veteran, can you lower my drug prices. And the pharmacist looks at me and says: Well, no. But if I bring millions of people into the store, the pharmacist is going to say: You know, now I can talk to you about some bargain prices.

That is what we have done with the VA. In the original bill that came out of the Senate, Medicare could have bargained. We will talk about the current bill in a minute.

Then, No. 4, there were steps to privatize Medicare, but they were minor steps. They were balanced by a $6 billion sum that was added to Medicare. So while they gave the private plans $6 billion in the Senate bill to ''encourage'' them to stay in the Medicare business, I didn't agree with that. When I think about competition, I don't think about paying people to compete. I didn't think that is what capitalism is. I was a stockbroker. That is news to me. To me competition is what it says. You come in, you see you have a chance to make a profit, and you compete.

Well, we were giving them $6 billion. I wasn't happy about it, but I felt that, all in all, because we balanced it and gave $6 billion to Medicare to add prevention and some other very important benefits, it was worth it.

So just sum that up. I want to be clear here. I supported the Medicare prescription drug bill that was before the Senate because it was a decent benefit for seniors. It gave them about a third off their drugs. So it gave you a third off of your drugs. I thought that was a good benefit. You paid two-thirds and you got a third off. Again, I thought it should have been better. It was modest. I wasn't thrilled with it. I tried to have amendments to close the benefit shutdown, to bring the benefit up to 50 percent, but I did not succeed in that effort.

All seniors were guaranteed a Medicare drug benefit, that fallback, if they didn't have two private drug plans competing. Frankly, I wanted a Medicare fallback for everybody. I remember the debate. But they convinced me to compromise. I wasn't thrilled, but I voted for it. Medicare could have bargained for lower prices for drugs. I assumed that would be part of what we would do. We didn't prohibit it. The steps to privatize Medicare, to incentivize HMOs to stay in the Medicare business, were balanced by $6 billion added to Medicare for some important new benefits.

The last thing is, for the lowest income seniors, they got prescription drugs at no cost. That was a wonderful thing in the Senate bill. The poorest of the poor people who worked all their lives and found themselves in a horrible situation today would have gotten drugs at no cost. For all those reasons, I was very pleased in the end that I was able to move that bill forward.

I want to show you something I hope you can appreciate, as I hold this bill up for a minute. The bill itself that has now come back to us is very heavy. Here it is. This is the bill that is before us today. This bill I am holding is 678 pages. How much of this is the prescription drug benefit? It is 181 pages. What does that tell you? It tells you that most of this bill has nothing to do with prescription drugs. Think about it. We sent a prescription drug bill into the conference committee to come back to us, and here it is. This yellow tab shows me where it is. This is the prescription drug benefit. It is 181 pages. The balance of this bill is way more, 5 times more.

Think about it. If the folks who brought you this bill were sincere about giving you a prescription drug benefit, why did they then use that as an excuse to begin changing Medicare—changing Medicare in ways that are perplexing, that are going to be difficult to understand, and the rest?

Now, I am not, generally speaking, someone who is paranoid about things. But I have to tell you, I am when I hear Newt Gingrich, praising all 600 pages of this bill, who said in 1995:

> Now, we don't get rid of it [Medicare] in round one because we don't think that that's politically smart, and we don't think that's the right way to go through a transition. But we believe Medicare is going to wither on the vine, because we think people are voluntarily going to leave it.

Voluntarily. If you mess up Medicare and you make it confusing and start doing the things that they do in this bill, Newt Gingrich will be proven right. Why do you think he went over to the caucus on the other side, in the House, and talked to the Republicans who didn't like the bill? Because they thought it was too good to seniors.

He said: No, it is not. Trust me. Would I lead you astray?

That is Newt Gingrich. The senior citizens in this country, in my view, are the smartest of the folks when it comes to Medicare. They know it. They get it. They understand Social Security and they understand Medicare. They understand when Newt Gingrich said that Medicare should ''wither on the vine,'' and that this isn't something they want to see happen.

Well, folks, please listen. ''We don't have to get rid of it in round one,'' Newt said, ''because we don't think it's politically smart.'' So what did they do? They take a prescription drug benefit that is popular—by the way, it is voluntary, but I will talk about that because it is not voluntary if you are on Medicaid, and it is not voluntary when you find out that your pension plan has dropped your prescription drug coverage because then you will have nothing. You will be forced into it. It is not voluntary for those folks.

But I can tell you that this is just what Newt Gingrich planned. You cannot do it all at once. Not in round 1. We have to go through a ''transition.'' Remember that word because it shows up in this bill—''transition.'' So here is prescription drugs, and here is the withering on the vine.

A lot of the people who fought Medicare in the beginning are embracing this bill. Do you think they had a change of heart? Do you think those of us who built our careers on protecting seniors have somehow gone wacko on you by saying that this bill does more harm than good? Think about the Senators who are standing up here and extolling the virtues of this bill. One of them was here before and he said that people on the other side are saying we are trying to destroy Medicare. How ridiculous, he said. That's crazy. We would never do that. Then he launched into a harsh criticism of Medicare and how it needs to change.

Another, I thought, belied his point of view when he stood up and said—it is on the record from this afternoon—we need to get away from the ''command and control'' of Medicare.

Well, I have news for the Senator from Texas, who said that. In Medicare, do you know who is in command and control? The senior citizens. That senior citizen can go anywhere—to the doctor of choice. That is the beauty of the Medicare system. They are in command and control.

What this bill does is start the unraveling of that command and control and gives it to a whole new system that is so confusing that I would assure you, when you begin to hear the words and the acronyms associated with this new system, if you went up to any Senator and asked him or her a question about it, not one of them would pass the test of understanding every acronym—not even close. So the Senate bill benefited seniors. What we have before us is quite different.

To me, the saddest thing about this bill is that it turned a modest, but decent, benefit for seniors into an enormous benefit for the largest pharmaceutical companies and HMOs in America. Here is what we have now in the bill. This is what we have now. The bill benefits drug companies and HMOs.

First of all, the bill sets up a slush fund of $14 billion for HMOs. I have to say something here. The deficit that we are facing in our country today is nothing short of an abomination. From the minute this President took over until today, we have seen deficits as far as the eye can see and balanced budgets turn into $500 billion-a-year deficits every year. But the folks in the conference committee found $14 billion to give to those profitable corporations in America. Why do you think that is the case?

There is an article today in the Washington Post that tries to explain it. This is the headline on the front page:

> 2 Bills Would Benefit Top Bush Fundraisers. Executives' Companies Could Get Billions.

This is the selling of America. I want to quote from this article.

More than three dozen of President Bush's major fundraisers are affiliated with companies that stand to benefit from the passage of two central pieces of the administration's legislative agenda: the energy and Medicare bills.

We stopped the Energy bill. I don't know how long we will be able to hold that, but the Energy bill is a clear-cut case. We talked about that the other day, and now there is the Medicare bill.

Continuing the quote:

The energy bill provides billions of dollars in benefits to companies run by at least 22 executives and their spouses who have qualified as either ''Pioneers'' or ''Rangers''—

That is what they call the big fat cats, Pioneers or Rangers——

as well as to the clients of at least 15 lobbyists and their spouses who have achieved similar status as fundraisers. At least 24 Rangers and Pioneers could benefit from the Medicare bill—

Twenty-four Rangers and Pioneers, and those are the people who give the most money——

could benefit from the Medicare bill as executives of companies or lobbyists working for them, including eight who have clients affected by both bills.

Talk about hitting the lottery. They benefit from the Energy bill and this bill. We know where the money is going. It is going out of the Federal Treasury to the fat cats. Face it. Unfortunately for the folks around here, we know now. We have it.

How about this?

Hank McKinnell—

He may be a lovely man; this is not a personal attack on him——

chairman and CEO of Pfizer, has pledged to raise at least $200,000 for Bush's reelection, although he is not yet listed as a Pioneer or Ranger. Pioneer Munr Kazmir, who runs a direct-mail drug company called Direct Meds Inc., estimates that he has about 100,000 customers on Medicare who will have more money to buy drugs from his company. ''We know the patients, we know how important this bill is,'' he said.

Follow the money. Dress it up any way you want. Talk about how great this bill is. Follow the money. I hope seniors are watching this tonight. They will make up their own minds. They are calling my office. My phones are overwhelmed. What are they running on this? About 1,000 calls to 200 calls against this bill. For every 100 yeses, there are 1,000 nos. Seniors are smart.

They trust the AARP. Now they are finding out that the head of the AARP wrote the foreword to Newt Gingrich's book. Now they are finding out that the AARP gets 60 percent of their funds from selling insurance. Now they are finding out that the head of the AARP represented big drug companies. Follow the money.

There is a $14 billion slush fund for HMOs at a time when we don't have money to fully fund education. We can't fully fund education, but we can find $14 billion for a slush fund for HMOs. They don't call it a slush fund. They call it a few other names—a stabilization fund. They call it a stabilization fund.

Over 7 years, HMOs get $14 billion. This includes $10 billion in direct subsidies to HMOs handed out at the discretion of the head of the agency overseeing Medicare. How would you like to be that guy? At his whim, this bureaucrat can write checks to HMOs to bribe them to participate in Medicare.

In addition, there are nearly $4 billion of payments to the HMOs that already participate in Medicare just to bribe them to stay in Medicare. What kind of capitalism are we living in this country when we have to pay the private sector extra money when they went in the business in the first place? Things have changed. When I was a stockbroker, it wasn't that way. We didn't give corporations the kind of welfare we are giving them today. This is corporate welfare. Follow the money to the Presidential campaigns and you will get a very interesting story.

This $14 billion slush fund is particularly egregious when you consider that Medicare already pays HMOs more than the per-patient cost of traditional Medicare. Let me repeat that.

HMOs are getting paid more than the traditional Medicare. Do my colleagues know why? The overhead in Medicare is very small. Do we know exactly—is it 2 or 3 percent? Anyway, we do not pay CEOs millions and millions of dollars. They are taking that money right off the top and lining their pockets. Oh, but why not? They are nice people, give them $14 billion.

It is not that they are so great, these HMOs. People get the runaround. They do not get the care they need. People want their traditional Medicare.

Remember what I said. The bill I voted for in the Senate gave $6 billion to HMOs. I was not happy with that at all, but at least it gave $6 billion to traditional Medicare to help us do more prevention. Guess what happened. It is gone. The conference committee took it away. But they have added it on to the $6 billion already there. They added $6 billion that was going to go to Medicare. They put it in the HMOs, and they added $2 billion just in case it was not enough money for their friends.

Secondly, this bill benefits drug companies and HMOs. There is a gag rule on Medicare price negotiation. I talked a little bit about that before. Medicare has all of these clients. Think about the clout Medicare could have when they call a drug company and say that their drug X, Y, Z is a drug for arthritis and our patients like it; we are going to buy a lot of it for our patients; please give us a deal.

Oh, no, the conferees said, Medicare has a gag rule. Watch out. They may do it to the veterans next. The VA can bargain, but Medicare cannot bargain. The drug companies and the HMOs can bargain explicitly. They can bargain, and they can pocket some of the profits that they bargain, but not Medicare. Medicare cannot bargain. There is a gag rule on Medicare.

They will stand up on the other side and say: We are not trying to destroy Medicare; we think it is a great program. Just remember Newt Gingrich: Let it wither on the vine.

