legislation, and there was objection to the unanimous consent to move it forward.

For the week, that is stall tactic No. 7.

What will next week hold? We are going to conclude PNTR on a vote on Tuesday, I believe. We have numerous appropriations bills that ought to be dealt with. Hopefully, we can and will deal with them and in doing so pick up the pace around here and get our work done so that we can adjourn—so that we can send a very clear message to the American people of the intent of this Congress to balance the budget; to hold sacred the Social Security surplus; to make sure that we deal with health care in a responsible way for our citizens; hopefully that we could give back a few of these surplus tax dollars, but if we can't do that, at least dedicate a large portion of it to debt buydown so that young people in their lifetime won't have to finance the debt structure of the generation before them.

Those are responsible and right things to do, and I hope we can do them. But I will be back next week to talk probably about stall tactic No. 8, No. 9, No. 10, and No. 11. At least I am going to until the minority leader comes to the floor and he recants and says that he didn't say this or that this isn't a strategy because if it is a strategy, it is bad politics, and it is darned bad government to simply say, no, we are not going to work until we get the right to spend billions and billions of dollars of more money. That is not bipartisan. Most importantly, that is bad policy.

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

The PRESIDING OFFICER. The clerk will call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

MORNING BUSINESS

Mr. CRAIG. Mr. President, I ask unanimous consent that there now be a period for the transaction of routine morning business with Senators permitted to speak for up to 10 minutes each.

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

PRESCRIPTION DRUGS AND PREVENTIVE CARE: THE KEY TO TRUE MEDICARE REFORM

Mr. GRAHAM. Mr. President, yesterday I started the first of what will be five or more brief statements on issues related to the subject of the Federal Government providing a prescription medication benefit to Medicare recipients.

Yesterday, I opened this series with a discussion of what I consider to be the most important reform required in the Medicare system; and that is reforming a 35-year-old health care system which was established to provide acute care; that is, care after an illness had matured into a major condition, or after an accident had caused a person to require specific medical attention largely in a hospital setting.

What was not included as part of the 1965 Medicare program was an emphasis on what seniors want today; and that is, they want a system that will not just treat them after they are seriously ill but to have treatment that will avoid or reduce the impact of those illnesses through effective preventive strategies.

Those preventive strategies have many components, including regular screenings for those conditions that can be detected at an early time; and then the management, through a variety of sources, of those chronic conditions so that they do not mature into serious health concerns, in some cases even death.

To me, the conversion of Medicare from a sickness program to a wellness program is the fundamental reform that this Congress must achieve.

If we are going to have this new orientation on wellness, prescription drugs will play a critical role. Prescription drugs are a part of almost every methodology of managing a medical condition which, if not appropriately managed, could mature into serious complications. Prescription drugs are a key to providing true quality preventive care for our senior citizens.

My point is illustrated by an example.

Mrs. Jones is a Medicare beneficiary. She has, like an increasingly large number of Medicare beneficiaries, no drug coverage. Unfortunately, Mrs. Jones also has diabetes, hypertension, and high cholesterol. These are three conditions which in the past would have been debilitating, even fatal. Today, thanks to the miracle of modern medicine, Mrs. Jones can treat these conditions and continue to live a healthy life.

Mrs. Jones is likely to be treated with Glucopahge, Procardia XL, and Lipitor.

The annual cost of Glucophage will be $708. The annual cost for Procardia XL will be approximately $500 to $900, depending on whether 30 or 60 milligram tablets are prescribed. The annual cost of Lipitor is approximately $700. The total annual spending for these three drugs alone for Mrs. Jones will range between $1,900 and $2,300. These costs, for most seniors—I would argue, for most Americans—are likely to cause significant economic hardship. But if Mrs. Jones does not take these drugs, she will find her conditions raging out of control and will surely be a candidate for expensive hospital stays and surgery.

Those last two comments underscore the fact that this is a medical issue in terms of will we make available and affordable to our older citizens those drugs which are available to manage conditions and avoid those conditions maturing into the need for expensive hospitalization, surgery, or even conditions that are beyond the ability of those heroic measures to stop the unending pace towards death. It is also an economic issue.

