Others wish to speak on other issues. If they feel so inclined, I hope they will come and speak now. We would like to have as little down time as possible before we go out this evening. If there are no amendments or further debate, of course, we can move to third reading. I am told there may be some amendments, but I don't think either leader wants us to wait around here doing nothing on this resolution.

If there are going to be amendments, I hope Members will come and offer them. If not, as I indicated, we can move to third reading at any time.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. BAUCUS. Mr. President, what is pending business?

The PRESIDING OFFICER. Amendment No. 4886 to S. Res. 304 is the pending business.

Mr. BAUCUS. Mr. President, I ask unanimous consent to speak as in morning business.

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

UNANIMOUS CONSENT REQUEST—S. 3018

Mr. BAUCUS. Mr. President, on October 1, Senator GRASSLEY and I introduced a bipartisan Medicare package, the Beneficiary Access to Care and Medicare Equity Act. Our bill would address a number of Medicare payment changes—primarily reductions—that went into effect at the start of the fiscal year. At the beginning of the fiscal year, Medicare payment reductions automatically went into effect in many areas. What were they? Cuts to home health services. Cuts to nursing homes. Cuts to hospitals. One of the most damaging cuts of all, for Medicare physician payments, is scheduled to take place beginning January 1, 2003. This is the second year in a row such physician payment cuts would occur. Mr. President, these cuts threaten access to care for tens of millions of seniors across America.

Sadly, since this bill was introduced, the Administration has indicated that preventing these cuts from going into effect is simply not a priority.

Tom Scully, the administrator of the Center for Medicare and Medicaid Services made this clear last Tuesday. He said:

> It would be fine with the Bush administration if Congress does not pass Medicare provider payment legislation this year.
>
> If I had to guess right now—I guess there won't be any give-back bill.

The White House Office of Management and Budget Director, Mitch Daniels, also said he thinks ''the Federal Government cannot afford to pass a Medicare provider give-back bill.''

Mr. President, the Administration says it cannot afford, after all the billions that have been spent elsewhere, to restore some of the cuts that have already gone into effect.

The chairman of the House Ways and Means Committee has been equally unenthusiastic about addressing these cuts.

The Administration and the chairman of the House Ways and Means Committee may believe this legislation is not a priority. I respectfully disagree. This bill is a priority. It is a priority for every senior who receives home health care. It is a priority for every senior who receives nursing home care. It is a priority for all Americans of all ages who depend on our teaching hospitals. And it is a priority to anyone who cares about ensuring our seniors receive access to physician services.

Again, a large cut goes into effect for physician services after January 1. Last January, physicians saw their payments cut by 5.4 percent. Already some doctors are talking about leaving Medicare. Why? Because they are concerned that Medicare payments may not be enough to allow them to pay for the costs of caring for seniors.

If this legislation I have introduced with Senator GRASSLEY does not pass, physician payments will be cut again by over 4 percent. This must be changed.

Our bill also is a priority for our children. Under current law, funds for the Children's Health Insurance Program that have not yet been spent are scheduled to be returned to the Federal Treasury. I think this money should remain where it belongs—with the States, helping children. It is helping children who need health insurance benefits. We have about 9,500 Montana kids, and many more children in many other States, who are currently receiving coverage through CHIP. If our bill does not pass, America's kids stand to lose as much as $2.8 billion.

This bill is also a priority for States. We have all heard about the budget problems threatening States in every corner of our Nation, about the possibility of deep cuts to important programs and services, such as Medicaid. Our bill will send an extra $5 billion in fiscal relief to the States to forestall these cuts.

This bill is a priority for rural America. From Montana to Maine, the Medicare payment system continues to discriminate against rural patients and rural providers. Our bill takes strong steps to address these regional inequities.

This bill is a priority. I cannot imagine the administration saying this is not a priority, given all the other areas where we spend dollars. Defense, homeland security, and other issues are vitally important. But our Nation's health is also important, and we should invest in it accordingly.

I cannot believe this administration is saying it is not a priority to prevent these cuts from taking effect. I cannot believe that. Nevertheless, that is what they say. This legislation tries to address that situation so those cuts do not go into effect.

I said this bill is a priority. It is a priority for our seniors. It is a priority for our children. It is a priority for our State governments and rural areas in our country, for anyone who cares about preserving access to quality care in America.

I might add, this is a bipartisan bill. Senator GRASSLEY and I have worked very hard on this legislation. Senator GRASSLEY is the ranking member of the Finance Committee. We worked together at every point to craft this bill. We sought input from our colleagues on both sides of the aisle. We met with our respective caucuses. We worked closely with members of the Finance Committee.

When the Senator from Oklahoma objected to my unanimous consent request almost two weeks ago, he suggested this bill appeared out of nowhere on the Senate floor. That could not be further from the truth.

The Senator also objected to this bill because we lack official CBO scoring. That issue has been cleared, as we received an official estimate of the bill on Friday. CBO estimates this bill would cost about $43.8 billion over 10 years. We guessed it would cost about $43 billion. CBO said our guess is pretty close; it is $43.8 billion.

I believe that is the minimum investment we should make to address the priorities I mentioned. So today as the Medicare payment cuts go into their 16th day, and as many more cuts loom on the horizon in January, I will again ask unanimous consent to pass S. 3018.

Mr. President, I ask unanimous consent that the Senate proceed to the consideration of S. 3018, a bill to amend title 18 of the Social Security Act; that the bill be read a third time and passed; that the motion to reconsider be laid upon the table; and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Is there objection? The Senator from Oklahoma.

Mr. NICKLES. Mr. President, reserving the right to object, unfortunately this bill did not go through committee. I ask the Senator if he would modify his request to refer the bill to the Finance Committee to be reported out within 48 hours. Will he be willing to modify his request?

Mr. BAUCUS. I am sorry, I was distracted.

Mr. NICKLES. Correct me if I am wrong, but the Senator is trying to pass his bill which never had a markup in the Finance Committee. I happen to be a member of the Finance Committee. I would like to offer an amendment. I know Senator SNOWE has an amendment she would like to offer. Senator SESSIONS has an amendment he would like to offer, or myself or someone else on the committee to offer on his behalf.

We would like other Members to have a chance to amend the bill. So will the Senator be willing to modify his request to request this bill be referred to the Finance Committee for 48 hours for a markup so all members on the Finance Committee would have a chance to have input on this particular bill?

Mr. BAUCUS. Mr. President, in responding to my good friend from Oklahoma, I have a couple points. First, as my good friend well knows, since he is a member of the committee, this issue, the Medicare provider bill, has been discussed for many weeks. It was in the Finance Committee informally, with several discussions and meetings.

In order to prevent the harm that these Medicare cuts represent, I believe, and I think Senator GRASSLEY believes—we should check with him and make doubly certain—that we should pass this bill now. It makes more sense to pass this consensus bill than to go back and try to make it perfect in the view of some other Senators.

Second, there are very few days remaining in the session. There are very few days remaining before the election occurs. What does that mean? It means under the Senate rules, anybody who wants to frustrate the will of the majority, frustrate the will of 99 Senators, can essentially do so by objecting or by offering amendments.

The Senator knows this because we have had four separate votes on the issues he is indirectly referring to. Any attempt to refer legislation back to a committee for the purpose of offering amendments is really a veto tactic. It is an indirect way of accomplishing the same objective by objecting. As the Senator well knows, the amendments he is thinking of will not pass the Finance Committee, will not pass the floor, and will have the effect of preventing the Medicare provider bill from being enacted.

So in good faith, in order to help millions of Americans, particularly the millions of seniors who need help right away, I could not agree to that modification. If there are other amendments on other issues such as prescription drug benefits, which I know the Senator is indirectly referring to, let us try at a later date to get that passed. We have tried for months, almost a year, to get prescription drug benefits passed, but there has been no breakthrough, there has been no agreement.

But there has been agreement on this Medicare provider bill, basic agreement within the committee and basic agreement between myself, the chairman of the committee, and Senator GRASSLEY, the ranking member of the committee. Let's not let perfection be the enemy of the good.

Seniors need help. They need help right now. The cuts have already started to take effect. So let's pass this legislation, and then we can deal at a later date with the issues to which the Senator is referring. Let us get this bill passed so the seniors can get some help.

The PRESIDING OFFICER. Is there objection?

Mr. NICKLES. Mr. President, I object.

The PRESIDING OFFICER. The objection is heard.

The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I will repeat to my friend and colleague, the chairman of the Finance Committee, I will work with him to try to come up with a package that can pass this Congress this year. I want it to pass, and I want it to be signed into law. To come up with a package that the administration is opposed to means it will not become law.

Some of us want to alleviate some of the problems. This particular bill the Senator has asked to pass by unanimous consent, which means no Senator gets to offer any amendment, flies in the face of Senate tradition.

Senate tradition has always been—I did a little homework on Medicare. Twenty-two of twenty-three significant Medicare changes passed the Finance Committee in a bipartisan fashion and passed the Senate usually with overwhelming numbers—not all the time but usually with overwhelming numbers. So I was sincere in saying let us refer it back to committee, let us have some amendments, let us have some votes, and maybe we can come up with a bipartisan package that then will have momentum to pass on the floor.

I might remind my friend and colleague from Montana, my suggestion was that is the way we should do the prescription drug bill. We did not do that on prescription drugs, and we ended up with no bill. Seniors got zero, and I am afraid if we continue going down this path on the so-called Medicare adjustment give-back bill, they will end up getting zero. I would like for us to provide some assistance by passing something that could become law.

When I objected to this previously—I believe it was a week ago Friday, October 4—there was not a Congressional Budget Office scoring. The bill was just introduced, and I said: How much is it going to cost? To my colleague's credit, he said about forty-some-odd billion dollars, and it was forty-some-odd billions dollars. I said: How much will it cost the first 2 years? Because sometimes these 10-year estimates do not mean a lot but the first year or two does.

He said that over the first 2 years it would be $10 billion. We did get CBO's estimate, and the first year's cost, 2003, was $10.1 billion. The second year's cost, 2004, was $11.8 billion. So the total cost is almost $22 billion the first 2 years, so it is twice as much as it was estimated in the original 2 years. That is real money. Can we do this right?

We have a letter from AARP, and I ask unanimous consent that this letter be printed in the RECORD.

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

AARP,
Washington, DC, October 9, 2002.

Hon. CHARLES GRASSLEY,
U.S. Senate,
Washington, DC.

DEAR SENATOR GRASSLEY: The legislative session is drawing to a close with no Medicare drug coverage in sight. Once again, after years of waiting and with drug costs soaring, beneficiaries and their families find that they get no help from Congress. What they face instead is yet another round of provider ''givebacks'' that will raise their Part B premiums.

The provider pay hikes enacted in the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) are already costing beneficiaries $14 billion over ten years in higher Part B premiums. The over $40 billion givebacks package being considered by the Senate will raise Part B premiums even higher—$6 billion in the first five years alone. Less than 10 percent of that package would directly benefit Medicare beneficiaries—the people the program is supposed to be serving.

These added costs to beneficiaries come in addition to double-digit hikes in prescription drug costs for older and disabled Americans, many of whom have little or no options for drug coverage. Employers continue to reduce or eliminate health care coverage. Medigap premiums continue to rise. And now, nine more Medicare+Choice plans are pulling out of Medicare.

AARP opposes giveback provisions without drug coverage in Medicare, and our 35 million members will not understand how the Senate can take this course of action. Our members want providers who treat Medicare patients to be paid fairly. Errors or miscalculations in Medicare payment formulas should be corrected. Fiscal relief to states to avoid drastic Medicaid cuts should be addressed. Those can be done for much less than $40 billion. And it must be done at a far smaller cost to the millions of Medicare beneficiaries still waiting for the Senate to fulfill its long overdue promise of affordable prescription drug coverage.

Sincerely,

WILLIAM D. NOVELLI.

Mr. NICKLES. AARP, which I do not always agree with, basically says—I will read this one sentence:

AARP opposes give-back provisions without drug coverage in Medicare, and our 35 million members will not understand how the Senate can take this course of action.

They have stated they are opposed to doing a give-back bill on a stand-alone basis.

The House passed a Medicare adjustment bill, or give-back bill, in addition to passing prescription drugs. I know the Senator from Maine has indicated an interest in trying to do that. Asking unanimous consent to pass it without amendment would deny the Senator from Maine the opportunity to offer an amendment either in committee or on the floor. It would deny the Senator from Alabama the chance to do more for a rural provider wage adjustment, which I know Senator SESSIONS has repeatedly said he wanted to address. He should at least have that opportunity, either in committee and/or on the floor. To do something strictly by unanimous consent denies them that opportunity.

