Richard R. Clifton, of Hawaii, to be United States Circuit Judge for the Ninth Circuit? The clerk will call the roll.

The legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from North Carolina (Mr. HELMS) and the Senator from Ohio (Mr. VOINOVICH) are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 184 Ex.]

YEAS—98

| | | |
|---|---|---|
| Akaka | Dorgan | Lugar |
| Allard | Durbin | McCain |
| Allen | Edwards | McConnell |
| Baucus | Ensign | Mikulski |
| Bayh | Enzi | Miller |
| Bennett | Feingold | Murkowski |
| Biden | Feinstein | Murray |
| Bingaman | Fitzgerald | Nelson (FL) |
| Bond | Frist | Nelson (NE) |
| Boxer | Graham | Nickles |
| Breaux | Gramm | Reed |
| Brownback | Grassley | Reid |
| Bunning | Gregg | Roberts |
| Burns | Hagel | Rockefeller |
| Byrd | Harkin | Santorum |
| Campbell | Hatch | Sarbanes |
| Cantwell | Hollings | Schumer |
| Carnahan | Hutchinson | Sessions |
| Carper | Hutchison | Shelby |
| Chafee | Inhofe | Smith (NH) |
| Cleland | Inouye | Smith (OR) |
| Clinton | Jeffords | Snowe |
| Cochran | Johnson | Specter |
| Collins | Kennedy | Stabenow |
| Conrad | Kerry | Stevens |
| Corzine | Kohl | Thomas |
| Craig | Kyl | Thompson |
| Crapo | Landrieu | Thurmond |
| Daschle | Leahy | Torricelli |
| Dayton | Levin | Warner |
| DeWine | Lieberman | Wellstone |
| Dodd | Lincoln | Wyden |
| Domenici | Lott | |

NOT VOTING—2

| | |
|---|---|
| Helms | Voinovich |

The nomination was confirmed.

## NOMINATION OF RICHARD R. CARMONA, OF ARIZONA, TO BE MEDICAL DIRECTOR IN THE REGULAR CORPS OF THE PUBLIC HEALTH SERVICE

The PRESIDING OFFICER. Under the previous order, the clerk will report Executive Calendar No. 921.

The assistant legislative clerk read the nomination of Richard H. Carmona, of Arizona, to be Medical Director in the Regular Corps of the Public Health Service.

The PRESIDING OFFICER. The majority leader is recognized.

CLOTURE MOTION

Mr. DASCHLE. Madam President, I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on Executive Calendar No. 921, the nomination of Richard H. Carmona, of Arizona, to be the Surgeon General of the Public Health Service.

Edward M. Kennedy, Debbie Stabenow, Tom Daschle, Harry Reid, Jack Reed, Richard J. Durbin, Barbara Mikulski, Patrick Leahy, Jean Carnahan, Tom Carper, Byron L. Dorgan, Paul Wellstone, Jon Corzine, Jeff Bingaman, Daniel Inouye, Kent Conrad.

## LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will now return to legislative session.

## GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS ACT OF 2001—Continued

AMENDMENT NO. 4309

(Purpose: To amend title XXIII of the Social Security Act to provide coverage of outpatient prescription drugs under the medicare program)

Mr. GRAHAM. Madam President, I send to the desk an amendment, which reflects the contents of S. 2625, the Medicare Outpatient Prescription Drug Act of 2002.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Florida [Mr. GRAHAM], for himself, Mr. MILLER, Mr. KENNEDY, and Mr. CORZINE, proposes an amendment numbered 4309.

Mr. GRAHAM. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

AMENDMENT NO. 4310

(Purpose: To amend title XVIII of the Social Security Act to provide for a medicare voluntary prescription drug delivery program under the medicare program, to modernize the medicare program, and for other purposes)

Mr. HATCH. Madam President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Utah [Mr. HATCH], for Mr. GRASSLEY, for himself, Ms. SNOWE, Mr. JEFFORDS, Mr. BREAUX, Mr. HATCH, Ms. COLLINS, Ms. LANDRIEU, Mr. HUTCHINSON, and Mr. DOMENICI, proposes an amendment numbered 4310.

Mr. HATCH. I ask unanimous consent that further reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. GRAHAM. Madam President, this amendment represents the essence of S. 2625, which currently, in addition to those who cosponsored this amendment, has 29 other colleagues' sponsorship.