Seniors are expected to spend $1.6 trillion in prescription drugs over the next decade. By the way, there are a lot of pharmaceutical companies and a lot of wonderful research companies in my State. I have a great relationship with them. I support them getting an R&D tax credit; in other words, a tax credit for every penny they put into research and development. Why? Because I think that is important. I support their patents—reasonably support their patent rights. I support research through the NIH very strongly, and a lot of that benefits the drug companies as well. So I work very closely with my biotech companies, with my pharmaceutical companies, but, by God, I do not believe in giving them welfare.

Fourteen billion dollars? Is that because we have so much money? Is our deficit not big enough? It is only up to $500 billion in 2½ years or 3 years. Gee, we could do better. Why do we not make it $600 billion? Do I hear $700 billion?

I do not know what has happened, but it is not good. It took us 8 years to balance that budget. The other side said: We want a constitutional amendment to balance the budget. And our side said: Let's just balance it. Why do we need to amend the Constitution? Let's balance it. And President Clinton did that with us over 8 years.

Now it is gone. Now we have $14 billion to add to the deficit, and we are not going to let Medicare negotiate for us because, for whatever reason, they are tying Medicare's hand. I think it is because they want Medicare to wither on the vine. That is what Newt Gingrich said. That is the only thing I can come up with.

We know the cost of drugs could be lowered if Medicare negotiated those drug prices. One might say, well, maybe, Senator BOXER; that would be highly unusual for Medicare to negotiate with the drug companies. I would say, not at all. Medicare negotiates payments to hospitals. They have done that for years. When the bill left the Senate, there was no prohibition, but now there is. Why? Because they do not want the Medicare drug plan to be able to offer lower prices. They have given the right to negotiate to the private sector. They are going to push seniors into those plans.

Just remember where I started from. Just remember, ''wither on the vine,'' and ''follow the money.'' These are some simple concepts. At the end of my statement, just put a little ribbon and tie the bow and everyone will get the picture as to why we are going down a very dangerous path.

In this bill, we are going to be giving to HMOs payments above their stated cost to deliver service. Has anyone ever heard of anything like that in their entire life? A firm bids on a contract.

They say: We can supply you with X number of widgets for a thousand dollars. On the dot, you get it. You deliver the thousand widgets, I give you $1,000.

Here, HMOs are saying: We can deliver health care for patients at a cost of X dollars per patient. In this conference committee, they said: Well, we are going to give them more money than they say they need. It is called a lot of different names, such as premium support. It is payment above and beyond what they said it would cost. So put together the slush fund and the payments above their cost of service and you are scratching your head, saying, maybe I ought to get into this business.

I say to people all over the country, small businesspeople who work hard in their business, be it retail or wholesale, you do not have a deal like this. You open up your doors, you go into business, and suddenly Uncle Sam is knocking on the door: Hey, I got a check for you HMOs, $14 billion over 7 years just to stay in the business; and, by the way, we love you so much, we are going to give you dollars above and beyond what you say it costs. And, by the way, no one will catch on. We are going to call these names different things. We are not going to call it a slush fund.

So the bill left the Senate. It was a good benefit, a decent benefit, but a modest benefit. It was not perfect, but at least it was a bill on prescription drugs. It came back a benefit for drug companies and HMOs. Somebody said to me there was a hostile takeover in the conference committee of the Medicare bill, that the Senate passed, by the HMOs and the prescription drug companies.

If we look at Wall Street, follow the money. Look at the prices of these stocks. They are going out of sight because people know this is a deal of a lifetime, that is for sure.

The last point I want to make is that this bill hurts our seniors. I am going to be specific. First, it hurts all our seniors, and in the end I am going to show you how it hurts my seniors in California, the largest State in the Union.

These are facts. We have gotten them from the staff that worked on this conference bill. Six million seniors will pay more for prescriptions than they do now. Let me tell you who these people are. Six million low-income and disabled beneficiaries currently receive prescription drug benefits from the Medicaid Program, which is a matching Federal-State program administered by the State. These programs are more generous in coverage than the proposed bill that is before us because they serve our very sickest Americans.

For example, a Medicare/Medicaid-eligible person in California can, but does not have to, pay a $1 per prescription copayment. The copayment is voluntary. A dollar may sound like zero, nothing, to people. But if you are an inch away from owning nothing, every dollar counts.

Under the conference bill the same person will now be required to make a copayment, maybe, up to $5. Some will pay premiums of $50 and be subject to a strict asset test. Studies have shown that even small copayments for prescription drugs can make essential medicines unaffordable for low-income seniors, resulting in an 88-percent increase in hospitalizations and deaths, and a 78-percent increase in emergency room visits.

So they say to my State, now you can't help these poorest of the poor. Sorry. They gave that a name, too, which we will get into later. They give it a nice name, but the bottom line is the people, the poorest of the poor, the States that help them can no longer help them once they get into this program.

The copayments to these poorest of the poor are indexed for inflation. So they can and they will go up. Remember, most of these people don't make any money. When you get hit with inflation and you are on a fixed income, that bites. That takes food off the table. So we know there will be an increase in hospitalizations. That was in the background information, that 88-percent increase in hospitalizations and deaths because people will not take their medicine.

States are prohibited from covering the out-of-pocket costs of these dual eligibles, and the bill prohibits States from establishing more expansive drug lists for the mentally ill, disabled, and other groups.

That is important. They may be taking a drug that isn't covered on this formulary.

I want to talk about people with AIDS. We have a high number in our State. People are suffering. Many of them are dual eligibles. They are eligible for Medicare disability and Medicaid. For them this bill is catastrophic. My phones are ringing off the hook with calls from them, their parents, their families. It is likely that they may not have access to or be able to afford all the drugs they need. So this is why this bill is opposed by the AIDS Medicare Project, San Francisco; AIDS Project, Los Angeles; Project Inform, San Francisco; San Francisco AIDS Foundation. But let's face it, it is not just AIDS patients who are going to be harmed. Anyone with a life-threatening illness runs the risk of not having coverage for the drugs they need. If they are denied coverage for these drugs under Medicare, they can appeal the decision, but this doesn't mean they can afford them.

So when it comes to my State, I will show you later the numbers of people who will be worse off. It goes in the hundreds of thousands—the hundreds of thousands.

Now there is a very cruel asset test. When I voted for the bill in the Senate that the Senator from Iowa worked so hard on with the Senator from Montana, that was a good bill. That bill would have allowed low-income seniors to receive assistance without forcing them to sell a car because it was worth over $4,500 or a ring that maybe was their most precious possession from their loved one or a family heirloom.

The conference bill imposes a Draconian asset test of $6,000 per person, $10,000 per couple, for the poorest of the poor. As a result, 3 million low-income seniors nationwide, and 300,000 in California, will be deprived of assistance that would not only help them with their prescription drugs but help them pay the premium so they could receive the coverage in the first place.

In other words, the bill that is before us has some generosity towards the poorest of the poor, but they have added an asset test into it so if you have a family heirloom or you own a car worth more than $4,500 or you have a diamond ring and a gold wedding band that your husband may have given you when you were married, you have to sell it. You have to get rid of it. Otherwise you don't get the benefit of this prescription drug benefit.

I don't get that. I am sad the conferees didn't go with the bill that most of us voted for in the Senate.

Now you come to seniors who are forced into demonstration projects that penalize them for staying in Medicare. That happens in 2010. You say we are just in 2003. We are almost in 2004—that is 6 years away, big deal. One thing I have learned, as long as I have lived, is that time goes fast. Six years will be here. If you are in one of those demonstration projects, what is going to happen is plain and simple: Your premiums are going to go up if you stay in Medicare—bottom line. Even though people say you are not forced into these other plans, the costs may force you into these other plans.

One in six Medicare beneficiaries will be forced to participate in this experiment. In California, 12 of its metropolitan statistical areas will qualify for these demonstration projects. Let's say two of the largest are chosen; one is in L.A. and the other is in San Francisco. So what we will have is my seniors in those areas will have to make a very tough choice. Do they stay in Medicare and pay more money or do they go into an HMO and lose the choice of their doctors?

We have already had some experimentation. We know the healthy people will choose the HMOs because they are cheaper. After all, they are healthy so they are not worried about getting messed up by an HMO. If they are not sick, you know, it is not a problem.

But the sicker seniors would be left in Medicare, and we know that we will see costs spiral out of control because there will be a sick pool of seniors, rather than spreading the risk, which is what insurance is all about.

Now we have a situation where premiums for middle and upper class people are going to go up. My colleagues say they are only going to go up if you earn $80,000 a year. I understand that is

quite a bit. That is not that many people. But this is the problem. This number of $80,000 a year is not indexed for inflation. So it looks like it is a lot now, but in the future it will not look like it is that big.

For example, if this provision, the one that my colleague from Iowa supports, was in place in 1980, the equivalent level of income would be $33,000, and the person at that level would have to pay much more for their Medicare. So the fact is, they have done an interesting thing: They have not indexed this, so in the end you will have people of very moderate incomes paying huge premiums to Medicare.

Now what is going to happen? It will wither on the vine because people will say: I don't want anything to do with this. It is too costly. I don't need it. I will just go out and buy a catastrophic policy elsewhere.

I will tell you, if you take that fact, along with the fact that this bill sets up health savings accounts for the wealthiest people, you are going to have middle-income people and wealthy people walk away from Medicare, and you will lose the class you have when you have a larger pool. That is just a fact of life. That is why we have had a successful program—because insurance needs a very big pool.

I am going to put up a chart that I hope all of you who might be crazy enough to be watching this will remember. I know this isn't exactly prime-time television. But I want to show you a chart of ''Fear and Confusion.'' This is a BARBARA BOXER homemade chart. This is the chaos and confusion that our seniors are going to be facing.

If any of you are watching this tonight, I am telling you to take note. I am telling you to call the AARP. Senator DURBIN gave you the number. I do not know it. I want you to take notes and ask them to explain each of these concepts they have endorsed in this bill. Then I want you to call everyone who votes for this bill, if this bill passes, and call your Senators and ask them to explain what all of this means. I am not going to tell you what it means tonight because we would be here all night. These are the terms that have been thrown around in this bill. You are going to have to understand this if you are going to understand what Congress is about to do to you. You will have to understand this.

Confusion and fear—some of them you know; HMO, you know that one. There is fear there, but it has nothing to do with the fact you don't know what Health Maintenance Organization stands for.

Risk corridors: I want you to learn what risk corridors mean; copayments, plan retention funding, MA-prescription drug plans, or MA–PD plans; donut hole. No, it is not what you buy in the store that is so good. I am on a diet. I haven't had one of them in a while. But a donut hole is something you had better understand because it is going to cost you when you get to it.

Here is another one: MA-Regions; catastrophic, premium support, assets test. I explained that one to you. That is one where you have to sell your wedding band, if you are poor, in order to qualify for getting your drugs free.

Average weighted premium; MSP, Medicare Secondary Payment; coordination requirements; initial coverage limit; CMS, you had better know that because the man who is the head of it is the one who is going to control the slush fund for HMOs.

Here is one which is kind of my favorite because I actually understand it: Claw back. That is a new word for you. That expresses what happens if you are a State and you have helped your poorest people pay for their Medicaid. You no longer can help them, but you can't keep the money. You have to send it to Uncle Sam. That is a claw back.

Transitional assistance, MSA. That stands for Metropolitan Statistical Area. If you are in one of those, you are forced into a demonstration project even if you do not want to be.