I make those points, but I am still willing to work with our colleagues to see if we can do an affordable bill, one

that can pass both the House and the Senate and be signed by the President this year. Maybe that is this week, maybe it is next week, maybe it is the week after election, but I am willing to do that this year. I am willing to try to get all parties together so we can actually not make campaign statements but we can change the law and have that law changed by a signature of the President. I think that is doable, but we are going to have to get all parties together, and to my knowledge that has not happened at this point.

I yield the floor.

Mr. HATCH. Mr. President, today I rise to join my colleagues on the Senate Finance Committee in cosponsoring S. 3018, the Beneficiary Access to Care and Medicare Equity Act of 2002. Although this bill does not include all that I would have wanted, and indeed includes some provisions with which I disagree, on balance, I believe it is necessary to pass such a bill this year in order to provide needed assistance to both Medicare providers and beneficiaries.

I would like to take this opportunity to express my strong support for provisions contained in S. 3018 which increase reimbursement rates for physicians, skilled nursing facilities and home health agencies. Physicians' Medicare reimbursements were reduced by approximately 5 percent in 2002. Unfortunately, the estimates used by the Centers for Medicare and Medicaid Services, CMS, when calculating the physician payment formula were erroneous in some cases, and, regrettably, physicians will continue to be subjected to large cuts in future years if Congress does not take appropriate action. This is simply not fair to physicians or their patients.

Doctors in Utah have been calling me about this issue since late last year and have explained to me over and over again that these reductions will have a lasting, negative impact on patient care. Some Utah physicians have told me that they will no longer accept Medicare patients or, even worse, are thinking about dropping out of the Medicare program all together. And what impact does that have on patients, especially those in rural areas? In my opinion, there is no question it could lead to reductions in the number of Medicare providers in rural areas. And, for those who are left, it will be virtually impossible to spend quality time with patients.

Is this our goal? I do not think so. And I will be doing everything possible to increase reimbursement rates to physicians to help them continue to provide the high quality care that patients so deserve.

Another important component of S. 3018 is the valuable assistance this bill provides to rural states, such as my home state of Utah. S. 3018 incorporates many of the recommendations included in the Medicare Payment Advisory Commission's, MedPAC, 2001 report on rural health care. This report found that beneficiaries living in rural areas encounter more obstacles when receiving health care than those who live in urban areas, primarily due to cost barriers. In addition, the MedPAC report stated that rural hospitals have had lower Medicare inpatient margins than urban hospitals throughout the 1990s. This gap has widened from less than a percentage point in 1992 to 10 percentage points in 1999. These statistics not only apply to inpatient care, but also to most Medicare services in rural regions of our country. In the end, the report states the obvious, current Medicare payment policy places rural communities at a distinct disadvantage and changes are necessary. S. 3018 takes steps toward addressing these important concerns and attempts to provide equity between rural and urban Medicare providers and patients. In my book, this is sorely needed.

In addition, it is important to me that Medicare funding for Skilled Nursing Facilities, SNFs, is included in S. 3018. I have heard from facilities across my State about the dire financial situation many SNFs are facing due to reduced Medicare spending in fiscal year 2003. SNFs care for our nation's most vulnerable seniors and provide valuable medical assistance to these Medicare beneficiaries and their families. I have been working with both Finance Committee Chairman Senator MAX BAUCUS and Ranking Republican CHUCK GRASSLEY on this important matter. While I am pleased that the Senate Medicare provider give-back bill provides more money to SNFs than the House-passed bill, I believe that the funding level for SNFs should be even higher. I intend to continue to work with my House and Senate colleagues on improving the Medicare reimbursement rates for SNFs.

I also am pleased that S. 3018 includes provisions that will eliminate the 15 percent reduction in home health payments. There is no question in my mind that home health services are among the most valuable Medicare provides. Home health agencies are providing compassionate, caring services which, quite simply, help keep beneficiaries out of more costly institutional settings. Home health agencies across my State have urged me to support the elimination of this cut. They have shown me how these potential cuts could cause many home health providers in Utah to go out of business. Over my Senate career, I have been extremely supportive of home health services, and will continue my advocacy for this important program.

The preceding things having been said, one great concern that I have with S. 3018 is the impact that this legislation could have on small durable equipment manufacturers in Utah. The bill contains provisions on competitive bidding which my constituents believe could drive them out of business. On the one hand, I do recognize the need to ensure efficiency in spending for scarce Medicare dollars. On the other hand, though, I am deeply concerned about the effect this legislation could have on these companies. I am working with CMS officials and my Utah manufacturers to resolve concerns that have been raised about the competitive bidding program included in this bill and will do everything possible to protect small durable medical equipment companies in Utah and across the country.

Let me also mention the Medicaid program. There is no secret that the majority of States are running deficits in this program, expected to reach $58 billion during this fiscal year. Adding to the urgency is the fact that States have also used up two-thirds of their cash and their ''rainy day'' funds. According to a recent survey by the National Conference of State Legislatures, more than 40 States had instituted some kind of spending freeze or an across-the-board cut and 22 states have cut Medicaid funds.

Included in the Baucus-Grassley legislation is a provision that would direct some funds back to the States for their Medicaid programs. This legislation increases the Federal medical assistance percentage by 1.3 pecent for 12 months. Additionally, it directs $1 billion in state fiscal relief grants for Fiscal Year 2003.

In a perfect world, this is not the approach I would have preferred we take to address the issue of fiscal relief for States. I have doubts about the advisability of using an entitlement program to address a shortfall in State funds. The precedence for linking an entitlement program to the economy is unsound policy, in my opinion. If we had adopted that policy years ago and were consistent in following it in good times as well as bad, FMAP rates would have been lowered in the 1990s when States were experiencing surpluses, resulting in the current FMAP rates being much lower than they are now. I am also very concerned that this ''temporary fix'' will end up becoming permanent. Both the Federal Government and the States do not have the best record when it comes to cutting off a funding source we may have come to rely upon. However, I do recognize that States are being forced to cut back essential services to low and middle income individuals and families as a result of States' considerable budget deficits.

Additionally, this legislation includes a much-needed fix for the Children's Health Insurance Program, CHIP. Without this provision, some $2.8 billion of unspent CHIP funds are scheduled to revert back to the Treasury. It is critical that States are able to access these funds. Some States experienced significant challenges when implementing their CHIP programs. However, they are meeting that challenge and have ''ramped up'' considerably. They now are in a position to draw down these dollars. Given these uncertain economic times, we should not deprive states of funding to help finance the social safety net.

I also believe the provision prohibiting States from using their CHIP monies to cover childless adults is wise policy. While I am extremely sympathetic to the needs of the uninsured, it is important to note that Senator KENNEDY and I worked very hard to pass the CHIP program as a way of helping the 10 million uninsured children in the country. As the title reflects, the bill was solely directed at ''Children.'' Indeed, it was not the health insurance program, HIP, nor the Adult Health Insurance Program, AHIP, but the Children's Health Insurance Program, CHIP.

If we would like to help needy, uninsured adults, by all means, let's look at how we can accomplish that. In fact, Senator WYDEN and I have recently introduced a bill to jump-start that discussion. However, in the meantime, we should not distort the focus of a program that is working well to help its intended participants and lose the sense of mission that has made it so effective.

Finally, I have serious concerns about the provisions in S. 3018 on the Section 1115 waiver process for Medicaid and CHIP waivers. I will be submitting a separate statement for the record which will outline my thoughts on this issue in more detail.

In conclusion, I believe that passage of S. 3018, the Beneficiary Access to Care and Medicare Equity Act, is critical for both Medicare providers and beneficiaries. This legislation, while not perfect, will provide access to quality and affordable health care to Medicare beneficiaries across the country. I urge my colleagues to support this bill and, in my opinion, we must pass this legislation before we adjourn. Partisan politics needs to be put aside because this issue is much too important to both Medicare beneficiaries and providers. Medicare providers, and most importantly, the beneficiaries they serve, are depending on us to get this job done, once and for all. Let's not let them down.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, the two most powerful words in the Senate are ''I object.'' The Senator from Oklahoma has demonstrated the power of that by just objecting to the request by the Senator from Montana to bring up the Medicare provider reimbursement legislation.

Some seem to believe there is no urgency about this issue. The Senator from Montana has described bipartisan legislation that I support very strongly and that I think it is urgent we pass. This is bipartisan legislation addressing an urgent, serious, and difficult problem. Let me describe it from the standpoints of two different types of health care providers.

First of all, with respect to nursing homes, on October 1, long-term care facilities experienced a cliff, or a sharp drop, in their Medicare reimbursement. As of October 1, skilled nursing homes face a 10-percent, or $1.7 billion, reduction in their payment rates for the current fiscal year, and a 19-percent cut in 2004 unless Congress acts to respond to it.

We can talk about numbers, this can all be about finances, but my colleagues know what it really is about. It is about the quality of care for people in our nursing homes. If the decision is made not to reverse these cuts for long-term care, the quality of care is going to be diminished for those folks who are in nursing homes.

I suppose one of the saddest days of my life was when I took my father to a nursing home some months after my mother had been killed. I will never forget the moment we decided he had to go to a nursing home and then when I took him there. He did not want to go. The time he spent in that nursing home meant I spent a lot of time there as well, and I came to understand what long-term care was all about and what the quality of care for our senior citizens was about. I have deep admiration for the people who ran that nursing home. I do not know what my father would have done without the care he received in that facility.

In my State, we rank right near the top in this country with respect to the number of nursing home beds per resident in the State are concerned. Yet, on October 1, at a time when nursing homes are already struggling and do not have the money they need, we find this cliff exists where they get a reduction in reimbursement—and a pretty substantial one at that.

Now we are nearing the last few days of this session and my colleague Mr. BAUCUS brings to the floor legislation that I think makes great sense. It is bipartisan. The chairman and the ranking member of the Finance Committee are sponsors of this legislation. They say we need to get this done, it is urgent, but we have people who stand up and say, I object.

There are a thousand reasons to object, but there is only one good reason to do what we need to do here to protect the quality of care for vulnerable seniors in nursing homes, and that is because it is our responsibility.

I have talked about nursing homes and how important they are. The same is true with hospitals. For hospitals in my State, and I suspect the States of Montana, Iowa, and many other States, the level of Medicare reimbursement is going to determine whether we have hospitals that are available to people who need acute care, who need emergency care, in the future.

Now, we have the opportunity to do something to provide decent payment to these hospitals.

Under the 1997 Balanced Budget Act, everyone in this Chamber understands we cut too deeply. We understand that. The fact is, we have hospitals and nursing homes on the brink of going out of business or cutting back services. Rural hospitals, just about all of the hospitals in my State, are disadvantaged by lower reimbursement rates. In my State, and many others, rural and small urban hospitals receive a standard payment that is woefully inadequate. We have to fix that. When you take a look at the standardized payment for hospital payments, you realize the standardized payment is not standard at all. This legislation fixes that concern.

I know it is the eleventh hour. The fact is that Senator BAUCUS and Senator GRASSLEY have offered a piece of legislation that everyone in this Chamber knows must be done. Yet we have people walking around as if to say this is not an urgent problem. Check yourself into a nursing home and tell me it is not an urgent problem. Check into a rural hospital and check the financial records as you walk through the front door and tell me it is not an urgent problem.

We spend a lot of time in the Senate during the year on things not so serious. But there is a serious problem with Medicare reimbursement. We often treat the light too seriously and the serious too lightly. This is serious. We have a responsibility now to deal with this issue.

I hope the Senator from Montana will come to the floor every single day we are in session and make the same unanimous consent request until at some point we will not see people standing up to object. I hope he will come tomorrow and I hope next week. At some point we will see this Senate and the other body on the other side of this Capitol say: Yes, let's do this. We have a responsibility to get this done for nursing homes, for hospitals, and for other providers.

I did not mention physician reimbursement. I will mention that when I talk tomorrow about this subject.

I appreciate the leadership of the Senator from Montana and the leadership of Senator GRASSLEY. This legislation is the right thing for right now. Not next year, not the year after, but right now. It will have an impact on the quality of care for the American people in hospitals and nursing homes across this country.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maine.

Mrs. SNOWE. Mr. President, I am deeply disheartened by what I am hearing today, the refusal to refer the Medicare provider give-back legislation to the Finance Committee for the deliberation and the consideration it deserves. Time and again this Senate has circumvented the traditional and conventional procedures to undermine the possibility of enacting a prescription drug benefit for our Nation's seniors.