This legislation is designed to provide to American seniors affordable, comprehensive, and reliable universal prescription drug coverage. This coverage will be available to 39 million older Americans and disabled citizens who are covered by Medicare—citizens who voluntarily elect to participate in this new Medicare benefit. More than 2,750,000 of those 39 million live in my State of Florida and, as have citizens across America, been waiting year after year after year for Congress to finally deliver on the commitment that we have made to modernize Medicare through the provision of a prescription drug benefit.

When I made remarks on this issue on Tuesday of this week, I based those remarks on six principles that I believe should be the touchstone for an affordable, comprehensive universal prescription drug benefit for senior Americans. Let me briefly reiterate those six principles.

First, we must modernize the Medicare Program. We must bring Medicare into the 21st century. In my judgment, the provision of a prescription drug benefit is the single most important reform of the Medicare Program that we can make. Why is this benefit so central? Because in the 37 years since the Medicare Program was created, the practice of medicine has been fundamentally altered by the use of prescription drugs.

Prescription drugs have improved the quality of people's lives. They have reduced long recovery periods, and they sometimes can even avoid surgeries and disabling illnesses, such as strokes and heart attacks.

We must convert Medicare from a program which, since its inception in 1965, has focused on sickness. If you are sick enough to go to the doctor or to the hospital, Medicare will pay 77 percent, on average, of your costs. But if you want to maintain the highest level of health, which generally involves screening, early intervention, and prescription drugs to monitor the condition, Medicare will pay nothing.

Medicare must be converted from a sickness program to a wellness program if it is to serve the needs of senior Americans in the 21st century. That is the first principle.

The second principle is that beneficiaries must be provided with a real benefit. To be successful, this program must attract a wide variety of beneficiaries.

The program will be voluntary, so it must attract enrollment with reasonable and reliable prices and a benefit that pays off from day one. In this manner, we will be able to attract all seniors, from those who today have high drug needs to those who are healthy but might be concerned that they, too, could be struck down with a heart attack or other disabling condition.

If we are able to have a program that will attract that broad range of elderly in terms of their current state of health, then we will have a program that will be actuarially solid for years to come.

Seniors must be able to understand the benefit they receive. The coverage should be consistent, and seniors should receive that coverage without any unexpected gaps or omissions. In other words, it should operate as much as possible as the employer-provided coverage which they had during their working years.

The third principle is that beneficiaries must have choice. All Americans deserve choice in how they receive their health care. We must offer choice in who delivers their prescription drugs, which is why we must assure that each region of the country has an adequate number of providers of the prescription drug benefit. This will encourage competition, helping to keep costs down for seniors, as well as the taxpayers of the Medicare Program, and assure a sustainable prescription drug benefit for this and future generations of America's seniors.

Principle No. 4 is we must use a delivery system upon which seniors can rely. It must be a tried-and-true system, not an untested scheme that will turn older Americans into laboratory animals upon which to be experimented. We want to model our delivery system on what private sector plans have used and with what seniors are familiar.

Principle No. 5 is the program must be affordable. The reality is the majority of seniors live on fixed incomes. In my State of Florida, where many people have the idea that all or most of the seniors live at a level of luxury, the median income of our 2,750,000 seniors is $13,982 a year, and 770,000 seniors in our State live on incomes below 150 percent of poverty.

These fixed-income seniors need a prescription drug benefit that has a low premium, that does not require a deductible, has reasonable copayments that are easy to calculate, and will avoid wide variations from month to month in their coverage.

Finally, principle No. 6 is we must have a fiscally prudent program. We must find that balance between giving seniors what they need, that balance between a realistic assessment of what prescription drug costs are likely to be over the next 10 years for our seniors, and, finally, the balance of what our overall Federal budget will allow.

The Graham-Miller-Kennedy-Corzine amendment meets these six criteria. As a result, it has the support of the major organizations that represent America's seniors, including AARP.

I ask unanimous consent to print in the RECORD eight letters of support of this legislation.

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

AARP,
NATIONAL HEADQUARTERS,
*Washington, DC, June 12, 2002.*

Hon. BOB GRAHAM,
Hon. ZILL MILLER,
*U.S. Senate, Washington, DC.*

DEAR SENATORS: We are pleased to restate our position on your revised Medicare prescription drug proposal. Action on a bipartisan prescription drug benefit is a top priority for AARP, our members and the nation.

Medicare beneficiaries have waited long enough for access to meaningful, affordable prescription drug coverage. We know from our membership that in order for a Medicare prescription drug benefit comprehensive coverage it must include:

An affordable premium and coinsurance;

Meaningful catastrophic stop-loss that limits out-of-pocket costs;

A benefit that does not expose beneficiaries to a gap in insurance coverage;

Additional assistance for low-income beneficiaries; and

Quality and safety features to curb unnecessary costs and prevent dangerous drug interactions.