Benefit shutdown: This is one I know very well. After you buy a certain amount of drugs—around $2,000—you get a letter in the mail from your company that is giving you this drug benefit, and they say: Sorry, sir, your benefits shut down until you go past $5,100. Benefit shutdown is not a good thing.

Risk adjustment premiums—you all know what that means; Part D, income relating, SA-wraparound; national bonus payment. But don't get excited. It doesn't go to you. Comparative Cost Adjustment Program; Stabilization Fund—that sounds as if it is a good thing. If you are an HMO, that is the money you get to keep you in business.

I tell you, if something happens to me and I am not back here after my next election, which could happen to anybody, I am going to consider helping one of these big HMOs. I understand half of this. I may help them.

Medicare advantage competition, wraparound—we did that—MA-regional plans; MA-prescription drugs; annual out-of-pocket threshold. Watch out for that one. Annual out-of-pocket threshold is what you have paid for your drugs out-of-pocket before you can get the benefit. However, if your drug isn't on the formulary, it doesn't count. So don't count on it too soon.

Return disclosure: This has to do with your tax return. You are going to have your tax return sent to the IRS from the Health and Human Services Department if you are an upper income senior. They want to know what you earn. Before, Medicare never asked that because it is an insurance program. Now, do you know in this bill that the people who do not like taxes are making sure the IRS receives from the Health and Human Services Department information about your tax return?

Deductible: Again, very tricky. You have to understand that.

PDP sponsors, Prescription Drug Plan sponsors; monthly benchmarks. I am not sure about that one myself. But monthly benchmarks, we have to be careful about those.

Fallback: The fallback is in the prescription drug plan. In the Senate bill that I voted for, if you didn't have two plans come in to compete, you could always fall back to Medicare. Now it is basically one plan.

I told you about fallback. I went over all of it. MSP; average weighted premium—I think I pretty well went over this; coverage gap; plan retention funding.

The way I have done this chart, it looks kind of chaotic. It is to make a point. I don't even have half of the terms that are in this bill. I am going to work on this so that after the cloture vote when we have a little more debate, I will be able to get a better list.

But there is no secret why seniors are calling up our offices. They are smart. They are the smartest folks around. They have lived a long time. They are smart. They know what Newt Gingrich said: Let it wither on the vine. And then he endorses this. They weren't born yesterday.

The one thing I was interested in with C–SPAN is the people who were calling were Republicans and Democrats, and they all sounded alike. One out of 10 said they liked the deal. So this bill hurts seniors. We know that for sure.

Confusion and fear, large benefit shutdown, which is daunting and penalizes innocent seniors.

I told you before. You get to a certain point, and your benefits stop. A couple of thousand dollars, and then it starts up again at $5,000. Name for me one other drug program that does that. I checked it out. There are hundreds of them. Maybe there was one other that had a small benefit. I have never seen it. We don't have that in our plan. We just go in the pharmacy and give them our Senator's health card. We get a good deal. They never shut us down. Why should we shut you down? It is a bad thing. It is not right. If I was a local pharmacist, I would say to my seniors, I can do better than this plan. Come into my store, buy your drugs here, and I will give you a discount card.

Seniors will have to worry about filling out this form, filling out that form, is this drug on the formulary, and so on—fear and confusion. The bill hurts seniors.

Now we will look at what it does to my State's seniors. This is the direct impact on my State's seniors: 867,000 sick low-income seniors will have worse Medicaid prescription drug coverage. Boom. This starts in 2006 when 867,000 sick low-income seniors will have worse Medicaid prescription drug coverage than now.

Mr. President, 250,000 retirees will lose their more generous prescription drug coverage even after we give payments to the employers. I supported that. That was a good move. But even

with that, they are dropping coverage once they know their retirees have another option. Wait until those people get the clue that is happening.

Years ago we passed a catastrophic medical bill and I remember seniors were attacking Congress people. Wait until they hear they get dropped—retirees who worked all their life, who like their plan and they get dropped. They do not have a choice. If they want prescription drugs they have to come with this plan. Wait until they have to deal with benefit shutdowns.

Mr. President, 296,000 fewer low-income seniors will qualify for low-income protections than under the Senate bill because of the assets test that I talked about and lower-qualifying income levels. The poorest of the poor—when compared to what we did in the Senate, the bill I voted for—are worse off. These numbers are huge because I represent a big State. And 230,000 Medicare beneficiaries will pay higher Part B premiums because they are upper middle income and wealthy. That will happen to them.

Also, because they are in the MSA or metropolitan statistical area, that demonstration project, 1.4 million could be forced into them as we projected because we have the big metropolitan areas, or be penalized for staying in traditional Medicare because the people who are healthy will go into those private plans and the people who are sick will stay in Medicare and the costs will go up.

We have fear and confusion. I don't know how many of these figures are double-counted, so I cannot just add them up. Some of these figures may fit into more than one category, but I can state with certainty a couple of million of my 4 million people on Medicare are going to be worse off with this bill, much worse off. That is a very bad thing to do.

I don't know where the votes are. I think they have the votes to pass this. But if seniors across this country got a couple of days—there are about 48 hours to pick up your phone, call your Senator and say: Senator, maybe you are right. But this thing is confusing. I am fearful. Give me a little more time.

The bill was just printed and we saw it for the first time the day before yesterday. This bill is bigger than I am, and we got it the day before yesterday.

I have shared some of the new bureaucratic ''wordspeak'' in the bill and I have just had a couple of days to look it over. At the least, we should say to our colleagues, put this thing off. We are going to come back in January. This Congress goes 2 years. That is the beauty of it. If it was next year, the legislation would die. But we have 1 more year of this session. What is the rush? Tell your Senator, maybe Senator BOXER is wrong when she says this will hurt me. I am not sure, but she has raised some issues.

Change, if it is positive change, is something we all want. But change could be negative, could be disruptive, could cause us to be confused or fearful. What is the problem in taking a little while longer? To be honest, I would love to have the Christmas holiday recess to read every line of this bill. I started to do that. That is how I came up with all of these words, by reading the bill and trying to understand all of this. I did not even scratch the surface.

This Senate voted down an Energy bill which I felt, frankly, was in many ways a giveaway for a lot of special interests. And the good that was in it—and there were good things in it—was outweighed by the special interest provisions. We should be here for the public interests, for the people we represent.

I remember one of my colleagues saying to me, when someone asked a question about oncology, because there has been some concern about how the oncologists are being treated—someone in the room said, just look, there is a company being traded, a health care company that deals with oncology, and the stock is shooting up. It must be that oncologists are being treated fairly.

I used to be a stockbroker. It is not of any interest to me to do things that make the stock of a company go up. Do you know what I want to go up? The stock of the American people, the lives of the American people, the quality of life of the American people, the quality of life of grandmas and grandpas and their families.

This is truly not a partisan issue. It is an issue of how do we give a prescription drug benefit to our senior citizens and keep Medicare strong and not make this bill a giveaway to the largest HMO and pharmaceutical companies and insurance companies in the country. They are doing very well. This debate has been a good debate so far. We have serious disagreement. I am sure I will be back in the Senate after we have a cloture vote, one way or the other, just to add more terminology to my fear and confusion chart.

I know my colleagues on the other side of the aisle are waiting with bated breath to see my next version of this fear and confusion chart because I know they understand every single one of these terms. It is interesting to look at these terms and to realize how far reaching and how bureaucratic this new bill is.

I will say one last thing and then I will leave the floor, much to the delight of the Senator from Iowa and the Senator from Montana. I say to any senior citizen, any human being who is within the reach of my voice, and there may be a few at this late hour, if you feel we need more time to see whether Senator BOXER is right or Senator GRASSLEY is right or Senator BAUCUS is right or Senator KENNEDY is right or Senator DURBIN is right or Senator HATCH is right, if you think you need more time to take a look at this bill, to get this bill analyzed, this bill that weighs a lot, this bill that is over 600 pages, call your Senator, e-mail your Senators and tell them to take some more time, to put this thing over until after the first of the year and we can come back here and have the whole year to work on this bill, which is really rewriting the Medicare Program.

Thank you very much, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I think the place for me to start is where the Senator from California left off; that is, the impression that is left that this bill is going to confuse the seniors of America, and almost that the purpose of it might be to confuse seniors.

But let me make very clear to all the seniors who are listening, and everybody else who is listening, one of the keystones of this legislation is to say to the seniors of America: If you do not want to do anything, if you do not want anything to do with this, you do not have to have it. This is strictly voluntary.

For any senior in Iowa or California who comes to their respective Members of Congress and says: Congressman so and so, or Senator so and so, just leave my Medicare alone; I am satisfied, each of us can say to them: If you do not want to worry about all this that we are talking about—prescription drugs or anything new about Medicare—you do not have to because you can keep traditional Medicare as you have known it for the last 35 years. Just keep it as is, if you are satisfied with it.

But for those who might not be satisfied, we give them several options. They have a right to choose. They have a right to keep traditional Medicare with a prescription drug program that they can choose to go into, or they also have the right to choose a new Medicare—preferred provider organizations—that is very close to what baby boomers now have in the workplace. They can choose that with an integrated drug benefit plan.

So we are not trying to confuse anybody. We are trying to give seniors the right to choose. We are trying to give seniors who are totally satisfied with what they have right now an opportunity to just stay where they are right now. It is the right of seniors to choose.

I think I better be very clear because so much of the opposition to this bill today has come from the other side of the aisle, mostly Democratic Members of the Senate.

We are here today with a piece of legislation because over the years 2001 and 2002—after Senator JEFFORDS switched from being a Republican to being an independent and casting his lot with the Democrats, so they were a majority during the remainder of 2001 and all of 2002—there was an effort early on to develop a bipartisan approach to a drug benefit during the last Congress.

When that was developing, there was a fear that there might be a bipartisan

bill reported out of the Senate Finance Committee, a year ago, and the then-majority leader, now the minority leader, Senator DASCHLE, decided that this was an issue that ought to be brought to the Senate floor, not worked out in committee.

Remember, you develop bipartisanship in the Senate in the committee. You do not do it very often here on the floor of the Senate. You build coalitions.

Remember, nothing gets done in the Senate that is not bipartisan—unlike the House of Representatives, where partisan things can be done—because, remember, the Senate of the United States is that only institution in our political system where minority rights are protected.

So a year ago, the then-majority party decided that this ought to be debated on the floor. But they also knew that it would be impossible to get the bipartisan majority that it takes to get things done. They gambled that they needed an issue for the last election rather than a product. They gambled on an issue that we would not do anything last year, and the way they maneuvered this, nothing was done because nothing in a partisan way, even by majority Democrats, can be produced out of this body that is not somewhat bipartisan.

Then there was an election, and they found out that issue did not work for them; that Republicans were put in a majority. This gave, in this new majority, in this new Congress, Senator BAUCUS and I, the top Democrat and the top Republican on the committee, an opportunity to do our magic and put together a bipartisan bill. That bill came to the Senate floor and was passed 76 to 21. It went to conference, and came out of conference in a bipartisan way. And we are here because the majority Republicans and some sensible Democrats want to produce a product and not have an issue for the next election. I happen to think, from the comments I have heard today—all the fault that can be found with this bipartisan product—that there are still too many people on the other side of the aisle who have not learned a lesson: No. 1, how do you get anything done in the Senate? It has to be bipartisan. And, No. 2, they did not learn from the mistakes of the last election when they thought they needed an issue. Do they think if it did not work in 2002, it is going to work in 2004?