For most seniors, there are many years of preparation for retirement, preparation which is particularly oriented to assure that there will be an economic foundation under their retirement years. There are many challenges and risks to that economic foundation. Today the most prominent of those risks, the one which is most feared by millions of older Americans, is the fact that they will, in fact, be diagnosed as having some condition which, the good news is, is treatable and controllable. The bad news is, it will wreck their economic foundation to pay the cost of those drugs. We are dealing not only with an issue of medical humanity but also of economic security. We owe it to our Nation's seniors that they have the chance to live a full, healthy, and economically secure life in retirement. Prescription medications are a key to allowing them to do so.

When Medicare was established in 1965, Mrs. Jones may have benefited most by a system that provided effective hospital care, that did not have a particular focus on preventive benefits, where outpatient prescription drug coverage was not a particularly significant factor. But in the 35 years since that time, medical science and our set of values of what we want from our health care system have changed dramatically.

Today pharmaceuticals, not surgery, are the first line of defense against illnesses. The number of prescriptions for American seniors grew from 648 million as recently as 1992 to more than 1 billion in the year 2000. One example of this transition from surgery to pharmaceuticals is the treatment of ulcers. It used to be that the standard treatment was surgery. Today surgery for ulcers is a very rare event. What has happened is the substitution of effective pharmaceuticals to treat, remedy, and reverse ulcerous conditions.

A senior is better because he or she has avoided the necessity of intrusive surgery. Our taxpayers are better because they have avoided the cost of that surgery, and the senior is able to resume a normal quality of life.

We should think of preventive medication today as the anesthesiology of the last century. I have suggested that if Medicare had been created, not in 1965 but at the end of the Civil War in 1865, there would have been the same debate that we are having today over whether we should include anesthesiology. As we know from our study of Civil War history, it was not uncommon for very serious surgical procedures to be conducted without anesthesiology. Today we would think it to be

ludicrous to the extreme and inconceivably inhumane not to have anesthesiology as a core part of a health care system. I suggest that in a few years people will look back on this debate with the same shock and surprise that we thought there was any debate over the question of whether pharmaceuticals should be part of an appropriate humane health care system as we begin the 21st century.

Medicare beneficiaries should not have to choose between bankrupting themselves and their families or succumbing to a preventable disease. The key to modernizing Medicare is turning it from a sickness program to a wellness program. Prescription drug coverage is a crucial component of that change.

Let me give another example. A senior with gastrointestinal problems is most likely to be prescribed a drug known as Prilosec. Based on 1998 data from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly program, which is the largest outpatient prescription drug program in the country, Prilosec is the second highest selling drug prescribed for seniors. The annual cost is $1,455. For a senior who, for instance, is at 200 percent of the poverty level, $16,700 per year, Prilosec will consume $1 out of every $11 of that senior's income. This price is very high for that senior. But the price the senior would pay if he or she did not take Prilosec is even higher. They would sacrifice an active, pain free life for one riddled with chronic pain.

This body should recognize that prescription drugs are an integral part of a preventive care strategy for the Medicare program. As one of the primary guardians and trustees of the Medicare program, the Senate has the responsibility to reform and modernize Medicare so that it focuses on health promotion and disease prevention for all of our Medicare beneficiaries. It can improve the quality of life for older citizens through making this conversion from a sickness to a wellness program.

The Medicare program can also slow the cost to the taxpayers by making this transition. The cost of one senior, typically an older woman who falls and, because of her shallow bone mass, injures her hip and requires hospitalization, often surgery, and always a long and painful recovery period, the cost of that to the taxpayers is much greater than the cost of one of the preventive measures which is now being recommended but which is yet to be covered by Medicare; that is, effective hormone management techniques which will contribute to maintaining strong bone conditions and reducing the vulnerability to that kind of a serious mishap.

It has been proven time and time again that a combination of preventive services and appropriate medication can reduce the incidence of stroke, diabetes, heart disease, and other potentially fatal conditions.

Detailed programmatic changes—changes based upon the realization that prescription drugs and preventive services go hand in hand—are necessary to convert the current Medicare system into one that best serves our citizens by keeping them well as long as possible.