It is clear to me if my colleague from the other side of the aisle wish to achieve and accomplish a victory for our Nation's seniors, they will work with me and others—the Senator from Oklahoma, those of us who worked on this legislation in the committee—who crafted a tripartisan package to provide comprehensive prescription drug

coverage for our Nation's seniors. The Senator from Vermont, Senator JEFFORDS, Senator BREAUX from Louisiana, Senator GRASSLEY from Iowa, the ranking member of the committee, worked together. We could make it possible.

I am deeply disappointed by what I am hearing today. Again, it gets back to the all-or-nothing proposition. Some have said, we have already had votes on this issue. What does that have to do with our Nation's seniors who are denied the possibility of having a prescription drug benefit included in their Medicare package? That is who we should be talking about today. It is not an all-or-nothing proposition. We can do both. It is possible to do the Medicare provider give-back package the Senator from Montana is referring to.

It is also possible to do a prescription drug benefit for our Nation's seniors and include it in one package. There is no reason we have to be in any other situation than including and considering these issues in tandem. That is the desire of the Senator from Oklahoma, Senator NICKLES. That is my desire. That is the desire of our Nation's seniors. In fact, it is the desire of the largest organization that represent our Nation's seniors, AARP.

I know the letter has already been printed in the RECORD, but I will read it. It is important to read.

> The legislative session is drawing to a close with no Medicare drug coverage in sight. Once again, after years of waiting and with drug costs soaring, beneficiaries and their families find that they get no help from Congress. What they face instead is yet another round of provider ''givebacks'' that will raise their Part B premiums.
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> The provider pay hikes enacted in the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) are already costing beneficiaries $14 billion over ten years in higher Part B premiums. The over $40 billion givebacks package being considered by the Senate will raise Part B premiums even higher—$6 billion in the first five years alone. Less than 10 percent of that package would directly benefit Medicare beneficiaries—the people the program is supposed to be serving.
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> These added costs to beneficiaries come in addition to double-digit hikes in prescription drug costs for older and disabled Americans, many of whom have little or no options for drug coverage. Employers continue to reduce or eliminate health care coverage. Medigap premiums continue to rise. And now, nine more Medicare+Choice plans are pulling out of Medicare.
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> AARP opposes giveback provisions without drug coverage in Medicare, and our 35 million members will not understand how the Senate can take this course of action. Our members want providers who treat Medicare patients to be paid fairly. Errors of miscalculations in Medicare payment formulas should be corrected. Fiscal relief to states to avoid drastic Medicaid cuts should be addressed. Those can be done for much less than $40 billion.

The fact is AARP, our Nation's largest organization that represents the seniors' interest, is opposed to passing a give-back program without including a prescription drug benefit for our Nation's seniors.

Mr. President, we have the opportunity. Yes, we have the time. Over the last month, there have been a number of hearings and markups that have been scheduled in the Finance Committee. They have then been canceled on a variety of pieces of legislation, including the Medicare give-back. I and others in the committee, and Senator BREAUX, were planning to offer an amendment to the Medicare provider give-back more than a month ago again when that legislation was scheduled for markup in the Finance Committee which is appropriate because that is the committee of jurisdiction. We intended to offer an amendment to that legislation. Then the markup was canceled. There were a variety of other markups that were scheduled in the Finance Committee over this last month on various issues.

Again, we were saying if we can have time to consider these other important pieces of legislation, clearly we should have the opportunity and we have the time to consider a prescription drug package.

Now, you might say, we had votes in July on this issue in the Senate. That is true. Did the Finance Committee have a markup on the prescription drug bill? The answer is an unequivocal no. I can't state why. The Finance Committee, the committee of jurisdiction, did not have a markup on a bill I think virtually everybody in this Chamber would agree is one of our Nation's top domestic priorities. Everyone would agree with that. So you might ask, why didn't the committee have a markup, going through the conventional procedures, so that both sides have the chance to deliberate, to amend, debate, and vote upon a package? It is a very good question, a question to which I do not have an answer. Yet I have never had an answer. This is close to a $400 billion package that would provide prescription drug coverage to our Nation's seniors. Yet we did not have a markup. That clearly undermined our ability to achieve a consensus on this legislation.

You could take the tax-cut legislation in the year 2001. No one knew what the end result of that bill would be when it came before the Finance Committee. We had the ability over several days to amend it, debate it, and vote upon the various issues the Members had presented to the committee. Ultimately we voted on a package. It came to the floor. We had more amendments. We had more than 50 amendments to the tax cut bill because we had the right and the prerogative to express our positions and our views of the States that we represent. During the natural course of the legislative procedure, we had the ability to express ourselves on that very important piece of legislation and then ultimately vote for its enactment.

The same was not true when it came to this significant issue that affects most of our Nation's seniors. So it became an either/or approach. What I am saying today is let's take the Medicare provider give-back legislation and let's have the opportunity to also consider an amendment—amendments to that legislation that would include a prescription drug package. I will make a unanimous consent request shortly on that issue.

But I think we have the time, we have the ability to do both in this Chamber right now. The question is, Do we have the political will? Some people, as I said earlier, say we have voted on this issue. It is not about us. It is not about us. The last time I checked, Members of the Senate had health care coverage that included prescription drug coverage. It is about our Nation's seniors, and it is making this institution work on behalf of the people we represent. Each of us have an individual and collective responsibility to make that happen.

It is a true failure on our part that we did not make this possible. We worked a year and a half ago—the Senator from Vermont is here, Mr. JEFFORDS, and Senator BREAUX from Louisiana, Senator GRASSLEY and I worked—more than a year and a half ago to begin the process of shaping a comprehensive package so we could include this significant benefit in the Medicare Program to avoid political collisions, to avoid the scenario that has now manifested itself in this institution on this particular issue.

But what we got instead was denial and obstruction and circumvention of the conventional processes of this Senate—No. 1, because we did not have a markup in the Finance Committee; and, No. 2, it was an up-or-down vote in the Senate floor on two packages, no amendments. So we did not have the ability to work through our differences, work through the concerns that each of us might have in terms of how do we shape this most significant benefit that nobody denies the seniors deserve and desperately need. No one is denying that. So what is impossible about doing it right here and now?

If we have had time over the last few months to schedule markups in the committee on various initiatives, including the Medicare provider giveback, then why don't we have the time to also include, in conjunction with those bills, a prescription drug coverage?

How can we fulfill our commitment to our Nation's seniors if we fail to do that in this session of this Congress? And to provide a provider give-back bill that I certainly support, but also one that raises Part B premiums? It raises Part B premiums. And that is not my estimate. That is the estimate of the Congressional Budget Office.

What we are saying is, recognizing the impact that will have on our Nation's seniors and the costs to them directly, when you raise Part B premiums, you are obviously going to have to pay more of their out-of-pocket costs for their Medicare coverage. So why then are we not also considering a

prescription drug benefit to ease the impact of the cost to our Nation's seniors, if they can even pay? Even if they can afford to pay out-of-pocket costs for their drugs. But most, as we know, are forced to choose between food and paying for their prescription drugs prescribed by their doctors.

I believe we have a greater obligation. We have a greater obligation to build upon the support of both goals here today. I hope we will be able to do that. That is why I think it is so clear that we do not have to end this session this way. If we had the ability to consider a $43 billion package that provides reimbursements to our rural hospitals and home health care, to medical providers—and they, too, will acknowledge how imperative this benefit is to our Nation's seniors—they certainly would welcome the Senate's action on both pieces of legislation in tandem.

The House of Representatives passed, months ago, both a prescription drug bill and a Medicare provider give-back. While some may have differences in this Chamber with what direction and what provisions they included in that package, they ultimately passed a package that included both initiatives. I happen to believe that we have a greater obligation to do the same.

I don't think we can use the rationale that we are here at this point in time and that we do not have the time anymore. Let's send this back to committee. I regret the Senator from Montana objected to the request made by the Senator from Oklahoma to refer this back to the committee. We have the next couple of days. We are going to be here. We may be here next week. We have the ability to mark up this legislation, both the provider give-back and the prescription drug bill—we have the time—and then report it back to the floor so each of us have the opportunity again to debate and amend, if at all possible, on various issues, and have a final vote.

I think we should try to work together to advance a viable, comprehensive prescription drug plan that warrants strong bipartisan support. We developed a tripartisan package beginning more than a year and a half ago. We announced our principles a year ago July, setting out the framework so we would avoid the political collisions and the polarization and partisanship that seem to be the monkey wrenches grinding this legislative process to a halt.

But again, I guess it was not sufficient to overcome those impediments. Those negotiations we did have during the course of the summer, even in the aftermath of the votes that were taken, the up-or-down votes on the two packages—one by Senator GRAHAM, one that was offered by those of us who represented the tripartisan plan—we even had negotiations this fall. We all felt a breakthrough compromise was near.

The foundation of that compromise was going to be, in fact, the tripartisan package. In fact, we had one of the meetings that was chaired by the Senator from Montana that included more than 14 Senators, almost equally divided across the political aisle. We were really focusing on the several issues that really did represent the areas of disagreement. Somehow the meetings were canceled.

No explanation was given. This is all the more unfortunate and disappointing because I think we did have a sense of agreement.

The bottom line is we have never been closer than we were in September of providing this package—a universal, comprehensive Medicaid benefit for our Nation's seniors. The basis of a consensus package exists today.

I hope we can agree today to do both. I am committed to doing that.

I know there are others here who are committed in this Senate to do what is right for our Nation's seniors. We can argue about not having the time. Tell that to our Nation's seniors—that we just didn't have time. We have time for other issues, but we don't have time for our Nation's seniors when it comes to this vital benefit that can make the difference between life and death.

We have all heard the traumatic stories and circumstances that many of our Nation's seniors have been placed in because they do not have the kind of coverage that is extended to each of us here in this institution.

I happened to come across a poll not too long ago. It says when asked, Should senior Americans have the right to choose between different health care plans with different benefits just like Members of Congress and Federal employees? Of course 90 percent said, yes, they want to have that choice. They want to be able to choose in their Medicare benefit package prescription drug coverage. They would have a choice under the tripartisan package. They could choose the traditional Medicare Program, the new enhanced fee-for-service program, or the Medicare+Choice. But whichever program they would choose, they would have the option of a prescription drug benefit. That is the way it should be.

We all know the Medicare Program was developed almost 40 years ago. It needs to be reformed and overhauled in a way that modernizes and reflects the kind of health care that seniors are getting today. But some say the traditional program works, and they should have that option and benefit. If they want a new, enhanced fee-for-service that also includes prescription drug coverage, they should have that benefit. But the fact is they should have a choice.

We are told, ''the next Congress.'' I have been hearing that every Congress. As far as I can check, we have been talking about this for almost the last 4 years or more—the next Congress; the next year. It is here and now that we have an obligation. We have an obligation to do it now.

AARP is right in saying that you can't do one without the other—especially because it has the impact on increasing our Nation's seniors' Part B premiums. That, of course, has been underscored by the Congressional Budget Office as well—that it will raise the cost of Part B premiums as a result of this give-back bill. If we are going to do the give-back—and I wholeheartedly support that—then we also have a responsibility to provide this most critical coverage to our Nation's seniors.

It would be a terrible oversight if we fail to do what is right. This action is warranted. Seniors cannot put off their illnesses, and we must not put off a solution.

I come to the floor to offer a proposal that we consider not only Senator BAUCUS' legislation and provide for his legislation but also the tripartisan prescription drug package. I made a commitment to our Nation's seniors that I would protect their interests and do everything possible to pass the Medicare prescription drug benefit this year.

Now is the time to be giving that consideration. To say that we don't have time is really failing our Nation's seniors. We do have time. We have time because we are considering the Medicare-provided give-back. We have time because a number of markups were scheduled before the Senate Finance Committee, and they were canceled. But there was obviously time that was included on the schedule for the members of the committees to consider other pieces of legislation for markup in committee. I don't object to that. But what I object to is denying our Nation's seniors the ability to have a prescription drug benefit because we are denied the ability to give voice to that benefit and to express our will through the traditional procedures of the committee and here on the floor of the Senate.

I regret that the majority leader will not allow a vote and a vote on an amendment and consideration on both issues in tandem. We could do it in the committee and bring it to the floor. That is certainly what I would prefer. But if not, we ought to be able to consider both of these initiatives before the full Senate. We should let the process work the way it is designed because our Nation's seniors deserve at least that.