So that is why we are where we are because there are Democrats who know that you do not get anything done in the Senate if there is not a bipartisan coalition. There are Republicans who have understood that for a long period of time.

So that is background to what I want to tell the people of America and my colleagues about why this bill should be adopted. During this process, I am going to correct some of the statements made by my colleagues so far today.

I want to correct what my colleague from Iowa said earlier about this bill's impact on rural America and on our State of Iowa in particular.

The rural health provisions of this bill go further and wider than any other legislation that this Congress has ever considered. It enjoys the strong support of the Nation's doctors and hospitals, and it is also strongly endorsed by the Iowa Medical Society and by the Iowa Hospital Association, two of the strongest advocates for rural equity in my State and my colleague's State.

I will read an excerpt from each and then ask unanimous consent that both letters be printed in the RECORD.

This is from the Iowa Medical Society president, Tom Evans, M.D.: ''[P]assage of the bill,'' meaning the bill before us, ''is critical for rural states like Iowa.'' ''He said: ''In addition to providing seniors with prescription drug coverage''—and I want to emphasize this part of his statement—''this legislation fixes many of the reimbursement issues that have unfairly penalized rural States. Congress must pass this legislation before the Thanksgiving [Day] recess.''

Now, I go to the Iowa Hospital Association, which in 2001 circulated statistics, already referred to, showing Iowa in last place in per-beneficiary spending. The Iowa Hospital Association: ''The Iowa Hospital Association strongly endorses passage of this legislation.'' ''In an evaluation of the per-beneficiary increase, this legislation provides Iowa hospitals with the second largest percentage increase per Medicare beneficiary of any state in the Union. This amounts to a per-beneficiary increase of $583, which is the thirteenth highest increase of any state in the Union.

Mr. President, beyond those quotes, I could give a lot of evidence, but I think those quotes speak volumes about our rural package. That package in this legislation speaks for itself. It brings real improvements and equitable payments to hospitals and doctors in Iowa and way beyond.

I ask unanimous consent to have these letters printed in the RECORD.

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

IOWA HOSPITAL ASSOCIATION
Des Moines, IA, Nov. 20, 2003.

Hon. CHARLES GRASSLEY,
U.S. Senator, Hart Senate Office Building Washington, DC.

DEAR SENATOR GRASSLEY: Congratulations in reaching an agreement on a conference report that directly and significantly impacts the issue of equity and fairness for hospitals and physicians in rural America and particularly for Iowa. Just this morning, the entire Iowa Hospital Association Board was briefed on the impact of your Medicare legislation and on a unanimous vote endorsed the pending legislation.

In an evaluation of the per-beneficiary increase, this legislation provides Iowa hospitals with the second largest percentage increase per Medicare beneficiary of any state in the Union. This amounts to a per-beneficiary increase of $583, which is the thirteenth highest increase of any state in the Union.

The Iowa Hospital Association strongly endorses passage of this legislation and will today ask its entire membership to weigh-in on behalf of the legislation with the entire congressional delegation of Iowa in an effort to support your work to achieve passage of this legislation before the Thanksgiving holiday. It is our hope that when Congress completes its work and you return to Iowa for the holidays, that all Iowa providers will have an opportunity to congratulate you for successful passage of this historic legislation.

Sincerely,

KIMBERLY A. RUSSEL,
IHA Board Chair.
KIRK NORRIS,
President/CEO.

IOWA MEDICAL SOCIETY STRONGLY SUPPORTS PASSAGE OF MEDICARE REFORM LEGISLATION

The Iowa Medical Society (IMS) announced today its strong support for the Medicare Prescription Drug and Modernization Act of 2003 conference report.

IMS President Tom Evans, MD, said passage of the bill is critical for rural states like Iowa. ''In addition to providing seniors with prescription drug coverage, this legislation fixes many of the reimbursement issues that have unfairly penalized rural states,'' he said. ''Congress must pass this legislation before the Thanksgiving recess.''

Evans said the bill protects Iowans' access to physicians by replacing a 4.5 percent payment cut scheduled for 2004 with two years of modest payment increases. The bill also fixes a component of the reimbursement formula that deals with geographic practice cost adjustors that causes huge reimbursement swings from state to state.

''If this legislation isn't passed, the American Medical Association estimates that a 4.5 percent cut in reimbursement will take $30 million away from Iowa's health care system in 2004,'' he said. ''Now add to this the fact that Iowa already receives among the lowest payment rates in the country, and you can see how Medicare is threatening our ability to care for our patients.''

Evans also thanked Senator Charles Grassley for his work on this bill as Chair of the Senate Finance Committee, and he urged Iowa Senator Tom Harkin and Iowa's Congressional Representatives to support the Medicare conference report.

The Iowa Medical Society is the professional association representing over 4,600 MDs and DOs. The IMS core purpose is to assure the highest quality health care in Iowa through its role as physician and patient advocate.

Mr. GRASSLEY. Now let me speak to what this bill does for Iowa's seniors. The bipartisan agreement provides all of the 485,042 beneficiaries in Iowa with access to Medicare prescription drug benefits, as I have stated previously, on a voluntary basis. It does it for the first time in the history of the Medicare Program. That begins January 2006. Beginning in 2006, the bipartisan agreement will give 142,297 Medicare beneficiaries in Iowa access to drug coverage they would not otherwise have and will improve coverage for many more.

Within 6 months after this bill is signed—in other words, during the year 2004—Iowa residents will be immediately eligible for Medicare approved prescription drug discount cards which

will provide them with savings between 10 percent and 25 percent off the retail price of most drugs. Beneficiaries with incomes of less than $12,123, or $16,362 for couples, who lack prescription drug coverage, including drug coverage under Medicaid, will get up to $600 in annual assistance to help them afford their medicine along with a discount card. That is a total of $100,840,345 in additional help for 84,034 Iowa residents during these years of 2004 and 2005, as this interim program is in place, helping Medicare recipients with drugs until we get the permanent program put in place. Then beginning in the year 2006, all 485,042 Medicare beneficiaries living in Iowa will be eligible to get prescription drug coverage through a Medicare approved plan.

In exchange for a monthly premium of about $35, seniors who are now paying the full retail price for prescription drugs will be able to cut their drug costs roughly in half. In many cases, they will save more than 50 percent on what they pay for their prescription medicines. One hundred thirty-three thousand beneficiaries in Iowa who have limited savings and low incomes—and this would generally be those below $12,000 for individuals and $16,000 for couples—will qualify for even more generous coverage. They will pay no premiums for their prescription drug coverage, and they will be responsible for a nominal copayment. That copayment would be no more than $2 for generic drugs and $5 for brand name drugs.

We have 41,300 additional low-income beneficiaries in Iowa with limited savings, and incomes below $13,500 for individuals and $18,000 for couples, qualifying for reduced premiums and a reduced deductible of $50 and a Medicare that will cover 85 percent of their prescription drug costs with no gap in coverage.

Additionally, Medicare, instead of Medicaid, will now assume the prescription drug cost of 50,000 Iowa beneficiaries who are eligible for both Medicare and Medicaid. These seniors generally will pay $1 and $3 per prescription and those in nursing homes will pay zero dollars for their prescriptions. This will save Iowa $175 million over 8 years on prescription drug coverage for its Medicaid populations.

I have tried to address for my colleagues, but particularly for my residents and constituents in Iowa, how this program will impact them as individual beneficiaries of the prescription drug part of our bill. And I have tried to inform my colleagues and my residents of Iowa how the rural equity package will help provide quality care for Iowans because we are increasing the reimbursement for our hospitals and for our doctors in rural America.

Now I will address several of the most egregious misconceptions about the bill that have been spoken on the floor of the Senate today. First, I will address the issue of protecting retiree drug coverage. This would be those people who have, for the most part, coverage from places where they used to work that also continue to cover people with health benefits and prescription drugs after they leave employment.

During the debate on S. 1, when this bill passed the Senate the first time in June of this year, it passed by a 76-to-21 bipartisan vote. At that time, even though we had that high bipartisan majority, my colleagues raised concerns about what they referred to as the high level of employers that would drop their retiree prescription drug coverage should we enact the prescription drug benefit into the Medicare Program.

At that time, the Congressional Budget Office told us that 37 percent of the seniors who have drug coverage—that is roughly one-third of the seniors under Medicare—would lose that coverage if we passed the bill. I think I ought to say that there was another group, the Employer Benefit Association, that studied the same issue and said it would be 3 percent to 9 percent who would lose coverage. So we probably have an intellectually honest difference of opinion by the Congressional Budget Office on the one hand and the Employer Benefit Association on the other hand. But we in the Congress are stuck, as we determine the cost of programs, with what the Congressional Budget Office says. We would rather—and it would be easier—if we could just go by what the Employer Benefit Association says, but we go by CBO because they are God when it comes to saying what something costs. So we had to live with that 37 percent.

Well, as we all know, however, employers have been dropping or reducing prescription drug coverage for many years. So this is really nothing new. If we were not even talking about this bill today, some board of directors of some corporation in America could come to the conclusion that they couldn't afford to cover their retirees anymore and drop them. What could Congress do about that? Nothing. But it is nice to have a program when that happens for people to fall back on. That is one of the reasons for this legislation.

Of course, we want to take care that we can do everything possible to make sure that corporation X doesn't do that. In just the past 2 years, retiree health care coverage has dropped by 22 percent. That was with this Congress not doing anything, not considering this legislation.

We know these days employers are finding it harder and harder to continue to voluntarily provide health insurance coverage. That is due to a lot of factors, including rising health care costs overall. Now, as we were in conference between the House and the Senate, we took this marketplace dynamic of company XYZ, ABC, or whatever corporation—that they could do this. This is a dynamic we had to take very seriously. So we went to great lengths to improve employer participation in drug benefits to keep employers in the game; to keep their retirees covered, as retirees would expect to be covered, but sometimes they are surprised when they are not.

Our conference report reflects this. It includes remarkably better policies for employers than those that were in either the bill that passed in the Senate 76 to 21 or that passed the House in June as well. So I am saying to you we brought back a conference report that was better in regard to employee-retiree coverage than either passed the Senate or the House in the first place.

So what happens when we do that good work? The policies in this conference report have led to major corporate plans endorsing our conference report. So the people on the other side of the aisle, with their charts, who are saying bad damage is being done by this legislation, what would they have us do? Pass nothing? If corporation X decides to drop, and there is nothing there for their employees, do you think those same people are better off if Congress does zilch? Where were they when they voted in the first place, complaining about S. 1 or H. 1, the House bill, when we passed them in June?

Here we are bringing back a conference report that is being endorsed by these corporate plans. Doesn't that mean anything to any of you? Under this conference report, employers will be given an enormous amount of flexibility and options—employers that already provide retiree benefits beyond Medicare coverage. This legislation will help make it more affordable for these employers to continue providing these benefits. We do that by a direct subsidy worth 28 percent of their drug spending between deductibles and the coverage gap.

I should add, too, this conference report makes this 28 percent completely excludable from taxation, so that instead of doing 65 percent good because of a 35 percent tax bracket that corporations are in, it does 100 percent good, bringing down the number of people who might lose coverage.

Now, some people would say, what is this corporate welfare all about—Congress giving money to corporations to do something they have been doing forever. Some people might say, well, when you buy a Chevrolet, you pay for these retirement plans. How many times do you have to pay for them? You pay for them when you buy a car and when you pay a 28 percent subsidy. We are cautious about the fact that some do that.