Mr. President, we are very fortunate to be living in an era of unprecedented prosperity. This period gives to us, the trustees of the Medicare system, an even greater responsibility and opportunity. We can use this period of prosperity to reform the Medicare program, to assure that our seniors will be able to live longer, healthier lives through preventive care and the treatments that are available to us today. To capitalize upon this opportunity we must provide a prescription benefit which is affordable and comprehensive for our Medicare beneficiary citizens.

I implore each of us to take advantage of this opportunity and use the funds that are available to us now to implement change that will benefit our seniors today, our children and grandchildren tomorrow.

We have discussed the need to reform the Medicare program to shift its focus from the treatment of illness to the maintenance of good health. We have discussed the critical role that prescription medications play in ensuring a successful preventive care strategy for Medicare. If we agree on these issues—and I believe there is broad consensus—the next question we must answer is: How should a prescription drug benefit be made available for our Medicare beneficiaries?

Next week, I will discuss the critical question of whether a prescription drug benefit should be part of the big tent of Medicare program, or if it should be placed as a sideshow act outside of Medicare. I look forward to discussing this with my colleagues next week.

BUSH HITS GORE ON DRUGS AND TAXES

Mr. GRAHAM. Mr. President, I want to close with a comment about an article that appeared in today's Washington Post under the headline, ''Bush Hits Gore on Drugs and Taxes.''

I ask unanimous consent that this article be printed in the RECORD immediately after my remarks.

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

(See Exhibit 1.)

Mr. GRAHAM. Mr. President, according to this article, there is a new 30-second ad being run that is entitled ''Drugs and Taxes.'' According to the Washington Post article, the audio of this tape begins as follows:

Al Gore's prescription plan forces seniors into a government-run HMO. Governor Bush gives seniors a choice.

The Post, in its analysis of this statement, makes the following comment:

In a classic contrast ad furthering the theme that Gore is untrustworthy, Bush misrepresents the vice president's drug plan. First, it isn't mandatory; seniors can opt for drug coverage or not. Second, Medicare recipients could remain in traditional choose-your-own-doctor plans. Drug payments would be administered through private cost-control groups—such as those now employed by the insurance industry—that are not ''government-run'' or health maintenance organizations. In fact, many analysts say Bush's plan, while providing choices, would encourage more seniors to join cost-conscious HMOs.

I only add to that analysis of this ad that it is interesting to me that the word ''HMO'' is inserted in the ad of Governor Bush as a pejorative. This Senate has been trying for the better part of the last 2 years to pass a Patients' Bill of Rights in order to lay out some basic standards of protection as they relate to the beneficiaries of HMOs, the citizens who look to the HMO to finance their health care, the providers—doctors and hospitals—who are the source of that health care, and the HMO which has received the premium dollars from the patients and is now called upon to pay the providers for the cost of services delivered to the beneficiaries.

It has been my position—and I believe today a majority of the Senate's, as well as a very strong majority in the House of Representatives—that it is a Federal responsibility to establish some basic standards of that relationship so that there will be a comfort level that people know what will be expected. They will know how they would be treated, whether it is in the emergency room, whether it is in access to a specialist physician, whether it is a woman's right to use her gynecologist as her primary care physician; all of those very intimate issues will have a known, federally established standard.

Yet in spite of that majority support in both Houses of the Congress, we have gone month after month after month unable to even have the conference committee report out a bill that we can debate and decide whether it meets the appropriate standards of providing those standards of treatment for patients, providers, and the HMO itself.

It is surprising to me, therefore, in that context that now Governor Bush apparently has concluded that the HMOs are sufficient pejorative that he can use them as the target of his attack of what we don't want in our health care system. I hope this ad might serve the probably unintended purpose of galvanizing an even broader coalition within the Congress behind the necessity for HMO reform and for the establishment of a basic set of patients' rights.

If Presidential candidate Governor Bush has seen the HMO as such a pejorative figure that he is now attacking it in his ads, that might send a signal as to what the American people want us to do in terms of beginning to rectify that negative image by providing some effective nationwide standards of Patients' Bill of Rights for HMOs.