AARP supports your initiative to incorporate these goals. We commend you for including key elements in your proposal that Medicare beneficiaries and our members have indicated they find valuable. For instance, your proposal includes a premium that many Medicare beneficiaries view as affordable and a benefit design that does not include a gap in insurance coverage. Your proposal also now includes co-payments specified as dollar amounts, an approach that our research shows our members prefer to coinsurance. In our view, this plan could provide real value to beneficiaries in protecting them against the high costs of prescription drugs.

It is important that any prescription drug benefit be made a permanent and stable part of Medicare, and we want to work with you to achieve this before enactment.

Thank you for your leadership on this issue. We look forward to working with you and your colleagues as the legislation moves forward. AARP will continue to urge Congress to work in a bipartisan manner to enact affordable, meaningful Medicare prescription drug coverage.

Sincerely,

WILLIAM D. NOVELLI,
*Executive Director and CEO.*

---

GENERIC PHARMACEUTICAL ASSOCIATION,
*Washington, DC, June 12, 2002.*

Hon. BOB GRAHAM,
*524 Hart Senate Office Building,*
*Washington, DC.*

DEAR SENATOR GRAHAM: On behalf of the Generic Pharmaceutical Association (GPhA), we would like to commend you and Senators Miller and Kennedy for your leadership in introducing legislation to create a Medicare prescription drug benefit for our nation's seniors. We agree with you that the passage and enactment of a voluntary Medicare prescription drug benefit is long overdue. We are strongly supportive of your innovative tiered co-pay structure, as well as the other provisions advocated by you and your colleagues, that are designed to increase the utilization of high-quality, affordable generic medicines.

Generic pharmaceuticals have a proven track record of substantially lowering drug costs. Studies have shown that for every 1 percent increase in generic drug utilization, consumer, business, and health plan purchasers save over $1 billion. The increased use of generics can play an invaluable role in helping Medicare, Medicaid, the Federal Employees Health Benefit Plan (FEHBP) and other Federal and private plans assure that beneficiaries have access to quality, affordable medications. A tiered co-pay system with a significant differential between brand and generic pharmaceuticals will ensure an appropriate incentive is in place for seniors to consider more cost-effective options when making choices about pharmaceutical therapies. We believe an explicit dollar co-pay will also provide seniors with the comfort of knowing they will pay a fixed cost to have their prescriptions filled.

With your leadership, the Graham/Miller/Kennedy bill employs a number of private sector best practices that are now widely used to assure access to cost-effective, quality affordable medications. These provisions not only encourage the appropriate and beneficial use of these products, but provide unbiased and greatly needed educational information to the public about the benefits of these medicines.

The Graham/Miller/Kennedy bill adheres to GPhA's principles for creating a Medicare prescription drug benefit and steers the Medicare reform debate down a prudent public policy path. We look forward to working with you, your cosponsors and with other Members of the House and Senate of both parties to further our common objective of providing our nation's nearly 40 million Medicare beneficiaries and the taxpayers who help support them with the most affordable and highest quality prescription drug benefit possible. If the rest of the Congress and the Administration follow your lead in recognizing the role generics must play in reaching this objective, we are confident we will achieve this goal.

Thank you again for your efforts. If we can be of any assistance to you, please do not hesitate to call.

Sincerely,

KATHLEEN JAEGER,
*President and CEO.*

---

THE NATIONAL COUNCIL ON THE AGING,
*Washington, DC. June 11, 2002.*

Hon. BOB GRAHAM,
*524 Hart Senate Office Building, Washington, DC.*

DEAR SENATOR GRAHAM: On behalf of the National Council on the Aging (NCOA)—the nation's first organization formed to represent America's seniors and those who serve them—I write to commend and thank you for your proposal to provide meaningful Medicare prescription drug coverage to America's seniors. The Medicare Outpatient Prescription Drug Act of 2002 is consistent with the principles supported by the vast majority of organizations representing Medicare beneficiaries. It provides the foundation for a vehicle that we hope can achieve bipartisan consensus on this issue this year.

NCOA is particularly pleased that your legislation would provide prescription drug coverage that is universal, voluntary, reliable, and continuous. Other proposals being offered include significant coverage gaps and would fail to solve the problem. Under such bills, a significant number of beneficiaries would not want to participate in the program, and many of those who do participate would continue to be forced to choose between buying food and essential medicines.