UNANIMOUS CONSENT REQUEST

I ask unanimous consent that the Senate immediately turn to the consideration of S. 2; that following the reporting by the clerk, a substitute amendment at the desk which contains the text of S. 3018, the Beneficiary Access to Care and Medicare Equity Act of 2002, and S. 2, the 21st Century Medicare Act, be considered and agreed to, the motion to reconsider be laid upon the table, and the bill then be open to further amendment and debate.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Mr. President, reserving the right to object, I say to my friend from Maine, the distinguished senior Senator, that maybe she protesteth too much.

The fact is the prescription drug package that she talks about did not get a majority vote in the Senate. The one that received a majority vote of 51 Senators was the Gramm-Miller amendment prescription drug plan. That received a majority vote of the Senate.

I think her idea is a good idea—that we go ahead and adopt what the Senator from Montana, the chairman of the Finance Committee, has come to the floor twice today and talked about doing the Medicare give-back—have that and have the prescription drug bill have a majority vote. GRAHAM of Florida and MILLER—51 votes.

That would let the will of the Senate work where the majority of the Senate determines what happens. The problem was we didn't get 60 votes. We had 51 votes.

I also say my friend from Maine talks about protecting the interests of seniors. I know she wishes to protect the interests of seniors. I think the best way to do that is with the best prescription drug package that has surfaced in the Senate—the one that received the majority vote of the Senate. Let us pass that. That would protect the interests of seniors.

I would also say this: I say it with a smile on my face. To have the minority talk about us having enough time to do things is about as close to being ridiculous as anything I have heard. I have sat on this floor—not for minutes but hours, days—I have sat here for weeks while the minority has prevented us from doing anything. We can't pass our appropriations bills because they won't let us. We can't pass homeland defense because they won't let us. We can't pass the conference report on terrorism insurance because they won't let us. We can't pass the prescription drug bill because they won't let us. We can't pass the generic drug bill because they won't let us. I could go on and on.

So don't tell me that we do not have enough time to do things. We are not having enough time to do things because the minority won't let us.

So I object, unless my amendment is accepted.

I move to amend the unanimous consent request to accept the language——

The PRESIDING OFFICER. Objection is heard.

The Senator from Maine has the floor.

Ms. SNOWE. Thank you, Mr. President.

In response to what the majority whip mentioned, the fact is that we had the opportunity and the time. The motion that I offered with respect to the Medicare-provided give-back legislation and the prescription drug benefit is including further amendments and debate.

That is all we are asking, to have the opportunity to debate and amend a package on the floor of the Senate that gives our Nation's seniors the option of having a prescription drug benefit in the Medicare program. It is not a question of whether I protest too much. I can assure you, our Nation's seniors will protest when they learn about the failure of this institution to pass any prescription drug benefit.

We were close to working out our differences on the few issues that really did separate us on the two packages that were before the Senate back in July. It really came down to several different issues. We had ongoing negotiations, even including additional Members who had been working on this issue before, because we were reaching out. We were close to reaching an agreement, whether it was on the cost or the fallback, to ensure every senior had the option and the access to a prescription drug benefit that was designed in that program, regardless of where they lived in America, so no one would be denied.

We were close to reaching that consensus. But for some unexplainable reason, further negotiations were suspended. That was regrettable because we could have been at a point where we could have enacted a prescription drug benefit in the Medicare program.

When I asked for this unanimous consent, it was to also include the opportunity for the Senate to amend and debate this legislation. We do have the time. If we have the time to bring up Medicare provider give-back legislation of more than $43 billion, then clearly we also have the time to consider a prescription drug bill. Then, I would argue, we are even further along in this institution in examining all of the components and provisions and the issues surrounding the development of a comprehensive universal package. We are much further ahead because we did have debate on the two proposals on the floor, but we didn't have the opportunity to amend our various packages. It was up or down, all or nothing, either/or, take it or leave it, get the 60 votes or not—not expressing our will through the conventional procedures of this institution.

I cite again the example of the tax-cut measure we ultimately adopted in the Senate back in May of 2001. It required several days. In that case, there were 50 amendments. But we expressed ourselves. We had the opportunity to offer amendments and then ultimately vote on a final package, yes or no. That is not the same opportunity that has been given to this issue.

Our Nation's seniors deserve to know that. They also deserve to consider both of these initiatives in tandem. I have yet to hear a reasonable argument as to why we can't do that, why we cannot include both of these initiatives in one package, similar to what the House of Representatives did months ago. We should be able to do the same thing in the Senate, send the package to the conference, and work out the issues.

Believe me, there is great urgency to obviously resolve both of these initiatives to reach a final conclusion. I think there is genuine interest on both sides of the political aisle here in this institution and on the other side to work these issues out in the final and remaining days of this Congress. But to say it can't be done, tell that to our Nation's seniors.

Voting on an issue means nothing unless you produce results. Results means taking final action on a piece of legislation that is sent to the President of the United States. The President is eager to have legislation that can be signed into law to give this much-needed benefit to our senior citizens.

We can do it. I hope the Senate will recognize it is a very reasonable unanimous consent request. I hope they will reconsider their objection to this request.

Mr. REID. Would the Senator repeat herself? I was speaking to one of my staff.

Ms. SNOWE. I hope the Senator would reconsider his objection to my unanimous consent request because this motion really is asking to include both issues in one package in tandem and to be able to further amend and debate. I think it is a reasonable request, and it is one that should not be denied.

Mr. REID. Will the Senator allow me to respond?

Ms. SNOWE. I am glad to have the Senator respond.

Mr. REID. The Senator has asked if I would respond or reconsider. I have the greatest respect for the Senator from Maine. We have worked together on many issues. She is a fine legislator, but she is simply wrong.

It seems somewhat unusual to me that in the waning hours of this congressional session, suddenly we want to have a debate on Medicare give-backs and prescription drugs. We have fought the minority all year long on many issues. On the list, of course, is prescription drugs. That is the second one we have here. We were forced to pass something that is good, but certainly not what we wanted with the generic drug bill. It is buried in the dark hole of the Republican-led House of Representatives because they will not go to conference.

We have the Medicare give-backs, which is so important for the people of the State of Nevada and Maine and Vermont, West Virginia and Montana, any State in the Union, a very important piece of legislation. That is ready to move. We could pass that in a matter of minutes.

The prescription drug bill I referenced, the Graham-Miller legislation, had extended debate on the floor. We have heard enough about that. People understand the issue. It got a majority vote. We don't need another amendable item on which we have, frankly, your side stall, stall, stall, as you have done all year long.

I have reconsidered. The only thing I would suggest we do is adopt the proposal of the Senator from Montana, the proposal of the Chairman of the Finance Committee, on Medicare give-backs and stick in that, if we have so

many on the other side who suddenly found religion and want to do something to help seniors with prescription drugs; that we pass, as a majority of the Senate has already said we should do, the Graham-Miller prescription drug bill.

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

Ms. SNOWE. Mr. President, in response to the points made by the Senator from Nevada, obviously the minority do not design the floor schedule. That is the prerogative of the majority. The minority did not preclude the Finance Committee from marking up this legislation. We did not choose to postpone the consideration of a prescription drug package in the Finance Committee. The Senator from Nevada would acknowledge a markup in the Finance Committee was important and essential to achieving the consensus that is so critical in passing any significant piece of legislation.

In this instance, we are discussing a package that represents more than $400 billion over the next 10 years.

Mr. President, I think everybody would agree the Finance Committee should have had the opportunity to consider that initiative. I cannot think of the last time that creating a new benefit, a new package, or a new program that represents close to $400 billion over the next 10 years, has not had the benefit of a markup in the committee—at least, if you are thinking about enhancing the ability to create the consensus for the final passage of that legislation. So the process was circumvented, for whatever reason, I do not know.

But what I do know is what is possible today. I do know if we had the political will, we could resolve the few differences between the positions that were offered on the floor back in July that, regrettably, we didn't have the opportunity to amend or further amend. It was, again, as I said, up or down, either/or, all or nothing. Well, you cannot achieve cooperation and consensus on a major package of this kind without working through the various issues.

So all I am asking is we have the opportunity to consider a prescription drug benefit in tandem with the Medicare provider give-back. If we have time to provide $43 billion in additional assistance to Medicare providers—and I would wholeheartedly support that, but I also would support providing prescription drug coverage to our Nation's seniors. How can we do one without the other? I have not heard an explanation I think would be acceptable to the senior citizens of this country.

We didn't have time? Well, where have we been over the last 2 years? We didn't have time, Mr. President? I don't think that is acceptable. How does anybody go home and say to their constituents we didn't have time—especially because that has been the rationale given for the last 4 years: we will put it on to the next Congress.

We are elected to do what is important here and now. That is our obligation. If we have to stay here day and night, through the weekend, what greater obligation do we have than to do what is important to the people we represent? This is an issue that has been acknowledged by both sides to be one of our top domestic priorities, and we are saying we don't have time. We don't have time in the committee. We didn't have time in the committee last July. We didn't have time in the committee last spring. We have not had time. When do we have time around here, Mr. President? When do we have time to do what is right in this institution? When do we have time? How do we do it?

We had a tripartisan group from the Senate Finance Committee begin to work on this issue a year ago—I would say in June, and we announced our principles a year ago July—to avoid this type of political showdown, to avoid the all-or-nothing confrontation that seems to pervade this institution. Guess what. We are denied the ability to mark up this bill in the Senate Finance Committee.

Well, I might be protesting too much, but, frankly, I think our Nation's seniors deserve better. I know they are protesting. Tell them we don't have time. Explain to them why we didn't have a markup in the committee that would have increased the likelihood of the passage of this legislation.

Now we are hearing we should have this Medicare provider give-back. I endorse that, but I don't believe these are mutually exclusive issues. I want to make that clear. These are not mutually exclusive items. Obviously, AARP agrees because of the letter they sent to the legislative leadership, the committee leadership, and the ranking member of the Finance Committee, that you should not do one without the other. I am speaking on behalf of the seniors I represent in my State of Maine. They deserve better.

I hope the Senator from Nevada will reconsider, so we have the ability here and now to consider the provider give-back benefit, and if the Senator indicates there is general unanimous agreement to provide that, then we can focus on the prescription drug benefit and on the few areas we have identified to be the issues in disagreement between what was offered by Senator GRAHAM and the tripartisan package offered by the Senator from Iowa, Senator BREAUX from Louisiana, Senator JEFFORDS from Vermont, and myself. We can do that. I hope I will hear that message today. Let's begin here and now.

Mr. REID. Mr. President, I try to be very patient; sometimes I am and sometimes I am not. But I have to tell you the statement of my dear friend, the senior Senator from Maine, is really trying my patience. She has stated numerous times she likes the tripartisan piece of legislation. More power to her. The fact is, it could not get a majority vote in the Senate. We had a piece of legislation that got a majority, but she refuses to talk about that. She talks about committee, committee, committee. We recognize how the Senate works. The committee structure, I support. I have great respect for the traditions of the Senate. But there are times when the committees don't have full hearings on pieces of legislation.

The minority should become consistent because, on the one hand, they are telling us if the committee works and they don't like what the committee does, the matter should come to the floor anyway. Let's see how that would work here. If something happens in the Senate Judiciary Committee and they make a determination and the minority doesn't like what happens in the committee, then it should come to the floor anyway. It would seem to me if you are consistent, you have to recognize we have a situation where we have had extensive debate that took place over a period of many weeks on prescription drugs. The only one that got a majority vote is the one I talked about—on two separate occasions—by Senators GRAHAM and MILLER. Let's pass that now. I think that is fine.

I see the Senator from Michigan, who spent weeks of her time working on prescription drugs. We didn't get a prescription drug bill because we could not get 60 votes. But we had a majority. We passed a generic drug bill—not a perfect bill but a good one—that would lower the cost of drugs in America, not only for seniors but for everybody. It allows reimportation from Canada.

Where is that bill? It's buried over in the dark hole of the conferences of the Republican-led House of Representatives. They won't even let us do that. Here we have somebody telling us we have lots of time. Let's do another prescription drug bill, but we want to start this one in the committee. When it comes to the floor, we want to have a lot of amendments, or a few amendments.

We know that is a prime-time word for the big stall. That is all this is. I have great respect for the AARP. It is a great organization, but they don't run the Senate or this country. There are many people in the State of Nevada, and all over the country, who badly need this Medicare give-back. So I am willing to take my chances with AARP because the Republicans would not let us pass a prescription drug bill, a generic drug bill. I will take my chances with AARP and go with the Senator from Montana. Let's pass the Medicare give-back bill to help millions of people in America—rural America and urban America—people who badly need this. I am going to have convalescent centers going broke in Nevada, filing bankruptcy.

Is that what we want? We had a convalescent center in rural Nevada. They had all kinds of problems. They did not know what to do with the people in the

center because they were going broke. What do they do with them? It was the only center in town. This legislation would direct money to that situation.