So I tell my colleagues over there—each of them who are complaining about this—this 28 percent subsidy is something you ought to be glad to have. Sometimes when we give corporations something, you condemn us for giving corporations something; but you cry when we do it and you cry when we don't do it because they might dump their retirees. In the final analysis, we are also doing it to protect the

taxpayers and the Medicare Program because it is better to encourage these employers to keep their retirees in these plans at a 28 percent subsidy, which is about $750 per person, instead of having those corporations dump those plans on the Medicare Program, and it is going to cost about $1,250. So that is why we do that.

Now, besides this 28 percent help, we also say that employers can use the flexibility this legislation provides to structure plans that complement Medicare's new drug benefits and provide them even enhanced benefits for their retirees. They can even do better than they are presently doing because of this flexibility we have in the legislation.

These new choices and options will do much more to help and, consequently, not threaten employer-sponsored health care coverage for those who currently receive it.

In fact, the Congressional Budget Office now estimates that the so-called drop rate—in other words, the rate by which corporations will drop their retirees—is now 17 percent because of the changes that were made in conference. In other words, we listened to our colleagues over there complain about a 37 percent potential drop rate because of the way S. 1 was written. But it goes to conference and it comes back from conference with, instead of 37 percent, 17 percent, and you folks are still complaining. I don't understand it. And these 2.7 million retirees will still be better off with Medicare coverage, likely paid for by their former employees. In other words, the 2.7 million people who would have been dropped, according to CBO, because of what we did in the conference—that is better than either bill when first passed in June; 2.7 million people are still going to be in their corporate retiree plan.

So I say to my colleagues—I hope you hear this—we have come a long way since June, when 76 people, in a bipartisan way, voted for this. Half of you over there voted for it. I believe company plans have a lot to be happy about under this conference agreement.

All seniors deserve health care benefits. All seniors deserve access to prescription drug programs. This compromise between the House and Senate provides that, and it makes certain that good sources of existing coverage remain intact. I urge my colleagues to embrace the strong employer provisions we have agreed to and vote for this conference report.

We have also heard from a lot of them over there that somehow we are trying to privatize Medicare. How many times do I have to say it? This program is voluntary. Nobody has to go into anything in this bill if they don't want to. If they want to keep traditional Medicare, keep it. But this issue has been brought up. Do you know why? Because these folks over there, my colleagues over there—every one of them—like to scare seniors. You know, it is called Medicare, but you like to make Medicare into ''medi-scare.''

You know, it is easy to scare seniors. I have my town meetings around Iowa. I hold town meetings in each of the 99 counties every year so I can keep in touch with my constituents. There are people—the older, the more so—but seniors come up to me and they actually believe what is said on that side of the aisle when people say somebody is going to take their Medicare away from them. They believe that ''medi-scare.''

They are really nervous. Some of them even have tears in their eyes. I tell them, if you just knew as seniors how you have a hook on Congress, that Congress is scared to death of you, you would be laughing at me instead of being scared of something we might do. That is how the concerns of the seniors of America are taken into consideration by people in the Congress of the United States.

Maybe we ought to have a little more of an independent view than be so concerned about the electoral power of the seniors, but they have tremendous influence on Congress. Maybe some people say too much influence. Regardless, it is wrong for people over here to ''medi-scare'' our seniors.

I wish to address this issue of privatization, but the easiest answer is that if you are satisfied with what you have—traditional Medicare—don't worry. Also, if you like other provisions in this bill, they are voluntary. You don't have to do them.

This bill before us today brings Medicare into the 21st century practice of medicine. It does not privatize traditional fee-for-service Medicare. Overall, this conference agreement relies on the best of the private sector to deliver drug coverage, supported by the best of the public sector to secure consumer protections and important patients' rights. This combination of public and private resources is what stabilizes the benefits and helps keep costs down.

Seniors will be able to purchase prescription drug coverage on a voluntary basis as part of Medicare's traditional fee-for-service program or be part of a new Medicare-approved private plan where the drug benefit is integrated into broader medical coverage. These Medicare-approved plans have the advantage of offering the same benefits of traditional Medicare, including prescription drugs, but on an integrated, coordinated basis. This creates new opportunities for chronic disease management and access to innovative new therapies.

Let me comment on chronic disease management. That is very important if we are going to keep costs down in the future. We won't have to squeeze seniors at all. In fact, seniors will have a better quality of life under chronic disease management because 5 percent of the seniors are responsible for 50 percent of the cost of Medicare. The reason for that is that we only pay doctors to make people well after they get sick. We never pay enough to keep them well in the first place.

We can concentrate on this 5 percent in chronic disease management, and by so doing, we are going to provide a better quality of life because they will not be in and out of the hospital as much, and we save money there. But also their quality of life is going to be better, and it protects the taxpayers in the process and preserves the longevity of Medicare.

Unlike Medicare+Choice, we set up a regional system where plans will bid in a way that doesn't allow them to choose the most profitable cities and towns. Cherry-picking cannot take place. Systems like this work well for Federal employees, such as the postmaster in New Hartford, IA, my hometown. He has a choice of several plans. We want to give that same choice to his parents who today only have traditional Medicare. They have no right to choose.

We provide an alternative plan for people who want to try something new, something that is probably close to what baby boomers have for health plans where they work. We have set up preferred-provider organizations. Are they right for everyone? We give seniors the right to choose. Our bill sets up a playing field for preferred-provider organizations to compete for beneficiaries. We believe preferred-provider organizations can be competitive and offer a stronger, more enhanced benefit than traditional Medicare, assuming seniors want to choose that. They have that choice.

Let me be clear, no senior has to go into a preferred-provider organization. My policy has always been to let seniors keep what they have if they like it with no changes. All seniors, regardless of whether they choose a PPO or not, can still choose prescription drug coverage if they want to, to go along with their traditional Medicare, but it is their right to choose.

I can't mention preferred-provider organizations without correcting the record regarding the preferred-provider organization stabilization fund that the other side has called a slush fund. It is no slush fund. It is something that those of us who live in rural America know we have to have. We learned a lesson from Medicare+Choice because in 1997, I worked hard to bring greater reimbursement to rural America through Medicare+Choice so that people in Iowa would have the same options that 40 percent of the people in Miami have chosen: to go into an HMO. It is a voluntary choice. If they don't like it, they can get out tomorrow. Get in today; get out tomorrow. In rural America, we enhanced greatly the reimbursement for them, but they have not come because of cherry-picking.

We want the preferred provider organizations to serve all of America, rural as well as urban. The stabilization fund is so those of us in rural America have an opportunity to get the same benefits as people in New York City or Los Angeles or Miami.

The bipartisan agreement on a final Medicare bill establishes this stabilization fund. It was not in the Senate bill. Some people say the Kyl provisions were similar to that, but Senator KYL will tell you he had a whole different idea in mind. His idea is not even in this bill, but we did take a stabilization fund to accomplish something he wants to accomplish. He wants his entire State of Arizona to be served by PPOs, not just Phoenix. We did this in an effort to expand access to private health plans in all areas of the country and, additionally, to maintain existing health care choices in areas where health plans face particularly difficult challenges.

My colleagues on the other side who find fault with this conference report are always talking about this slush fund as benefiting some organization's profit motive.

Every one of them has rural areas. My colleagues ought to want the people in the rural parts of their State to be served the same way as people in the urban parts of the State.

The reality is that this is not a slush fund, but it is to help beneficiaries have equal services, whether they live in rural America or urban America, and that will be helped by this stabilization fund. It is targeted and its plans are held accountable. Resources will be distributed from the stabilization fund only when specific conditions are met. Moreover, in instances where these conditions are met, then health plans will be accountable for using these funds only to promote affordable health coverage to beneficiaries, not for profit. Under no circumstances will plans then be permitted to use these funds to pad their bottom line.

It expands choices and ensures access in rural areas. The fund is designed to expand and preserve beneficiary choices and benefits in areas where it is most difficult to provide private health plans and to get them to participate in this program.

The stabilization fund will ensure that millions of additional beneficiaries, including many in rural areas, will have access to health plans offering high quality, comprehensive benefits, and low out-of-pocket costs. If the stabilization fund is not successful, the worst case scenario is that the funds will be returned to the U.S. Treasury.

Now I will speak about the accurate explanation of how this bill helps low-income seniors. We did something in the conference report that the House did so the Senate receded to the House on this point, and that is where we in the Senate decided to leave dual eligibles who were covered by Medicaid. That is the way it passed the Senate. The House wanted to have one program for seniors, a totally Federal program, so dual eligibles in the House bill were taken away from Medicaid and put in Medicare. We accepted what the House wanted to do, as a matter of equality I suppose. We had other motivations for doing it in the Senate.

In fact, most of the support for doing that—that was one of the shortcomings that Democrats said about the Senate bill in June. Now we are hearing complaints from them about aspects of this dual eligible, how it impacts seniors, particularly on asset tests. That is one of the reasons we tried to avoid putting dual eligibles under Medicare in the Senate bill, because we wanted asset tests to be the same for this group. Now they are complaining, I think inaccurately, which I will prove in a minute, about it negatively impacting people with less coverage than they presently have.

We have heard from the other side how 6 million low-income eligible seniors will be worse off under this conference report. That is inaccurate. It is a lot of talk, and I want to tell the American public the truth about this issue. Beneficiaries are not hurt by this bill. They are helped. This bill provides generous predictable coverage to 6.4 million dual eligibles, but it does not stop there. It provides coverage to an additional 7.7 million low-income seniors. Madam President, 14.1 million seniors are eligible for low-income subsidy, nearly 36 percent of Medicare beneficiaries.

So who are these dual eligibles? They are the 6.4 million who are enrolled in both Medicare and Medicaid.

This conference report for the first time provides drugs to dual eligibles through Medicare rather than Medicaid. This is a great help for the States that have budget problems, and Medicaid is a growing, biggest part of State budgets.

As I said, the Senate bill left dual eligibles in Medicaid. That policy allowed the Senate to provide generous coverage for low-income seniors. S. 1 focused on providing drug coverage to seniors who did not have any coverage whatsoever, and duals did have that coverage. So in the spirit of compromise, the Senate conferees changed the policy in the Senate bill.

The conference report provides prescription drugs for dual eligibles through Medicare. It is not exactly the same, but in general policy it is the same way they were treated in the House bill. Providing drugs for dual eligibles through Medicare was a cornerstone issue for House conferees.

The conference report covers duals in the Medicare Program. The coverage is designed to benefit as many low-income seniors, including duly eligibles, as possible, given the budget constraints of $400 billion in our budget.

This bill comes out at about $395 billion. Blanket statements about the reduction of benefits for the dual eligibles in the conference report are not accurate. We have heard some of those inaccurate statements this Saturday as we have debated this bill. This bill is generous and does not leave 6.4 million seniors worse off. I will bet tomorrow those over on the other side will be putting those signs up again that say that. Well, don't do it.

For instance, unlike the Senate bill or the current Medicaid Program, the conference agreement does not have cost sharing above the catastrophic limits for the dual eligibles. That is right. There is no cost sharing. I hope my colleagues on the other side get that.

I will put this in perspective, then, from the State level. According to the Kaiser Family Foundation, the Commonwealth of Massachusetts currently charges $2 for every prescription filled by dual eligibles. There is no catastrophic limit for duals in that Medicaid Program in that State, just a requirement for beneficiaries to pay $2 for every single prescription.