We commend many of the modifications you have made to your Medicare bill from last year. These improvements include a significantly lower premium, the option to provide a flat copayment, an earlier effective date, and assistance with the very first prescription. We believe these changes will make the coverage affordable and attractive to the vast majority of beneficiaries, which is so critical to making a voluntary prescription drug program work. While we have concerns about the need to reauthorize the program after 2010, we understand the budget trade-offs needed to provide meaningful and attractive coverage, and fully expect that the Congress would reauthorize the program.

NCOA is also pleased that your proposal does not include price controls and that the

program would promote stability and efficiency through administration by multiple, competing Pharmacy Benefit Managers (PBMs), using management tools available in the private sector in which PBMs would be at risk for their performance, including effective cost containment.

NCOA deeply appreciates your efforts to move this critical debate in a direction that guarantees access to meaningful coverage—even in rural and frontier areas of the country—and responds in a constructive manner to many of the specific concerns that have been raised regarding other Medicare prescription drug proposals.

It is impossible to have real health security without coverage for prescription drugs. Prescription drug coverage is the number one legislative priority for America's seniors. Virtually every member of Congress has made campaign promises to try to pass a good prescription drug bill. The time has come to get serious and to work together to achieve consensus on the issues in controversy. Your proposal provides us with an excellent starting point.

NCOA looks forward to working on a bipartisan basis with you and other members of Congress to pass legislation this year that provides meaningful, continuous, affordable prescription drug coverage to all Medicare beneficiaries.

Sincerely,

JAMES FIRMAN,
*President and CEO.*

---

FAMILIES USA,
*Washington, DC. June 13, 2002.*

Senator BOB GRAHAM,
*524 Hart Senate Office Building, Washington DC.*

DEAR SENATOR GRAHAM: We congratulate you and Senators Miller, Kennedy and Rockefeller on the introduction of your bill, ''The Medicare Outpatient Prescription Drug Act,'' which provides prescription drug benefit for Medicare beneficiaries.

This is an issue of utmost important to all Americans who need prescription drugs, especially to seniors and people with disabilities. As you well know senors' ability to afford prescription drugs is a particularly difficult problem today. In our 2001 report entitled, ''Enough to Make You Sick: Prescription Drug Prices for the Elderly, ''we concluded that the 50 top drugs used by seniors rose 2.3 times the rate of inflation between 2000 and 2001. We are in the process of updating this report for last year, and our preliminary data shows that this devastating rate of price increases continues. Millions of seniors have limited income and no, or limited, drug coverage and will find themselves deciding whether to buy drugs or pay for other essentials.

Your bill addressees many important design issue that we care about in a Medicare prescription drug benefit. The benefit is universal, comprehensive, and is delivered through the Medicare program, ensuring that seniors know it will be available to them when it is needed. Low-income people get extra assistance. Also, there are provisions to assure that costs will be contained and quality maintained.

Please let us know how we can assist you to move this bill toward enactment so that all Medicare beneficiaries can have access to the prescription drugs they need.

Sincerely,

RONALD F. POLLACK,
*Executive Director.*

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE,
*Washington, DC. June 12, 2002.*

Senator BOB GRAHAM,
*Senate Hart Office Building 524, Washington, DC.*

DEAR SENATOR GRAHAM: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I write in support of your Medicare prescription drug legislation that will provide much needed relief to seniors. Your bill contains all of the elements that seniors need in a comprehensive drug benefit under Medicare, such as universal, voluntary, affordable, not means tested and most importantly, with a defined benefit, so that seniors can plan accordingly. Prescription drugs prices are increasing over 17% per year (faster than inflation) and seniors are spending more on out-of-pocket drug expenditures than ever. The time is now to enact a drug benefit that will provide the Medicare beneficiary with some assistance.

We are pleased that your plan would be available for seniors, no matter where they live. Our members have expressed to us that a prescription drug benefit must be affordable. We believe that a plan such as yours, with no annual deductible and a $4,000 cap on out of pocket expenditures, is reasonable and one that most seniors would be able to afford.

We applaud you for your leadership in this area. Please let me know how we can further support your efforts.

Sincerely,

BARBARA KENNELLY,
*President.*

---

AFSCME®,
AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL–CIO,
*Washington, DC, June 12, 2002.*

Senator EDWARD KENNEDY,
Senator BOB GRAHAM,
Senator ZELL MILLER,
*U.S. Senate, Washington, DC.*

DEAR SENATORS: On behalf of the 1.3 million members of the American Federation of State, County and Municipal Employees (AFSCME), I am writing to express our support for the Medicare prescription drug benefit proposal you unveiled today.

