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.