Like many Medicaid Programs, this bill establishes copayments for a majority of the dual eligibles who are either equal to or less than those required by most State Medicaid Programs. So let's get that straight. These copayments are no more than, and in some cases less than, those required in most State Medicaid Programs.

More specifically, today 25 States have copayment levels for generic and brand-name drugs set at $1 or higher for dual eligibles enrolled in their Medicaid Programs. In this conference agreement, dual eligibles with incomes below 100 percent of poverty will be responsible only for a copayment between $1 and $3 for their Medicare drug benefit. Taking a step back, it seems to me that this level of cost sharing is very similar to what the duals pay for in Medicaid coverage.

In fact, in South Dakota, duals pay $2 per prescription. That policy is on par with the coverage offered through this bill. This conference report contains a generous drug benefit, then, for dual eligibles. There is no donut, or no loss of coverage, no gap in coverage, for low-income Medicare beneficiaries. But my colleagues on the other side would lead us to believe otherwise.

The bill guarantees all 6 million dual eligibles access to prescription drugs. Under the conference report, dual eligibles will have better access through Medicare than they do today, specially since State Medicaid Programs are increasingly imposing restrictions on patients' access to drugs because of budget problems that 45 of our 50 States have.

Further, States have the flexibility to provide coverage for classes of drugs, including over-the-counter medicines that might not even be covered by the Medicare Program.

This bill ensures appeal rights for dual eligibles. Under the agreement, duals will maintain appeal rights, such as those that they presently have in the Medicaid Program. The dual eligibles are a fragile population and are well taken care of in this bill. The conference report recognizes and provides generous coverage to these 6 million beneficiaries and in fact goes further by providing full drug coverage to 7.7 million more low-income seniors.

So I turn now to highlighting what this bill does to protect Medicare in

the long run. I have heard some Members trying to assert that this $400 billion expansion of one of the most successful social programs in our country's history is going to destroy traditional Medicare; you have said it, ''Medicare as we know it.'' That is another one of your ''medi-scare'' tactics.

I know Members are tired. I know we are nearing the closing of our first session of the 108th Congress. Many Members are using these wornout lines because they would rather not take a serious look at the bipartisan Medicare agreement we put together and really assess whether or not those scare tactics are true. I am here to tell all my colleagues and the people of this country that the allegations that this Medicare bill destroys traditional Medicare are falsehoods.

This Medicare bill strengthens and improves traditional Medicare in a number of ways. We are not talking about just Medicare as it has been for the last 38 years. We are talking about some improvements we made in traditional Medicare that seniors will have the choice, the right to choose to stay in if they want to. I will discuss just three.

First, we add new preventive program benefits. For the first time ever, every new Medicare enrollee will receive a ''Welcome To Medicare'' physical; they go to the doctor when they go into Medicare, get a benchmark physical. Hopefully, nothing is wrong. But if something is wrong, we know about it right away and it is part of our effort to see that we zero in on keeping people well, as opposed to waiting until they get sick and it costs a heck of a lot more. It is part of our program, of a quality of life for our seniors. It is part of our program of zeroing in on the 5 percent of the people who, because of not having chronic care management, are costing us 50 percent of the total costs.

Seniors are going to have physicals that will help them—maybe their lifestyle, like getting their weight checked, but more seriously, the heart; receive cancer, diabetes, and bone mass screenings. It is very important to have an initial physical because, as we say in Iowa, an ounce of prevention is worth a pound of cure.

Consider these statistics. In 2000, 6.2 percent of the U.S. population had diabetes. Heart disease and stroke are the first and third leading causes of death in the United States. In 2003, 1.1 million Americans will have a heart attack. Diabetes, heart disease, and other chronic conditions exact an awful toll on our seniors. By getting an initial physical, seniors can get valuable information on their health status. They can enroll in weight loss programs, start a blood pressure medicine, or know whom to call if something goes wrong.

We have also eliminated the deductibles and the copays on screening tests for heart disease and diabetes, so beneficiaries do not incur any costs. There is an extent to which that cost today may inhibit them or divert them from having needed tests, so this is an additional incentive, particularly for those with limited resources who might not otherwise access these benefits. Adding preventive benefits is just one way we have improved traditional Medicare.

A second way we have improved the fee-for-service program is by providing access to disease management. It is a common option available to younger people in health insurance. If you have a chronic health condition such as heart disease, diabetes, asthma, you can get extra help managing your condition. You may be taking a lot of medications and seeing several doctors. Disease management programs help patients take responsibility for their health care and better control of their lives, but they also involve health professionals in that process, to aid you.

When this Medicare bill becomes law, seniors with access will have access to these services. It will be a voluntary program and one that will improve the quality of life for millions of Medicare beneficiaries.

Another improvement is this bill provides an additional $25 billion for rural health care providers. That is new money to strengthen our Nation's hospitals, physicians, ambulance riders, and dialysis clinics, just to name a few. This is the biggest funding boost Congress has ever passed for our rural health care system. This is going to help fee-for-service, traditional Medicare because in some places in this country there is not an adequate number of health care providers. Providers in rural States such as mine, Iowa, practice some of the lowest cost medicine in the country. Yet health care providers in rural areas lose money on every Medicare patient they see. This Medicare bill takes historic steps toward correcting geographic disparities that penalize rural health care providers.

So when I hear people in Washington say this bill is going to destroy traditional Medicare, I suggest that each of them take a closer look at this legislation. Providing new preventive benefits, allowing seniors to access state-of-the-art disease management programs, and mending the rural health care safety net will help millions of seniors with these three important ways we are strengthening Medicare.

I would like to turn now to a subject that is important to me, to the taxpayers, and to the seniors, and that is the issue of curbing waste, fraud, and abuse. You just read in your news releases from HHS, $11.5 billion of waste, fraud, and abuse within health care. If we can save that money, we are going to make Medicare strong for a long time in the future.

When it comes to reimbursements for many of the items and services that Medicare covers, the price, historically speaking, has not been right. That goes, for instance, for doctors and hospitals in rural areas who are paid too little, and some drugmakers and equipment suppliers, to name a few, who are paid too much.

This conference agreement makes great strides toward correcting both the underpayment and the overpayment that plague the Medicare Program. I have already talked about the underpayments to rural States such as Iowa and how this bill corrects that through the $25 billion of new money we are injecting into making Medicare reimbursements equitable.

But I want to talk now about just the opposite. There are overpayments in Medicare. Overpayments eat away at Medicare's reserves, eating away at its solvency slowly, like a cancer. Overpayments are bad for taxpayers, they are bad for beneficiaries, both of whom deserve to pay a fair price. In certain areas of Medicare, in many payment systems there are few fair prices.

Fee schedules pay too much, providers play games with complex rules and regulations, and beneficiaries pay a higher copay as a result. The sad fact is that Medicare's price is often far higher than the marketplace price. This conference agreement begins to change that in significant ways.

My colleagues should read title III of the conference report, and that is entitled, ''Combating Waste, Fraud, and Abuse.''

Our bipartisan initiative in this bill will end overpayments, reduce fraud, and cut down on opportunities for abuse to the tune of $31.3 billion as scored by the Congressional Budget Office. That is significant.

These measures in this bill directly reduce Medicare's spending on overpriced, wasteful, fraudulent items, and services to the tune of $31.3 billion over 10 years.

Throughout my time in Congress, I have worked hard to combat fraud and waste in Federal programs. In 1986, I successfully passed False Claims Act improvements that give whistleblowers new rights and protections under Federal law. In just the last year alone, civil fraud recoveries have tallied a record $2.1 billion, the Justice Department announced just last week. This is a 75-percent increase over the prior years' recoveries of $1.1 billion, and brings total recoveries to over $12 billion since I got that bill passed. Of the $2.1 billion, $1.4 billion is associated with suits initiated by whistleblowers.

While the False Claims Act is one of our best weapons in the war on fraud and abuse, our policies in this new language of the title III conference agreement adds still more weapons to our arsenal.

First, we make important technical clarifications to existing law that strengthen and improve what is known as the secondary payer statute. The purpose of the statute is to ensure that Medicare pays first for seniors' medical needs when other sources should be, in fact, paying instead of the taxpayer paying.

These other sources include, for instance, employer coverage. In addition, when a Medicare beneficiary is injured by wrongful conduct of another entity, that entity's liability insurance or the entity itself, if it has no insurance, or it might be self-insured, is always required to pay first instead of having the taxpayers pay. The provisions in title III do not change existing law in this area but, in fact, clarify the intent of Congress in protecting Medicare's resources.

According to the Congressional Budget Office, these clarifications alone promise to restore Medicare over $9 billion out of that $31 billion.

Second, we change the way Medicare pays for durable medical equipment, first by slowing the spending growth in these areas for 3 years, and then by instituting a competitive mechanism that will deliver a fair market price for seniors.

While I have concerns about the impact of such a new system on very many small businesses across America, the supply of high-quality equipment especially in rural areas, I am confident that good protections are in this conference agreement for small business and for our seniors as well.

The Congressional Budget Office estimates that these changes will save Medicare $6.8 billion out of that $31 billion.

Next, title III institutes what we call market pricing mechanisms for drugs administered in the doctors' offices that both the Office of Inspector General and the GAO have concluded are priced far higher than their actual costs.

In addition to the financial toll these overpayments take on the taxpayers, they also affect Medicare's beneficiaries who are often required to pay dramatically higher copayments for the drugs they rely on. In some instances, these copayments can even exceed the actual prices the doctors paid for the drug.

In recommendations to Congress, the GAO urged Medicare to take steps to begin paying doctors for Part B-covered drugs and related services at levels that reflect the doctor's actual acquisition costs—not some inflated cost. And they use information about actual market transactions prices to bring that about.

I am pleased that our conference agreement accomplishes this first by reducing the so-called average wholesale price by 10 percentage points, and then instituting a new payment system based on manufacturers' reported average sale price—or ASP reporting—which will be closely scrutinized by the inspector general on an ongoing basis ensuring its accuracy.

Errors or abuse of the system will be corrected swiftly so that Medicare will never again pay an unfair price.

These changes result in Medicare savings of approximately $11 billion out of that $31 billion total.

Finally, title III takes similar steps to correct overpayments for respiratory medicine which the Office of Inspector General has said are priced far in excess of their actual costs. These drugs will be reduced by 10 percentage points in 2004, and then priced on a similar average sale price system, as others I just mentioned, and that will begin in the year 2005.

The Congressional Budget Office says that this policy alone will save Medicare $4.2 billion of that $31 billion total.

I have listed three or four examples of how you save that $31 billion.

I believe all of these changes have been carried out in a compassionate fashion with twin goals of protecting both the Medicare Program's resources and our senior citizens' access to those services. We have done both.

Our market-based improvement Part B drug payments are accompanied by sweeping changes in payments for clinical services associated with delivering them.

We worked closely with oncologists to ensure that access to cancer care was not harmed.

Similarly, we went to great lengths to ensure that seniors who rely on medical equipment supplies will be able to rely on them as they do today.

Finally, to my colleagues who talk about cost containment and the need for Medicare to curtail its spending, I say this: It starts right here. Cost containment begins by ensuring that the costs to Medicare and to the taxpayers who finance it are, in fact, fair.

The conference agreement starts us down the road. The sum total of $31.3 billion of savings, and the market prices we are imposing on future spending in this area, are in my view, the most significant cost containment policies in this conference agreement.