AARP is a great organization, but they can take that letter and carpet floors with it because that is not how we run the Senate. We do what is best for the people of our States, and the best for our States is to do what the Senator from Montana said to do. We tried to pass all kinds of legislation, and we have had the big stall. So do not have anyone lecture me on enough time to do things. I have spent days, weeks, and probably months of my life sitting here doing nothing because they would not let us do anything.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I am thankful the Senator from Maine is still on the floor. I wish to respond to a couple points she made.

I do not know that there is anybody in the Senate who wants to get a prescription drug benefit for seniors more than the Senator from Maine. Believe me, I understand that. I have been at many meetings with the senior Senator from Maine where she has made that very clear.

There is also no one on the floor who wants to pass a prescription drug bill more than the senior Senator from Montana. The same is true of the Senator from Michigan, the Senator from Nebraska, and the Senator from West Virginia, as well as the current occupant of the chair, the Senator from Wisconsin. We all want to get a prescription drug benefit passed.

On the one hand, there is the so-called tripartisan bill, which the Senator from Maine supports, and which is basically the insurance company model. On the other hand, there is the bill that would use pharmacy benefit managers, or PBMs, to administer a drug benefit. This is essentially the Medicare model. Reducing it to its basic simplicity, that is the argument.

The Senator says she wants a prescription drug benefit passed, but she slyly indicates she wants hers passed. But her bill did not get a majority vote in the Senate. There are others who want to get prescription drug benefits passed who have a different view of what a prescription drug benefit should be, and that is the problem. Neither side wants to give in. Both sides think they are right.

We just witnessed a good example of that. The Senator from Maine says: Bring up a prescription drug bill, but bring up hers, the way she wants it. She does not agree to bring up the other bill, apparently, that the Senator from Nevada suggested, the one that received a majority vote. That is the problem. Neither side agrees. Each side wants its bill passed.

I say to my good friend—and she well knows this—I have worked so hard with her to get a prescription drug benefit passed. I called the meeting in my office with the Senator from Maine and with other Senators who were key Senators on this subject as a last-ditch effort to get a bill passed because I share with her the view we owe it to our seniors to get a prescription drug benefit bill passed. I understand that.

But the Senator knows well that there are huge differences of agreement. The issue is basically, should we have a more privatized system or not? That is basically the argument.

The Senator from Maine suggests the approach that privatizes prescription drugs to seniors with insurance companies. That is basically her bill. There are others who say: No, do not do that; that is wrong because insurance companies will take too much for themselves; the insurance companies will not give the benefits to the seniors, and besides that, insurance companies are not sure they want to do it, anyway.

It is very easy for a Senator to stand up and say: Let's do prescription drug benefits. The hard part is actually coming up with a compromise so we can reach a solution and pass a bill that does give benefits to our seniors.

To be frank, I have not heard the Senator from Maine come forth to me or anybody with a reasonable compromise. She has been pushing for this insurance company model, and she is not coming up with a compromise. I say that because that indicates the degree of separation and the division in this Senate over how to get prescription drug benefits to seniors.

But while we all want to pass a benefit, we also want to make sure it is done right. If we are going to pass legislation on the order of $400 billion over 10 years, we have to make sure it is done right and that it works for seniors. It does not make sense just to pass a bill. It makes sense to pass a bill that works.

I could not agree more with the Senator that we should pass a bill, but in all candor, at this late moment, coming up to the Chamber without first suggesting an honest-to-goodness compromise sounds as if this is obfuscation. On the surface, it sounds good: Let's pass a prescription drug benefit. I know she means well, but there are others on her side of the aisle for whom this is an obfuscation, a desire not to get an underlying give-back bill passed.

The reason the Medicare give-back bill is here is because there is agreement. There is agreement on almost all of the provisions: an agreement that we should not allow the home health cut go into effect; agreement on what the restoration for physicians should be; agreement on hospital payments, the so-called standardized amount. There is agreement.

But there is not agreement on how to provide prescription drug benefits, and the Senator from Maine well knows that. Her argument is: Let's just try; let's try it.

Sometimes we have to tell it like it is. The fact is, both sides are so stuck in their ways that I have made the judgment that it is nearly impossible in the remaining days to reach agreement because we are in such a political season.

If the Senator from Maine wants to come forth and give me a legitimate compromise, then maybe we can get a bill passed. She says she wants the tripartisan bill up for consideration. She does not say: let's sit down and work out a legitimate agreement and see if we can put something together.

I would like to sit down with the Senator from Maine and see if we can reach agreement. I know the Senator from Maine would like to do so. To be honest, she has not suggested anything except the tripartisan insurance company model. And that plan did not even get a majority vote in the Senate. The approach by Senator GRAHAM received a majority of votes in the Senate.

Mr. President, if we don't pass this bill to restore Medicare payments, we should consider all of the seniors who may get less care in nursing homes, and seniors who may get less care because doctors will no longer provide Medicare services to patients.

My good friend from Maine points out that the Medicare payment bill will increase costs to seniors. She does not tell us that of the increased cost to seniors 90 percent is caused by a restoration of payments to physicians. This restoration is needed to ensure that physicians will still provide care to seniors.

If she wants doctors to continue to withdraw from Medicare, that is her right, that is her choice, when she complains about the amount of the increase seniors will have to pay. It is true that they will have to pay a little more. We have to figure out a solution to that. I am hopeful we can do it next year, and I am hopeful there will be more of a bipartisan mood around here.

I know the Senator's motives are pure. Hers are pure, but I cannot say that for the majority of the Members on the other side of the aisle on this issue at this moment. I have been around here a while and know how this place works. I have the utmost respect for the Senator from Maine. She has pure motives, but her offering this unanimous consent request at this time is clearly an effort on the part of others—not her—on the part of others to try to slow down and prevent the Medicare give-back bill from passing.

Mr. HATCH. Mr. President, as my colleagues are aware, I have agreed to cosponsor S. 3018, the Beneficiary Access to Care and Medicare Equity Act of 2002, because I believe it is imperative we act this year to correct deficiencies in Medicare payment levels that are certain to create hardships for providers and those they serve, beneficiaries.

I want to take this opportunity to underscore concerns I have with Section 706 which deals with the process for development and implementation of Medicaid and CHIP waivers.

I am sympathetic to the underlying concerns expressed by the sponsors of this provision, especially as they relate to coverage of childless adults under the CHIP program. CHIP was designed to address the needs of children of working parents who made too much money to qualify for Medicaid, but, many times, could not afford private health insurance. I believe that the integrity of the CHIP program must be maintained. For this reason, I have even opposed attempts to expand CHIP to cover pregnant women, because I believe funding should be devoted to providing coverage to uninsured children, preserving the original intent of this legislation. It should come as no surprise to my colleagues that I oppose expanding CHIP under a waiver to cover childless adults.

However, there are those who do not share my views on this issue and I believe that they should be heard. There are those who believe that CHIP enrollment is not as high as it could be because parents are not covered by the program. They believe that one way to capture children under CHIP is to offer family coverage. I do not agree with that approach, but I do believe that there should be a debate on the issue.

Before Congress adopts provisions which could limit both the Federal and State governments' ability to adopt innovative approaches to address the problem of the uninsured, we ought to have a thorough and comprehensive debate. The Senate Finance Committee should hold hearings on these important waiver issues prior to enacting legislation which could be detrimental to State flexibility and innovation. I strongly object to including a provision which is opposed by the Secretary of Health and Human Services and the National Governors Association in an attractive package of Medicare reimbursements and fiscal relief for the states. Both HHS and NGA have concerns with this provision because it limits a State's flexibility to provide expanded health coverage tailored to the specific needs of its residents.

I believe that, as drafted, Section 706 would deter a state's attempt to provide health insurance coverage to those who are currently uninsured. Additionally, it is my view that Section 706 would not improve the waiver process, but would actually function as a disincentive for States to undergo an open dialogue with stakeholders as they go through the process of securing a Medicaid or CHIP waiver.

Section 706 would require that 60 days prior to the date that a state submits a waiver or amendment application to the Secretary, the state must publish, for written comment, a notice of the proposed waiver that contains at least the following: projections regarding the likely effect and impact of the proposed waiver on any individuals who are eligible for receiving medical assistance or health benefits coverage. In addition, a State must make a statement regarding the likely effect and impact of the proposed waiver on any provider or suppliers of items or services for which payment may be made under the Medicaid or CHIP program.

It would seem to me, that we are putting the cart before the horse here. Isn't it the purpose of a public comment period to determine the effects and impacts on individuals and providers? Aren't we setting the States up to be criticized for coming to pre-determined conclusions about the effects of a proposed waiver by requiring them to effectively develop these conclusions before the public has had a chance to weigh in on the matter?

Section 706 goes on to require that the State must have one meeting with the state's medical care advisory committee and two public hearings on the waiver. I am somewhat confused by these provisions. It seems to me that rather than encouraging an open and comprehensive dialogue in the state over a proposed waiver, Section 706, if enacted, would curtail and truncate the process, effectively limiting input from the very individuals and groups which would be affected by the waiver. In short, to comply with Section 706, a State could conclude what the effects of the waiver would be prior to public comment, hold two perfunctory public hearings and be done.

Officials in my State of Utah, in developing their waiver, did not need the Federal Government to come in and tell them how to reach out to stakeholders on this issue. I am informed that the state held meetings for 10 months prior to getting approval for their waiver with low-income advocates, providers, insurance companies, employers and state legislators. The state held a series of work conferences and community meetings on issues associated with Utah's waiver. The State had several legislative task force meetings which were open to the public as well as several budget hearings, also open to the public. Officials from my State who were overseeing the waiver process attended monthly meeting of advocate groups and met repeatedly with their medical care advisory committee.

Now, it might be that other States contemplating a waiver might not need such a comprehensive public outreach effort. Other states could determine they should emulate such an approach. Is it really the role of the Federal Government to micro-manage this process?

Section 706 would also require states to file copious records documenting detailed descriptions of the public notice and input process; copies of all notices, dates of meetings and hearings; a summary of the public comments; and, a certification that the state complied with any applicable notification requirements with respect to Indian tribes.

If we are looking for ways to encourage unwilling states to reach out to the public for input, one of the least effective ways to do so, in my opinion, is to require States to jump through a bunch of bureaucratic hoops. This will not foster open debate nor will it encourage the states to try and draw a buy-in from stakeholders. Instead, in my opinion, it will create an atmosphere where the state will do the bare minimum in order to meet the requirements and no more. This is not the way to promote outreach efforts and a free-flowing exchange of ideas. In fact, I believe that if enacted, Section 706 will stifle such an approach.

In considering the role of HHS relative to the waiver process, I am informed that HHS Secretary Tommy Thompson has written in opposition to Section 706. I share the Secretary's concerns that, as drafted, this section would leave HHS vulnerable to costly and burdensome lawsuits. I agree with Secretary Thompson that State and Federal resources should be spent addressing the issue of the uninsured and should not go, instead, to fending off legal challenges from every national advocacy group who did not get exactly what they wanted.

Finally, one of the facts that gets overlooked in these waiver discussions is that we have 41 million uninsured Americans and states are trying to cover them. This is really the bottom line, here, the states are trying to find ways to get some coverage to Americans who would otherwise have no coverage. Rather than looking for ways to inhibit the states from accomplishing this, we should be making it easier for them.

I look forward to working with my colleagues on the Finance Committee to accomplishing this important goal.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, I find myself in total agreement with the Senator from Montana, sadly so but nevertheless very much so. But this situation strikes me as ironic.

I support the position of the Senator from Montana and what he is trying to do with the give-back. The Senator from Maine talked about resolving a few minor differences, and the Senator from Montana said they are not minor. They have to do with whether or not a State such as West Virginia, which this Senator represents, will have any prescription drug benefits at all because there are no insurance companies that have any intention of coming into the State of West Virginia and making those available.

I am not so sure that any would be willing to go to Maine. I do not think they would be willing to go to Montana. I do not think they would be willing to go to—well, I don't know. They probably would be willing to go to Florida, probably Nevada a little bit, Michigan a little bit, but Nebraska not very much; Wisconsin, I do not know.

Basically, all rural States—and 81 percent of all counties in the United States of America are rural—will be shut out by this prescription drug bill which the tripartite approach embraces. I hope the Presiding Officer

does not think for one moment the Senator from West Virginia is going to contemplate working out a compromise on the floor of the Senate, with only a few days left, when we have been filibustered on every single thing we have brought up, especially something as complicated as a difference between a pharmacy benefit manager and an insurance model.