In the months and years ahead as Medicare spending increases with the expansion of benefits that we are going to pass here shortly, our focus on cost containment will obviously increase. The best thing that Congress can do is to be vigilant. We all need to watch Medicare's outlays closely, and to listen to whistleblowers who are patriotic citizens telling us when there is fraud and crying for government to do something about it.

We also need to pay attention to other private individuals who have inside information on wrong doing. We need to heed the warnings of the Office of Inspector General, and, most of all, insist that Medicare never pay more than market price. Taxpayers, on the one hand, and the seniors' Medicare services, on the other hand, deserve nothing less.

I want to conclude by talking about the views of very many organizations that support the conference report.

Mr. GRASSLEY. Madam President, I want to quote from some.

As you know, I have a chart up here talking about the AARP. All of you colleagues on that side of the aisle have been saying to me all day how dastardly it is that the AARP is backing this legislation. Some Members have even spoken of them becoming a political organization. They cannot become a political organization or they will lose their tax-exempt status. But you accuse them of being a tax-exempt organization.

It is funny, last year when they did not come out for the bipartisan bill that several Members brought out, that the Democrat majority did not want to let pass because they wanted an issue in the last election instead of a product, the AARP was not backing what I, Senator SNOWE, Senator JEFFORDS, Senator BREAUX, and Senator HATCH wanted to do. Ours was a bipartisan effort, or a tripartisan effort, with Senator JEFFORDS being an Independent, to get a bill through because you cannot get through anything in this body if it is not bipartisan. The AARP did not like what we were doing. They did not discourage us but they did not help us. They actually sent letters out to support what Senator KENNEDY was trying to do a year ago.

I did not accuse the AARP of being a tool of the Democrat Party like Members on the other side are accusing the AARP of being in bed with the Republicans. They are not in bed with the Republicans. They are in bed with a bipartisan group of this body who want to do something for seniors of America. It is funny how the AARP is OK when they are helping Senator KENNEDY but they are not OK if they are helping a bipartisan group led by Senator GRASSLEY and Senator BAUCUS.

I would say they are discretionary in what they do. They may not be consistent, but thank God they are not consistent because they would not be representing the diverse group they represent.

Here is what the AARP says in their endorsement:

> AARP believes that millions of older Americans and their families will be helped by this legislation.

They continue:

> This bill provides prescription drug coverage at little cost to those who need it most: People with low-incomes, including those who depend on Social Security for all or most of their income. It will provide substantial relief for those with very high drug costs and will provide modest relief for millions more.

The last sentences I will read:

> An unprecedented $88 billion will encourage employers to maintain existing health retiree benefits. The legislation will help speed generic drugs to market and add important new preventive and chronic care management services. This legislation protects poor seniors from future soaring prescription drug costs.

All the Members complaining about the AARP, put that in your pipe and smoke it.

Then we have the National Council on the Aging:

> . . . we find it too difficult to again say to millions of vulnerable seniors in need: Sorry, come back in a few years and maybe there will be some help for you then.

Another sentence:

We urge Congress to pass the Medicare bill so that millions of seniors with greater needs will receive long-awaited and badly-needed prescription drug coverage.

Are Members trying to tell me the National Council on the Aging does not know what is good for seniors when they see it? Put that in your pipe and smoke it.

The Alzheimer's Association says:

This is a historic accomplishment that may potentially provide meaningful relief to the 4.5 million Americans dealing with Alzheimer's disease—many of whom also suffer other health issues.

That is from Sheldon Goldberg, president and CEO of the Chicago-based national organization for the Alzheimer's Association.

Are Members telling me the Alzheimer's Association cannot make a judgment if this bill is good for their members? Go put that in your pipe and smoke it.

From the American Diabetes Association:

. . . contains important improvements to the Medicare Program that will benefit many people living with or at risk for diabetes.

. . . the prescription drug package assists seniors living with diabetes by providing coverage for insulin and syringes, a critical component for seniors that take insulin to manage their diabetes.

. . . the American Diabetes Association supports passage of—and strongly urges Congress to enact—the Medicare package as a way to improve the lives of millions of seniors living with diagnosed and undiagnosed diabetes.

Are Members trying to tell me the American Diabetes Association does not know a good piece of legislation when they see it? Put that in your pipe and smoke it.

We have a statement by Advancing Health in America, AHA, saying:

It provides prescription drug benefits to the elderly and provides needed Federal relief to hospitals, particularly rural hospitals.

The legislation includes important provisions that help patients by providing hospitals the resources necessary to continue caring for America's seniors.

Tell me an organization called Advancing Health in America does not know what is good for their Members.

From the American Medical Association:

Congress listens to America's patients and physicians who serve it.

The status quo is unacceptable to patients and their physicians. The Medicare conference agreement includes numerous provisions that will improve seniors' access to medical services.

Tell me the American Medical Association does not know what is good for their members or what is good for their members' patients.

The Arthritis Foundation says:

The Arthritis Foundation supports a Medicare Prescription Drug, Improvement, and Modernization Act for 2003 that for the first time would provide coverage for prescription drugs and biologicals for persons with arthritis.

Can Members tell me the Arthritis Foundation does not know what is good for their members, know a good piece of legislation when they see it?

We have the American Pharmacists Association:

. . . APhA supports this as an important, long-overdue step toward providing Medicare beneficiaries greater access to medications and critical pharmacist services.

The proposal creates a comprehensive benefit that provides coverage for drug products and pharmacist services, and provides seniors their choice of pharmacists and ensures any willing pharmacist can participate in a plan and incorporates important administrative efficiencies.

Those Members who oppose this bill, are you trying to tell the people of America that the American Pharmacists Association does not know a good piece of legislation when they see it and that they cannot speak for not only their membership but also their patients and clients they serve?

From the College of American Pathologists:

This legislation will improve Medicare coverage for seniors and protect access to the physicians and services upon which they rely for quality of care.

The conference agreement also preserves critical health care services provided by independent laboratories in to hospital patients, especially in smaller and rural communities.

Are Members telling me, as they criticize this legislation, that the College of American Pathologists would support legislation that is not good for their patients and the people they serve?

The Federation of American Hospitals:

This agreement does more to improve Medicare coverage for seniors than any legislation since its program inception.

That is 38 years.

The Federation of American Hospitals commends President Bush, the Congressional leadership, and members of the Medicare Conference Committee for their great efforts in bringing these vital improvements to the Medicare to fruition.

H.R. 1 would greatly enhance the ability of hospitals to provide necessary care medical care to Medicare beneficiaries. It would make important strides in ensuring that all hospitals have sufficient funding to meet the medical needs of this nation's seniors and would particularly aids though hospitals that serve seniors in rural areas.

Every Member has rural areas in their State. And we have a major hospital association supporting this legislation because it is particularly going to serve seniors in rural America.

Now, tell me that they do not know a good bill when they see it.

Here is something that answers complaints that were heard late this morning or early this afternoon. One of the first speakers on the other side of the aisle, the Senator from Illinois, was complaining about this not doing enough for generics. But here we have the Generic Pharmaceutical Association:

The Generic Pharmaceutical Association today called the Medicare Conference compromise on generic drugs a tremendous victory for all consumers that will ensure timely access to affordable pharmaceuticals. . . .

The House and Senate conferees have met the challenge of eliminating some of the most serious barriers to generic competition by closing loopholes that have unnecessarily delayed the timely introduction of affordable pharmaceuticals—and American consumers, young and old alike, will be the winners.

Now, how many of you speaking today have complained about this legislation not doing anything about the cost of drugs? And we know that putting generics on the market sooner is one of the ways to bring down tremendous drug costs.

Now, the Generic Pharmaceutical Association supports this legislation, and yet you do not recognize that they understand a good piece of legislation when they see it.

We have the United Seniors Association:

We commend the Senate and House Conferees on their historic step to benefit every senior in America. Partisan politics and rhetoric-without-results on prescription drugs are simply unacceptable. Years of hard work by many in Congress and years of heartache for America's seniors have led us to this point. The whole senior world is watching and Congress must not collapse so near the finish line.

Are you trying to tell me that the United Seniors Association looks at this legislation and sees it is good for their members, and yet you cannot see that?

We have The 60 Plus Association:

The bill makes available much needed assistance to millions of seniors who lack any prescription drug coverage. Significantly, those who can least afford to pay will get the most help [from this legislation].

From the Rural Hospital Coalition:

We support your efforts to modernize Medicare and give senior citizens a prescription drug benefit that they deserve. . . . [T]his bill strengthens health care in rural America.

From the National Rural Health Association:

This bill is a big boost for the rural healthcare system. . . . A stronger healthcare system will help revitalize rural economies which will positively impact rural Americans throughout the country.

We have the National Hospice and Palliative Care Organization:

NHPCO strongly supports these provisions and believes these changes will improve the quality and timeliness of hospice and palliative care for seniors and their families.

From the Mayo Clinic, 150 miles from my home in Iowa:

Mayo Clinic supports the compromise Medicare reform legislation that has emerged from a congressional conference committee.

We have NAMI, The Nation's Voice on Mental Illness:

This conference agreement does represent an improvement for Medicare beneficiaries living with mental illness. . . . NAMI feels strongly that it is time for Congress to end partisan stalemate over this issue and take advantage of the $400 billion available this year to spend on a new drug benefit.

This is kind of a partisan statement I am going to read to you, but it does represent a group of people who are impacted by what we do here with dual

eligibles. It is from the Republican Governors Association:

Medicare will provide first-time access to prescription drug coverage to many of our seniors. The agreement also assists states with the costs related to the dual eligible population. Assistance to low income persons as well as critical protection against high out-of-pocket drug costs are essential components of this legislation. . . . [T]he preventive benefits found in this measure will keep our constituents healthier.

From the Alliance For Aging Research:

With this act the millions of Medicare beneficiaries will no longer have to wait from 15 months to 5 years for access to new state-of-the-art medicines and life-saving and life-enhancing technologies. In addition, and most importantly, it targets those with the greatest need by providing significant low-income subsidies for prescription drugs that will assist millions of Medicare beneficiaries living longer and healthier lives. . . . This will be a giant step toward expanding and modernizing Medicare, while preserving the power of science and technology to improve and enhance the lives of our people in the future.

Lastly, we have the American Benefits Council, a news release. The headline: ''Medicare, prescription drug reform bill represents historic, positive achievement.''

We urge swift enactment of the legislation. . . .

I have quoted these statements from these outstanding organizations for the RECORD because they speak louder than any Member of this Senate can about what is good about this legislation.

I would hope that you folks on the other side of the aisle would take these statements into consideration, particularly tomorrow, when I am told 15 of you are going to speak, probably most of you against this legislation. I would appreciate you taking into consideration what these major groups have said.

Madam President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Ms. MURKOWSKI. Mr. President, I realize the hour is late. This body has been discussing the issue of Medicare legislation for close to 12 hours now on this Saturday.

I want to speak briefly this evening about the legislation that is under consideration in the Senate and its impact on senior citizens in my home State of Alaska as well as around the Nation.

We have heard a great deal today on the floor about the need for reform, about what we need to provide for our senior citizens.

We must keep in perspective what we owe our seniors. This is the generation of Americans who paid most dearly to protect the freedoms we enjoy. Many of our older Americans today went through the Depression and have very personal, truly gut-wrenching memories of the hunger that they perhaps went through at the time. They were the generation who settled the frontier areas of America, including my State of Alaska. They remember the horror and the stories from Pearl Harbor. We owe this generation of Americans many things, not the least of which is honesty.

Since Medicare was enacted in 1965, it has provided health security to millions of America's seniors and people with disabilities. Medicare is that promise of health security we must always keep.

Many of my colleagues on the other side of the aisle would like Americans to believe that the bill in front of us today is designed to kill those promises made in 1965. I remind my colleagues that Americans deserve more than the rhetoric and the scare tactics we have heard saturating the airwaves from here. Earlier this evening in listening to the debate, one of my colleagues made reference to the fact that seniors are going to have to sell their wedding rings in order to meet certain levels for low-income subsidies for Medicare beneficiaries.

I thought, wait a minute, that can't be true. That is not a part of this legislation. Seniors will not have to do that. So I said: Show me. Let me know for sure that, in fact, this is not the case.

We pulled it out and looked at the application of the asset test. It very clearly states those resources that are not counted for an asset test, excluded resources, include, and No. 3 on the list is memorabilia such as a wedding ring. For us to stand here on the Senate floor and suggest to a senior citizen that in order to meet certain requirements to keep your Medicare benefits you might have to give up your wedding ring, I sure hope my 84-year-old next-door neighbor was not hearing that because I know she wouldn't sleep well knowing that that could be true.

We have to be real. We have to be honest with our statements, and we have to talk the truth about what is and is not contained in the legislation before us.

Americans deserve to know that this bill, while not perfect—I don't think any of us would suggest it is perfect—will provide good drug coverage for any senior citizen who wants to enroll. Americans deserve to know that this bill doesn't force seniors to join HMOs to get prescription drugs.

This legislation is designed to provide choice, not coercion. If seniors want to add prescription drug coverage to the Medicare plan that they have right now, they would have that option. Their benefits would not be reduced, would not be taken away. If they don't want the drug coverage or if they are happy with the coverage they have now through their retirement plan, they don't have to accept the voluntary Medicare benefit.

The incentives for employers to keep offering their own prescription drug benefits: The Employer Benefit Research Institute indicates that they expect between 97 percent and 99 percent of beneficiaries won't have any change in benefits. We need to clearly repeat these provisions.

The bottom line is this: If you like Medicare the way it is today, you can keep it that way because it is designed to be a voluntary benefit.

The problem is for many Americans, including those in Alaska, Medicare has not been living up to its promises. It will only pay for your drugs if you have been hospitalized. And for many, it does not pay for the health care professionals. Essentially, this program is still stuck in the 1960s mindset of reactive care rather than the kinds of proactive care we expect today.

Several months back I had an individual up in the State who was meeting with me and going out to senior centers. We were talking about the Medicare legislation in front of us at that time. She made the analogy that Medicare is like the telephone. In 1965, the telephones that we had in our homes were the black rotary dial. They came in one color and one style, and that was it. And that was how we talked.

Now in the year 2003, we talk on cell phones, by fax, e-mail, on colored phones. The technology has changed incredibly, but we are still doing the talking.

Medicare is essentially the rotary dial system of health care that just hasn't been ramped up.

Americans need to know that Medicare still doesn't provide full coverage for preventive care, including cancer, diabetes screenings. It doesn't offer protection against catastrophic medical costs, these things that can rob our seniors of their hard-earned savings. There has been a lot of rhetoric about the drug benefit. But if you cut all through it, if you do the number crunching, you get to the indisputable fact that the average senior citizen, after paying their premium, is going to see a savings in the cost of their drugs—we estimate about a 63-percent savings in the cost of drugs.

For those seniors with limited income and limited savings, which is about half of Alaska's senior citizens, half of Alaska's senior citizens are in this lower income bracket, they will have closer to 90 percent of their drug costs covered, and this is not a skimpy benefit.

The bill also adds important preventive benefits that are many years overdue. In order to combat our Nation's No. 1 and No. 3 killers, which are heart disease and stroke, Medicare would be required to cover screening blood tests with no cost to the senior. This bill helps the millions of Americans who struggle daily with the chronic diseases such as asthma and diabetes. The bill adds principles of disease management to Medicare which will help the seniors navigate the oftentimes confusing health care system and get them

the access to vital specialty care and educational resources.

While we all seem to agree that it is important to add preventive benefits to Medicare, there has been a lot of discussion about whether to allow government-regulated private plans to offer these Medicare benefits. I have to step back a little and wonder if perhaps I am the only one who finds it ironic that we would use taxpayer-funded subsidies to give each one of us in Congress a choice of health plans, but yet we would deny our senior citizens that same choice.

The bill before us rejects this philosophy of ''big Government knows best,'' and tells our seniors: You have the right to select a benefit that meets your needs. If you don't need drug coverage, you don't have to enroll. You can keep Medicare the way it is today. If you don't want to join a private plan, you don't have to. If you don't want to change anything about Medicare, you don't have to.

I also want to address a comment that a number of Members—primarily on the other side of the aisle—have made characterizing Medicare as good the way it is now. I have even heard a number claiming that the Medicare Program today gives seniors such things as a choice of doctors. While I agree with them that Medicare is a good program, and I believe we need to make sure it still exists for our children's children, I need to let my colleagues know that the way the current Medicare Program does business, it hurts those in my State who have been promised care.

Every week, Senator STEVENS, Congressman YOUNG, those in the Alaska delegation, and I come to work and we are faced with a huge stack of mail, e-mail, phone calls, and the like from Alaskans about the problems they are having with Medicare. I mentioned earlier that this summer, back in my State, I held a senior citizen forum in the community of Chugiak. What I learned may actually surprise some of my colleagues who seem particularly enamored with the way Medicare is today. Seniors in Alaska are not only being denied a choice of doctors, but in many cases they don't have the ability to see a doctor at all. This is because doctors, or health care providers, in Alaska are paid just about 37 cents on the dollar for the care they provide to seniors on Medicare. Medicare is a price-fixer. So what we have is somebody in Baltimore sitting in a cubical, and they are deciding how much to pay for medical care in the community of Delta Junction, in Alaska; or take the community of Bethel, not on the road system, completely cut off from the rest of the world. If the payment the folks in Baltimore have said we are going to be charging is less than the cost of actually providing the care, Medicare basically tells our doctors: Tough, you are out of luck. This price-fixing causes problems not only in the rural areas of the State—as I mentioned, in a place such as Bethel or Delta, where you would expect these problems—but the sad truth is that even seniors in the urban centers of Alaska, in Anchorage and Fairbanks, cannot find a doctor who will accept new Medicare patients.

Perhaps I need to go a little further in explaining to my colleagues how much of a problem this is in my State. When a senior in the lower 48 cannot find a doctor in their community to help them, they can hop into their car and drive to the next town and find a doctor—just go to the city. But when seniors cannot find a doctor in Fairbanks—and the whole State knows seniors in Anchorage are having the same problem—there are two options for them. The first one is that there are few things you can do. Second, there are bad things you can do.

The simple fact is that for many of my constituents, their choice for a doctor is limited to those who are practicing in the emergency room. Who is the doctor on call that night? That is their choice of doctors.

The only other choice is—and this is probably a choice only for a few—to fork over the $1,400, or whatever the price of the airplane ticket is, to make the 8-hour roundtrip flight to Seattle and try their luck with doctors there.

Just 2 weeks ago, I had a constituent in my office who told me she flies to Virginia every year to see her doctor. She lives in Alaska. She flies to Virginia to see her doctor. She does this because she cannot find one in Anchorage who will accept new Medicare patients. The cost for the ticket alone, not counting her lodging and meals while she is there, is about $1,500. Unfortunately, these situations in Alaska right now are not the exception; they are the rule.

We have somewhere between 1,000 and 2,000 senior citizens in Anchorage alone who cannot find a doctor who is willing to treat them. The situation in Fairbanks is not much better. We recently called up the State to one of the larger clinics there that accepts Medicare patients. We asked them: Are you accepting new Medicare patients, and when would the first available appointment be? We were told mid-July. This is not choice when it comes to your doctor.

How is this situation keeping the promise we made to our senior citizens in 1965 when we established Medicare? What kind of treatment are you advocating for when you keep Medicare the way it is? We can come up with grand plans here in Washington and we can talk about Medicare reform, but if we don't have doctors who can write the prescriptions, if we don't have access to physicians, we have not done anything to fix the problem with Medicare.

Keeping Medicare as we know it in Alaska means Alaskans will go to the emergency room for primary care. It means making Alaskans pay to fly across the country by themselves to go find a doctor, and it means making Alaskans go without preventive screening.

Medicare as we know it doesn't give patients a choice of providers or access to the care of their choice, as some of my colleagues have stated. Medicare isn't working perfectly and desperately needs reform. I believe the legislation we have in front of us is a good compromise. It includes provisions that will ensure that senior citizens around the Nation and in Alaska will be able to find a doctor somewhere other than in the emergency room.

We owe our seniors a little more honesty in this debate. They deserve to know clearly that the prescription drug is voluntary. They deserve to know they will not be forced to join a program they don't want to join. They deserve to know the average senior citizen who joins will save somewhere around 63 percent on the cost of their prescription drugs. They deserve to know low-income seniors will pay no deductible, no monthly premium, and have no gap in coverage; and Medicare will pay about 90 percent of their drug costs. They deserve to know the group purchasing power we are giving to seniors is going to make the drug companies work for their business.

Mr. President, those who stood defending our freedom deserve more than the partisan rancor that has been sailing around this Chamber. They deserve to know more than some of the half-truths that have been told. Medicare, as we know it, should provide seniors with access to vital health care services and the physician of their choice. I believe this bill does those things, and I believe it will meet the needs of my constituents.

We have come a long way toward making good on our promise to our senior citizens, and that is to the credit of the administration and to the leadership of this Congress, certainly to the leadership of the Senator who is presiding this evening. We do need to strengthen Medicare, and seniors do need access to vital prescription drugs.

Many who are now on Medicare fought for the freedom that we enjoy today, and Monday we will, hopefully, have the opportunity to keep our promise to seniors and to fight on their behalf by providing them with a voluntary prescription drug benefit.

I urge my colleagues to support this legislation.

ORDERS FOR SUNDAY, NOVEMBER 23, 2003

Ms. MURKOWSKI. Mr. President, on behalf of the majority leader, I ask unanimous consent that when the Senate completes its business today, it adjourn until 1 p.m., Sunday, November 23. I further ask unanimous consent 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 consideration of the conference report to accompany H.R. 1, the Medicare Prescription Drug Modernization Act, with the understanding that speakers will alternate between the sides with the order of speakers on the opponents' side, as previously requested by the assistant Democratic leader.

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

PROGRAM

Ms. MURKOWSKI. Mr. President, tomorrow the Senate will continue debate on the Medicare conference report. We had an extended and vigorous debate today, but there are many others who wish to make statements on this historic bill. Because we have a large number of Senators who wish to speak tomorrow, we ask Senators to limit their remarks to 30 minutes. We will talk further tomorrow on the best way to accommodate Members as we go forward.

As a reminder, a cloture motion on the conference report was filed today. That vote will occur during Monday's session at approximately 12:30.

Finally, on behalf of the leader, I thank not only the Members who participated in the debate but also the Senators who presided throughout this session.

ADJOURNMENT UNTIL 1 P.M. TOMORROW

Ms. MURKOWSKI. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 9:33 p.m., adjourned until Sunday, November 23, 2003, at 1 p.m.