There is a lot of educating that has to go on on the Senate floor that has taken place in the Finance Committee. There was a vote on the floor. The vote said one thing and the Senator from Maine says she wants something else.

I am extremely disappointed we are not able to get the unanimous consent that was sought to proceed to the Beneficiary Access to Care and Medicare Equity Act of 2002.

I have heard nonstop from those in my State concerning the effects of the declining Medicare reimbursement on access to critical care services. The reality is we will also be unable to enact a Medicare prescription drug benefit for this year. Why? Because of the huge ideological gap which I have just finished describing.

People can describe it as a minor difference. It is the Grand Canyon of difference, and it is the difference between whether people from populated, wealthier areas get a prescription drug benefit and everybody else does not.

If that is what one wants, fine; but that is not what the Senator from West Virginia wants, and it is not what my people want. It is not what the majority of the people in this country want. Yes, they want something called a prescription drug benefit. But there is a question of saying how do they get it and who gets it? The mechanism is important.

I want a prescription drug benefit. I dare say the income of Medicare beneficiaries in the State of West Virginia is lower—about $10,800—than the Medicare beneficiaries in the State of Maine.

People spend $4,000, $5,000, to $6,000 out of their pockets on prescription drugs. Do I want a prescription drug benefit? You better believe I do, but I want one which will actually get to the people I represent and which are represented across America in rural States.

We do not have a choice of being able to say let's do both. We cannot finish that debate on this floor. We cannot reach agreement on this floor. Not the Senator from Maine, but there are many on the other side of the aisle who do not want to see that happen in some respects because they do not want to see the Graham-Miller bill pass because that would be deemed a victory for the wrong people, or something like that.

However, one priority that cannot wait until next year is providing States with fiscal relief. That would include the State that the Presiding Officer is from.

On July 25, 75 members—talk about a consensus. The Senator from Maine, Ms. COLLINS; the Senator from Nebraska, Mr. NELSON; and this Senator put forward a compromise plan, and it got 75 votes. It got half the Senators on the other side of the aisle to vote to provide States with $9 billion in assistance. That has since been somewhat cut down in an agreement with the Republican leader on the Finance Committee to $5 billion, but that is still substantial relief—$4 billion in Medicaid and then $1 billion in Social Security's block grant. That is a lot of money. It will help all States.

Since we passed that amendment by an overwhelming vote, the situation in the States has, in fact, gotten much worse. The last time States faced a budget crisis this bad was in 1983. I happen to remember that because I was Governor of West Virginia and our unemployment rate was about 21 or 22 percent. One does not forget those things quickly.

At least 46 States struggled to close a combined budget gap of $37 billion in the past fiscal year. This year's gap is even wider. This year it is going to be a combined $58 billion deficit. Most States are required by law to balance their budgets, something we did up until a year and a half ago. Then a variety of things happened, and it is no longer balanced. So they are being forced to slash their spending. The Governors do not want to, but they have to.

This year coming up, 18 States are planning to cut families from Medicaid coverage, and 15 States are eliminating important health care benefits. Twenty-nine States are cutting or freezing provider payment, further jeopardizing access to health care. As a result, thousands of Americans, at the least, will join the ranks of the uninsured and countless more will find access to needed benefits reduced or eliminated altogether.

In this tough fiscal climate, a new survey of Medicaid programs shows an increasing number of States are dropping certain groups of patients, curtailing some services, requiring poor people to help pay for their own care when they can, limiting access to expensive drugs and then cutting or freezing payments to hospitals, doctors, nursing homes, and other providers of care. Is that kind of important? You bet your bottom dollar it is. Fundamental access to health care.

In Massachusetts, the legislature had to stop covering about 50,000 unemployed adults. In California, children spent longer in foster care because of cuts in adoption services.

In New Jersey, the working poor will lose access to State-funded health care. In Louisiana, there will not be future hospital beds available for low-income patients. The Kaiser Commission on Medicaid and the Uninsured, which nobody disputes, in a new study found that 18 States are planning to tighten their eligibility rules in the coming fiscal year, compared with 8 States last year.

The most common strategy that States are using to cut costs is to limit their expenditures on prescription drugs by reducing pharmaceutical payments or making it more difficult for doctors and patients to select expensive but necessary medicines. Forty States are trying to cut costs by limiting their drug expenditures. In Illinois last month, Medicaid officials began requiring patients who need the popular antidepressant drug Zoloft to get tablets that are twice as strong as they need and then break the pills in half. I do not know if that makes a tragedy, but it sure is a lousy way to do business.

In a subtler strategy, some States are curtailing recent innovations that were designed to find more people who are eligible for public insurance and then make it easier for them to stay covered once enrolled. Delaware stopped a very good initiative which had been paid through an outside grant to publicize Medicaid and the Children's Health Insurance Program and to help clients fill out applications. They had to stop that because they had no money.

So the decision being made by Governors, legislators, and Medicaid administrators underscores the pressure that States are confronting in a weakened economy, which I dare say will stay weakened for some time. Their revenues are plunging. Increases in unemployment and poverty are prompting more people to sign up for government help. As a result, States are reversing the trend that lasted nearly a decade when they added money and changed rules so the public insurance programs could help more Americans who lack health coverage and pay for more kinds of care.

The fiscal crisis has a direct impact on the families in our States but it also has a direct impact on local economies. Medicaid is the largest purchase of maternity care in the United States of America. It pays for half of all nursing home care which everybody faces at some point in their life.

Medicaid provides significant support for local hospitals and for nursing homes. Providers in some instances are struggling to stay in business, and in many instances have stopped. Eight out of 10 hospitals in West Virginia are losing money. How long can they continue in small rural counties? The bottom line is that means Medicaid plays a critical role in sustaining local economies as well as people's lives and health care. For every dollar a State cuts from Medicaid—and that is what is happening—it loses between $1 and $3.31 in Federal assistance. That is one large loss. That loss would have otherwise gone to hospitals, to home health services, nursing homes, and health clinics tied into our local economy.

For this reason, the legislation introduced last week in the Senate to increase payments to providers under Medicare, which we just failed to get unanimous consent on, also includes a

billion dollars in fiscal relief for States. In many ways, States are the largest providers of health care, and ensuring their stability is the best way to maintain access.

If Congress does not act to provide a temporary boost to Medicaid funding for States to help them meet their responsibility to protect the most vulnerable citizens, and all citizens, since a great majority of Medicare citizens are vulnerable, the situation will get worse.

We have made significant progress over the last 10 years in expanding access to health insurance. This year, 50 million Americans are expected to receive health insurance through two programs: Medicaid and the Children's Health Insurance Program which was started in the Senate Finance Committee. These programs provide health coverage to more than 10 percent of all Americans.

In closing, this coverage is now at risk unless, as the Senator from Montana wants, the Congress refuses to act. This is one priority that cannot wait until next year. We should pass the Senate's proposal to reduce the current law cuts to critical Medicare providers. Even if we fail to do that, we must enact a provision to provide additional relief to the States that struggle to provide our Nation's people with the crucial safety net.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. Mr. President, I respond to some of the issues raised by the Senator from Montana, for whom I have a great deal of respect. It is important to clarify some of the issues suggested by the Senator regarding the legislation I and others have proposed, the tripartisan legislation.

The Senator from Montana did schedule meetings in his office with Senators from both sides of the political aisle, Senators who were very concerned about the legislation. Obviously, there were differences among all the Senators. We were trying to narrow the areas of differences.

I was surprised by the characterization suggested by the Senator with respect to those meetings. He had established the agenda. In fact, he asked everyone at the meetings, what should be the basis for negotiations? What should be the starting point for discussions? It was agreed by those in the room, when he initiated the question, that the tripartisan legislation should be the basis for the discussion and negotiation. The staff had been given instructions to develop language with respect to the three areas in which we had identified to be the major areas in disagreement.

One was the assets test, one was the cost, and one was the fallback provisions as to whether or not the provision included in the tripartisan package was in and of itself sufficient to guarantee prescription drug coverage to a senior, regardless of where they lived in America. We thought our language certainly met the conditions for ensuring that our Nation's seniors, regardless of whether they lived in an urban or rural area, would have the benefit of a prescription drug coverage as designed in our legislation. But we were certainly amenable to additional language, additional protection in the legislation to absolutely guarantee we would provide seamless coverage in the event that an insurer was not providing the options for prescription drug coverage to seniors in a particular area of the country for whatever reason. So no matter what, a senior would have the benefit of the coverage, regardless of where they lived, and they would have a choice of at least two plans, so we were more than amenable. We were amenable even on the price tag. We were considering language on the acid test.

The chairman did not reconvene meetings after assigning the staff with the responsibility of drafting the new legislation. We were never given reasons no additional meetings were scheduled.

In the meantime, markups were scheduled in the Finance Committee this fall on various issues, including the provider give-back. We said we intend to offer the tripartisan package because that had the support of Senator GRASSLEY, who worked on it a year and a half ago; Senator JEFFORDS from Vermont, a member of the committee; Senator BREAUX from Louisiana; and myself as a member of the Finance Committee. We would offer that as an amendment and see where the process takes us in Finance Committee. The markups were canceled.

If our bill was not going anyplace, as the chairman suggests, then why were the markups canceled? If our bill had no opportunity to go anyplace, why were the markups canceled? Is it because these four members of the Finance Committee had at least offered a basis for a bipartisan—in this case a tripartisan—comprehensive prescription drug package? We did not say it was all or nothing. We did not suggest inflexibility or intransigence on our part. We say let's offer this as a basis for amendment, further consideration, and debate and votes.

The same was true in the unanimous consent request I presented on the floor that was ultimately rejected. It says ''be open to further amendment and debate.'' That does not suggest inflexibility. I didn't say take tripartisan package or nothing. I am saying the only way you work things out is being able to bring up the bill and offer amendments and debate and vote on the amendments and reach a final conclusion. Now we are talking about July.

Mr. BAUCUS. To be honest, I think if all Members of the Senate were like the Senator from Maine, we would have an agreement. The Senator well knows there are a lot of other Senators in this body who were dug in and who very much wanted their points of view.

We had the last meeting. We were working on five issues: Assets test, benefit design, Medicare reforms, consumer protections, and how to design a viable fallback mechanism, which would take effect in the event of private plans not entering a particular market. Roughly speaking, we were working off the basis of the so-called tripartisan view, but is it not also true at that time that was very loose and there were an awful lot of issues to work out?

Ms. SNOWE. I would like——

Mr. BAUCUS. It was my judgment after that meeting and checking with Senators on both sides of the aisle, that discussions were going backwards on prescription drugs. I basically made a decision that Senators were digging in so much that they were not going to agree.

Ms. SNOWE. I would like to pose a question to the Senator from Montana as to why we didn't have any additional meetings based on your instructions to the staff to work out language in the various areas? I didn't sense there was inability to reach a consensus. It might well have been, after we considered and pondered the legislative language they were drafting, language over the weekend. We didn't have the opportunity to talk about those issues.

Mr. BAUCUS. That is correct.

Ms. SNOWE. We didn't have an opportunity to talk about the language the staff was instructed to draft in these three areas.

Mr. BAUCUS. I might ask the question—the reason is because I checked with Senators who were at that meeting and they said: No, sorry, I am not going to agree with that. They are going backwards. They were going in the other direction. They didn't want to meet. It is unfortunate, it is so unfortunate. To be candid, Senator, you and I know you and I were the last two standing on this issue. Basically you are the last one standing on this issue trying to find agreement.

But it is clear there are not enough Senators in this body who also want agreement at this time. That is why I think we cannot let the Medicare provider legislation be held hostage to another bill which does have an agreement.

It is very unfortunate we could not get agreement. But it is partly because the Senate, as well as the House, is still a bit too partisan on all matters—not all matters, but most matters. Particularly on this issue, because it gets to a very fundamental question which this body and the other body will have to address, the whole country is going to have to address, and that is: What is the future of health care in this country? To what degree is it going to be privatized, to what degree not? That is a huge question. The prescription drug benefit debate is really the opening shot of that larger debate.

I wish that were not so. I wish we could pass the prescription drug benefit

quickly this year, but it is the judgment of this Senator, and I think it is the judgment of virtually every other Senator in this body, that it is not going to happen now. I wish that were not true.

Therefore, I think let discretion be the better part of valor and let this Medicare payment bill pass.

Ms. SNOWE. In response to what the Senator from Montana indicated, let me say this. Obviously I am not privy to his private conversations, but we were sitting in those meetings in good faith, and I didn't hear from anybody around that table—more than 14 Members—who resisted the idea we should not proceed, that we should not work out these areas, that it was impossible.

Maybe in the final analysis, it might have been impossible, but that certainly was not the expression of the sentiment in that meeting during that course of time. The fact is quite the contrary. I think most of the Senators—as I said, it was equally divided between Republicans and Democrats, including Senator JEFFORDS from Vermont. There was an indication of strong interest to proceed to try to see if we could work through and resolve the identified areas in disagreement.

Those are the ones I mentioned previously.

So I didn't hear any indication there was a ''can't do'' attitude. In fact, just the contrary. They were suggesting we could proceed and instructed the staff to work over the weekend on those various areas.

Suffice it to say we didn't have the process in the committee to work these through. Obviously, for whatever reasons, it did not work out as a result of those negotiations. But they were, I think, very close. I think we were very close.

I know if those individuals sitting around the table had agreed in these areas, we certainly could have overcome any political obstacles and impediments here in the Chamber because I think there is virtually unanimous desire to get something done on behalf of our Nation's seniors.

I cannot imagine anybody here in the Senate would want to tell their seniors that somehow it could not be done. We are elected to get things done. We are responsible for ensuring this institution functions in a way that does dignity to the process. Unfortunately, I think in this instance we failed.

I happen to believe on the Medicare provider give-back, if we were somehow to be able to resolve those differences behind closed doors, without a markup and on the floor, then clearly we should be able to do what has been deemed to be the impossible—the impossible in this institution—in advancing this legislation in the interests of our Nation's seniors. In fact, we invited the AARP to be part of our negotiations this fall to talk about some of the issues.

Yes, they had concerns with the tripartisan bill, as they did with the bill that had been offered by Senator GRAHAM, in providing an unfunded mandate on States. But the fact is, who is to say any legislation is perfect? We certainly didn't indicate ours was. This is the agreement we had reached. We were prepared to accept amendments and to consider different ideas. That is where we were in these meetings that were scheduled by the Senator from Montana in his office.

Ultimately, there were not additional meetings, even though the staff had been instructed to draft language in the three areas I mentioned originally. The fact is, this failure is at whose expense? It is at our Nation's seniors' expense. As prescription drug prices go up each and every year by more than 15 percent, it is 2½ times faster than the cost of additional health care components. By 2011, the prescription drug spending is expected to be 15 percent of all health care spending in America. Rising prescription drug costs have made prescription drug coverage for Medicare beneficiaries less available and more expensive. We have seen employer-sponsored retiree health plans provide 28 percent of Medicare beneficiaries with prescription drug coverage, more than any other source. It is a major source of prescription drug coverage for our Nation's seniors.

Now what are we finding? Far fewer employers are offering coverage to their employees. Those employers who continue to do so are requiring seniors to pick up a larger share of the costs. That is what we are talking about. The proportion of larger employers offering retiree health benefits dropped from 31 percent to 23 percent between the years 1997 to 2001. Those who were requiring Medicare-eligible retirees to pay the full cost of their coverage rose from 27 percent to 31 percent.

Those are not my figures. Those are the figures that have been given by the GAO, that have been certified. Certainly I think they underscore the costs of prescription drugs to our Nation's seniors and, I think, the challenges we face in this country if we fail to address this most serious problem.

As AARP indicated in its own letter, the costs of prescription drugs are going up, as was said, more than 15 percent on an annual basis. These added costs to beneficiaries, as we have seen, because the Medicare provider giveback is going to increase part B premiums. There is no question about that. So that is going to raise the premium $6 billion in the first 5 years alone. These added costs, as they said in their letter recently, come in addition to double-digit hikes in prescription drug costs for older and disabled Americans, many of whom have little or no options for drug coverage.

Employers continue to reduce or eliminate health care coverage. Medigap premiums continue to rise. And now, nine more Medicare+Choice plans are pulling out of Medicare.

So, you see, we do have an obligation to do what is right. I would not be standing here today insisting on getting this done if I didn't think it was possible. That is because I have had a number of conversations with colleagues on both sides of the aisle, on different sides of the issues, different philosophies. Many have indicated they are prepared to make concessions and develop compromise and consensus on this issue to get it done here and now.

I agree with the statement that was made by the Senator from West Virginia with respect to the provider giveback legislation, I think it is necessary for our Nation's hospitals and home health care. So is this. They are not mutually exclusive. They go hand in glove for our nation's seniors.

I have toured many of the hospitals in my State.

I have heard firsthand from seniors in my State about the plight of some who have gone without prescription drug coverage.

I was told a story about a man who had diabetes and was supposed to take his medication and couldn't take his medication. He knew what that would lead to. He didn't have prescription drug coverage. So he was unable to take the medication prescribed by his doctor after he was released from the hospital. He had diabetes which ultimately led to amputation and ultimately to his death.

Those are the kinds of tragic stories we hear over and over again. Those are choices our seniors shouldn't have to make.

We have the time. We have the time to do what is right.

Mr. KYL. Mr. President, I rise in support of S. 3018, the Beneficiary Access to Care and Medicare Equity Act, which was recently introduced by the Chairman and Ranking member of the Finance Committee.

This act would provide more than $40 billion over the next 10 years to improve benefits for Medicare beneficiaries, guarantee that Medicare beneficiaries continue to receive the high quality health care they deserve, and increase reimbursements to Medicare providers.

I would prefer that we address these issues as part of comprehensive Medicare reform, reform that includes a new prescription-drug benefit. Unfortunately, the process the Majority Leader used to bring a prescription drug benefit to the Senate floor guaranteed its defeat, and no drug proposal put forward won the 60 votes necessary for passage. While the Senate was unable to pass a prescription drug bill, we still have an opportunity to address other critical Medicare issues.

And it is critical. In 1997, Congress passed the Balanced Budget Act. This act made significant cuts in Medicare provider reimbursements and implemented new payment systems. In many cases, these cuts made sense. However, in some cases they went too far. Moreover, the process of implementing these new payment systems for home

health care, hospital outpatient services and skilled nursing-facility services has not been a smooth one.

One key area where we see this is in payments to physicians. Physicians are reimbursed for providing services to Medicare beneficiaries under a fee schedule. The fee schedule is updated annually under a very complex formula. The formula considers the sustainable growth rate which is based on four factors: the estimated changes in fees; the estimated changes in the average number of Medicare Part B enrollees, not including Medicare+Choice beneficiaries; estimated projected growth in real gross domestic product growth per capita; and estimated change in expenditures due to changes in law or regulations.

On November 1, 2001, the Center for Medicare and Medicaid Services (CMS) announced that the annual update of the fee schedule in 2002 would result in a 5.4 percent reduction in reimbursements. A number of factors led to this decline, including the adjustment by the sustainable growth rate. But the sustainable growth rate is flawed because of mistakes made by CMS. In the late 1990's, CMS overestimated the number of Medicare beneficiaries in the Medicare+Choice program and underestimated gross domestic product growth. These errors resulted in reimbursements greater than what they should been if CMS had not made them. As more accurate data came about CMS has corrected its previous errors. This correction has partially led to the −5.4 percent update this year. Additionally, physicians are looking at future payment cuts next year and the two years following that. Overall, physicians could see a 17 percent reduction in reimbursements from Medicare over these four years.

The key concern, of course, is really not so much Medicare reimbursements for physicians, but Medicare beneficiaries' access to medical care. There is increasing evidence that doctors are not taking new Medicare beneficiaries, are retiring early or accepting administrative positions. According to a report in the March 12, 2002 edition of the New York Times, 17 percent of family doctors are no longer taking new Medicare patients. The Beneficiary Access to Care and Medicare Equity Act would increase reimbursements to physicians over the next three years, and, in turn, help stem the tide of doctors refusing to treat new Medicare patients.

Of course, physicians are not the only health-care providers that this legislation would help. The legislation would eliminate a 15 percent reduction in home health-care reimbursements mandated by the Balanced Budget Act of 1997. As it turns out, the Balanced Budget Act's original change in the payment system for home health care services helped save money. But it is no longer necessary to implement the 15 percent cut. Additionally, this legislation would help smooth out the transition to a new payment system for skilled nursing facilities. S. 3018 would also provide both urban and rural hospitals with increases in reimbursements. It has many provisions to help alleviate the reimbursement differences between rural and urban hospitals. Of particular note, S. 3018 contains a technical change that will allow publicly-funded safety net hospitals to negotiate for lower drug prices. These hospitals bear a disproportionate burden in caring for the uninsured in our country; allowing them to negotiate lower prices will save them millions of dollars.

Another provision of note is section 805, which would provide $48 million annually for two years to States and other providers that offer federally-required emergency medical treatment to illegal aliens. A congressionally-commissioned study by the U.S.-Mexico Border Counties Coalition estimates that the 24 counties along the southwest border incur uncompensated costs of over $200 million per year in connection with the provision of emergency health treatment to undocumented aliens. The non-border counties in southwest States, and other states, including New York, Florida, Illinois, New Jersey, Massachusetts, Washington, Colorado, and Maryland, also incur tremendous costs. The entire state of Arizona, for example, incurs unreimbursed costs of approximately $100 million per year to provide such treatment.

These southwest States and counties, many of which have very small tax bases and small annual budgets, and other States should not be forced to bear the responsibility of providing emergency health treatment to undocumented aliens. These unreimbursed costs have helped put Arizona's and other States' affected hospitals in a state of dire fiscal emergency. Many hospitals have closed, or are in danger of closing, their emergency rooms either temporarily or permanently.

The Balanced Budget Act of 1997 provided funding to states to help defray some of these uncompensated costs; however, this provision expired at the end of fiscal year 2001. Section 805 would specifically extend and refine the Balanced Budget Amendment Act of 1997 to provide $32 million in each of fiscal year 2003 and fiscal year 2004 to the 17 States with the highest number of undocumented aliens, as defined by the U.S. Department of Justice. Additionally, in fiscal year 2003 and fiscal year 2004, $16 million would also be allotted to the six highest undocumented alien apprehension States, as defined by the U.S. Department of Justice.

Forty-eight million dollars per year is just a fraction of the unreimbursed costs that the States incur each year, but this funding will at least begin to defray some of the costs.

Although, I strongly support most of the provisions contained in S. 3018, I do have concerns about others. For instance, section 707 of S. 3018 provides States with a temporary 1.3 percent point increase in their Federal Medical Assistance Percentage, FMAP, payments, the amount that the Federal Government supplements States' Medicaid spending.

Under FMAP, Medicaid funds are distributed to States based upon a formula designed to provide a higher Federal matching percentage to those States with lower relative per capita income, and a lower Federal matching percentage to those States with higher per capita income. This formula, although not perfect, is justified because States cannot manipulate it for their own gain; the data are periodically published and can be estimated with reasonable accuracy. Additionally, the use of per capita income is a proxy for state-tax capacity which, in turn, relates to a State's ability to pay for medical services for needy people. To put it simply: poorer States get more help than wealthier States.

Unfortunately, S. 3018 ignores the Medicaid formula and gives each State a 1.3 percent point increase. Under this section, States that have been determined by the Medicaid formula to receive the lowest FMAP of 50 percent receive the greatest percentage increase in FMAP. States with the highest FMAP receive the lowest percentage increase. This is the exact opposite of how the funds should be allocated. The Medicaid formula, whatever its faults, does indicate a relative sense of need. It would be wrong to give the least needy States the largest percentage increase.

Even though I have concerns about how funds are distributed under this section, I urge my colleagues to support S. 3018. It is vitally important that Congress enact changes to Medicare payment policies before we adjourn. I also support the passage of a Medicare prescription-drug benefit, preferably the tripartisan modernization proposal; but we should not allow our inability to reach a consensus on that matter to stop us from making the appropriate changes to Medicare's payment policies. Medicare beneficiaries need guaranteed access to high quality care, and S. 3018 is a means to that end.

Mr. JEFFORDS. Mr. President, I first want to salute the Senator from Montana, Mr. BAUCUS, as well as my good friend and colleague, Senator GRASSLEY, for their bipartisan effort and leadership in crafting S. 3018, the Beneficiary Access to Care and Medicare Equity Act of 2002.

As the chairman and the ranking member of the Senate Finance Committee, they have worked long and hard on legislation that is critically important to the future of health care for our citizens that rely on Medicare. I am proud to be a cosponsor of S. 3018, and I urge all of our colleagues to support its passage as soon as possible.

In the closing days of the 107th Congress, there will be many bills that on their way to consideration and passage will enjoy the unanimous consent of

the Senators. There are few of these many bills more worthy of our consideration and unanimous consent than this measure.

Vermont, like so many of our States, has a healthcare system that is facing reductions in levels of Medicare reimbursement that are untenable. In some cases, these reductions took effect on October 1 and others will occur at the end of this month. The cuts have already led to fewer physicians and services being available to care for our elders.

The list of cuts and reductions is long. Physicians and other healthcare professionals, home health agencies, critical access hospitals, skilled nursing facilities, sole community hospitals, and others are being affected. And make no mistake, these cuts translate as cuts in access to healthcare for our elders.

But it is not too late. We can pass this legislation, engage in a conference with our colleagues in the other chamber, and have a bill for the President to sign before the end of this Congress.

Once again, I want to commend Senator BAUCUS and Senator GRASSLEY for their work on this bill and for this chance to speak to its merits today. It is needed legislation, it is balanced, and it is well crafted. Our elders need it passed. Our providers need it passed. Children depending on SCHIP need it passed, and our States need it passed. We should not let this opportunity to enact this legislation go by, and so I urge our colleagues to support its passage.

Also I want to commend the Senator from Maine for her statement with which I agree and commend her.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. Mr. President, the Senator from Maine has told us what the Baucus-Grassley unanimous consent request to move the legislation forward won't do, what it has been said is included, what has not been included in it, and, therefore, as a result it shouldn't be considered at this point.

I will concede the point to my friend from Maine that it is a tremendous shame we didn't somehow pass a prescription drug benefit for our seniors. I have worked with her. We even shared an amendment on the Patients' Bill of Rights. I know of her passion for health care and for the benefits for our seniors. I share those values, and I share the concern we all have today everywhere that we don't have a prescription drug benefit for our seniors.

I have to go back to Omaha and face George and Lee, who have spent so much time telling me about the importance of having a prescription drug benefit. But you know we had three shots at it this session. One was it was too expensive, one was it didn't provide enough benefits, and the one my friend from Maine supported—the insurance model—failed by getting only 48 votes.

But I come from an insurance State. And not one insurer that I spoke to told me they planned to offer this benefit anywhere, let alone in the State of Nebraska.

There were a lot of reasons why that particular bill didn't make it. There were reasons why the other two bills didn't make it.

I would like to have us pass a prescription drug benefit before we leave, but I don't want to do it at the expense of this legislation that is so necessary.

When I go back, if we don't pass it because we try to pass a prescription drug benefit that causes the failure of this legislation which I am going to describe in a minute, I will have to face George and Lee. Not only will they tell me we didn't get a prescription drug benefit, but their physician Medicare rates are down and their doctor doesn't want to provide the care for them anymore. Or I have to go back and find out the skilled nursing facilities are not going to be funded or the State fiscal relief that Senators ROCKEFELLER and COLLINS and I worked so hard to get through is now cut back from $9 billion to $5 billion and that is not going to be available to the State.

I agree with the passion of the Senator from Maine and her concern about the fact we didn't get a prescription drug benefit done yet this session. But I don't agree we ought to pull this legislation which is before us back into committee so they can attach to it a bill that failed, only got 48 votes, and which I don't think will work. I think we have to separate these two issues—and they have been separated.

Let us talk about the bill that is now before us, the Baucus-Grassley bill, a bipartisan effort. The ranking Member from Iowa is pushing to have this considered on the floor rather than to go back and be delayed in committee.

Under current law, Medicare's physician payment rates are projected to fall by 12 percent over the next 3 years. In Nebraska, physicians' losses due to the 2003–2005 cuts will total about $63 million or $17,230 per physician. This comes on top of a 5.4 percent payment cut which cost Nebraska doctors a total of $12.9 million or about $3,875 per physician in 2002.

An AMA survey conducted earlier this year found that one in four physicians either has restricted or plans to restrict the number or type of Medicare patients treated. One in three has stopped or intends to stop delivering certain services to Medicare beneficiaries.

Additional payment cuts of an extra year will only exacerbate these problems and cause significant access problems in the State of Nebraska—a State that is already challenged geographically to be able to provide access to our residents.

Let us talk for just a moment about skilled nursing facilities and what will happen there.

Our skilled nursing facilities are also in jeopardy. If action isn't taken and if this legislation does not pass, then Nebraska's facilities will lose $28.48 per patient per day next year, for a total of $10 million. There are just some that aren't going to make it. They are going to be in small communities that will be left out when it comes to skilled nursing facilities.

When it comes to State fiscal relief, my colleague from West Virginia and I—both former Governors from our States—know very well what the impact is going to be on the States of Nebraska and West Virginia, as well as the rest of the States. Forty-nine out of 50 States must balance their budgets by law.

It is no secret the economy is hurting. States are facing a number of difficult decisions as a result of that. When States have to make budget cuts, let me assure you it affects real people. There may be line items in a budget, but there are faces associated in every case.

In a special session in Nebraska in August, the legislature made some drastic cuts. It wasn't pretty. Thirteen thousand kids were cut from Medicaid.

That is why we have been working so closely, Senators ROCKEFELLER, COLLINS, and I, to pass State fiscal relief, which is part of this legislation. Seventy-five of our Senate colleagues agreed with us when they supported our amendment in July. Senators BAUCUS and GRASSLEY have included State fiscal relief in this very important provider package, and it is extremely important to the people in the State of Nebraska and the States of every one of our colleagues here in the Senate.

If I were one of my residents of Nebraska, or one of my constituents watching or listening to the debate today and heard about unanimous consent requests, objections, sending this back to committee for further consideration, trying to deal with what cloture is, how many times, what person did what, and how many of us are all interested in making sure we get not only this legislation through but also a prescription drug benefit, they have to be confused.

Their only question is, Why don't you just get this legislation done and work also on a prescription drug benefit? What has one got to do with the other? Don't, for heaven's sake, deny us our prescription drug benefit because you can't get it through, and at the same time now come along and make sure our doctors aren't going to get reimbursed enough, or our skilled nursing homes aren't going to have enough money, and our States are going to continue to cut back on Medicaid benefits. Separate the two issues and get them done.

Three tries, and I don't think we are out. That is true in baseball. I don't think it is true here. I think we can dust off one of these versions and make it work well.

I have met with Senator SNOWE on a prescription drug benefit. I have met with everybody I can in the interest of finding a prescription drug benefit. I know it is possible. I also know it is

difficult. But I think it is extremely important for us to first fulfill our obligations with the Baucus-Grassley effort. Let us let this come to a vote. Let us stop the objections. Let us withdraw the objection from the other side. Let us get a vote. Then let us see if a bunch of us can come back together—and we should—and get a prescription drug benefit.

But, for heaven's sake, even in the greatest and most sincere effort in the world, we should not think about one bill here because we are trying to save another, when we know very well it is not going to work. We have not run out of time. We can do this. We should bifurcate them. We should separate them, get the Baucus-Grassley bill done, withdraw the amendment, and let us work on a prescription drug benefit so I can go home and I can talk to Lee and George and tell them something more than: Well, we tried.

I sure don't want to have to go back and say: Well, we didn't get anything on prescription drugs. But that isn't where the bad news ends. There is worse news. We also didn't get the give-back bill through, and that means if you have to go to a nursing home, there may not be one. Your doctor may decide he is not going to treat you because he has had a reimbursement dropped or if, heaven forbid, they have to go on Medicaid, there will not be any benefits to provide for seniors as well.

I don't want to have to tell the children of Nebraska there are further cuts coming because we could not get the State relief, the FMAP, as it is called, back to the States to take care of the short budgets so that people are not going to be further disadvantaged by these unfortunate economic conditions in these times.

I agree with my friend from West Virginia, there is more passion in this Senate body to pass a prescription drug benefit than you can imagine. The problem is very simple. We just cannot agree on how to do it. It cannot cost too much, the benefits cannot be too little, and we cannot pass something that will not work.

I think we have the collective wisdom to find a way to do it, but it is going to require the collective will to do it. But this mechanism is not the mechanism on which to do it. And let's not sink it trying to do something noble for those who are the most vulnerable among us, our seniors. I think they can understand why we do not want to sink one trying to do the other.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. DAYTON). The Senator from West Virginia.

CONCURRENT RECEIPT

Mr. ROCKEFELLER. Mr. President, I rise at this point on a different subject, with the tolerance and forgiveness of the Senator from Louisiana, to discuss a different problem, concurrent receipt.

I am very pleased my friend from Minnesota is in the Chair because he is on the Armed Services Committee, and so it makes me very happy to be able to present this argument to him.

We are all very familiar with this practice of requiring military retirees to choose between military pay for retirement and disability benefits. There is a history of this which I will get into. The money comes from the Department of Veterans Affairs, but it is a very sad state of affairs that we have come into.

This is a practice that my friend, Bill Stubblefield, of Martinsburg, which is a large town in West Virginia, who serves on the board of directors of the Retired Officers Association, told me ''is patently unfair when a serviceman or woman, who has devoted 20 plus years of their life in service to this country—suffering physically as a consequence—has to be penalized by having their VA disability offset by their retirement pay.''

It is a huge subject. We have been fighting for years to eliminate this injustice. While the Senate, under the leadership of Senator HARRY REID of Nevada, has passed such a provision several times, this is the first time we have something to offer that approximates the Senate's efforts in dealing with the House, which is now a problem.

Money has been set aside in the deeming resolution to fund some version of concurrent receipt.

Now we learn that the Bush administration is threatening to veto—they have said the President will veto—the Department of Defense authorization bill. I think the enormity of that is $347 billion, something of that sort. They said the President will veto the entire bill because officials in this administration oppose concurrent receipt for service members who are retired from the Armed Forces with a service-connected disability.

A disability is a very special condition. Frankly, I find this opposition highly objectionable. I find it shocking. It wholly disregards the enormous dedication and sacrifice of our men and women in uniform, and it labels their claim to compensation earned in service to this Nation as ''double-dipping,'' which is a slam and a putdown. It is something you say in sort of contemptuous terms.

When did this become double-dipping? More than 100 years ago, Congress examined the military pensions of veterans of the Mexican-American war. At that time, Congress found the retired service members who returned to active duty could draw active duty, retirement, and disability pay. So life was good and right and fair.

During debate, the late Senator Francis Marion Cockrell, who, I confess, is unknown to me, argued that:

> [T]he salary we pay the officers of the Army is intended to be in full for all military services. We allow longevity pay . . . in lieu of pension and everything else.

In 1891, therefore, Congress banned what is called ''dual compensation'' for past or active service and disability compensation. So that is history, 1891.

That legislation accomplished its goal. Service members can no longer receive retirement or full disability compensation while on active duty. However, the Congress of 1981 painted with too broad a stroke. Retirement and compensation are and have always been intended to compensate very different purposes. One is called retirement; the other is called a disability. They are totally unconnected.

This is a very important issue to veterans in this Senator's State and to veterans throughout the country. In fact, I would say to the Presiding Officer, there is no single subject on which this Senator gets more mail and more telephone calls and more conversations when in my State than on this subject of concurrent receipt. It is an overwhelmingly emotional and powerful argument of anger and disgust and frustration on the part of the veterans of this country.

Veterans such as Hugh Weeks of Beckley, WV, a veteran of World War II, Korea, and Vietnam—that's not bad—a career military man, writes to tell me that while their military careers placed hardships on them and their families, they never stopped serving during those hardships. Hugh wrote to me: ''Now is the time for the government to stop discriminating against us.''

In yet another disturbing setback for retiree veterans, the House of Representatives Appropriations Committee, last week, reported out a VA–HUD appropriations bill for fiscal year 2003 spending. This bill contains a provision that would prohibit specifically VA from using any staffing funds to adjudicate claims for VA service-connected disability benefits that would result in concurrent receipt.

Mr. President, I ask unanimous consent that the applicable text of the bill and committee report be printed in the RECORD.

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

H.R. 5605—DEPARTMENTS OF VETERANS AFFAIRS AND HOUSING AND URBAN DEVELOPMENT, AND INDEPENDENT AGENCIES APPROPRIATIONS ACT, 2003

SEC. 114. (a) No appropriations in this Act for the Department of Veterans Affairs shall be available for the adjudication of any claim for disability compensation filed after the date of the enactment of a new concurrent receipt law by a veteran who is entitled to retired or retainer pay based upon service in the uniformed services if the Secretary determines that, if compensation under the claim is awarded to the claimant, the veteran will, by reason of the new concurrent receipt law, be entitled to payment of both compensation under the claim and some amount of such retired pay determined without regard to the provisions of sections 5304 and 5305 of title 38, United States Code.

(b) For purposes of subsection (a), the term 'new concurrent receipt law' means a provision of law enacted after October 1, 2002, that