AFSCME has long supported the creation of a Medicare prescription drug benefit that is comprehensive in coverage, affordable and voluntary for all Medicare beneficiaries. We believe that your proposal is a solid step forward in meeting these standards.

In particular, we applaud your proposal's provisions for continuous coverage. We believe that it is one of the most critical components of a meaningful prescription drug benefit. Beneficiaries must have coverage they can count on, with no gaps in coverage. Doing anything less would force our seniors to pay all prescription costs out of their own pocket when they will need the coverage the most.

Since Medicare was started over 35 years ago, many illnesses that were once only treatable in a hospital can now be effectively treated with prescription drugs. Adding a drug benefit to the program is the most urgently needed Medicare reform. We applaud you for not holding the prescription drug benefit hostage to force radical privatization proposals that would cut benefits and increase costs for retirees.

We look forward to working with you and the other sponsors of this important legislation. A Medicare prescription drug benefit is long overdue, and our nation's seniors deserve no less.

Sincerely,

CHARLES M. LOVELESS,
*Director of Legislation.*

LEGISLATIVE ALERT

AMERICAN FEDERATION OF LABOR AND,CONGRESS OF INDUSTRIAL ORGANIZATIONS,
*Washington, DC, June 12, 2002.*

Hon. BOB GRAHAM,
*U.S. Senate, 524 Hart Senate Office Building, Washington, DC.*

DEAR SENATOR GRAHAM. On behalf of the 13 million members of the AFL–CIO, I am writing to commend you for your efforts to provide much-needed relief to Medicare beneficiaries. Your proposal to create a voluntary drug benefit within the Medicare program represents an encouraging and solid step toward enacting the one reform most urgently needed for Medicare.

Seniors need a real benefit that provides comprehensive, continuous and certain coverage. The Graham-Miller-Kennedy bill provides that benefit, giving seniors coverage they can count on. A Medicare drug benefit must also be affordable for beneficiaries. The $25 monthly premium and zero deductible in your proposal means seniors need only pay an affordable premium to begin getting coverage immediately. And no senior will have to pay more than $40 for the drugs they need and often will pay less.

In addition, your proposal would not put at risk those retires who currently have some prescription drug coverage through an employer. Retiree heath care is the primary source of prescription drug coverage for seniors, and your proposal rightly provides from relief for employers that choose to continue that coverage.

A proposal widely reported under consideration by House Republican leaders offers only unreliable, expensive and unworkable coverage through private plans, with an enormous gap in coverage that leaves seniors without any coverage at all for drug costs between $2000 and $4500. And the only relief for employers is if they drop the coverage they now offer. Such a proposal will not move us any closer to a real benefit.

As this debate moves forward, we want to work with you and your co-sponsors to enact the best possible Medicare drug benefit. We appreciate your role in advancing that process.

Sincerely,

WILLIAM SAMUEL, *Director, Department of Legislation.*

---

ALLIANCE FOR RETIRED AMERICANS,
*Washington, DC, June 12, 2002.*

Senator EDWARD M. KENNEDY,
*U.S. Senate, Washington, DC.*

DEAR SENATOR KENNEDY: On behalf of the over 2.7 million members of the Alliance for Retired Americans, I want to thank you for your tireless work on behalf of older and disabled Americans to create a Medicare prescription drug benefit program. I also want to express our views on the Medicare prescription drug legislation proposed by you and Senators Graham and Miller. The Alliance supports this proposal as a positive step forward in the effort to create a Medicare prescription drug benefit program.

The Alliance for Retired Americans believes that all older and disabled Americans need an affordable, comprehensive, and voluntary Medicare prescription drug benefit now. Such a benefit program should have low monthly premiums, annual deductibles, and be administered as part of the Medicare program. Your proposed legislation meets these Alliance principles. Unlike other proposals that would begin in 2005, your plan would start in 2004, which gives beneficiaries the coverage they need a full year earlier.

The Alliance will work to enact your legislation. During legislative deliberations, the Alliance will seek to improve benefits because we believe that an 80/20 co-insurance

payment system, like the rest of Medicare, will provide the best benefits for older and disabled Americans. The Alliance also supports a $2,000 annual catastrophic cap. We will continue to work to improve any legislation that moves through Congress in order to reach these goals.

Older Americans will spend $1.8 trillion on prescription drugs during the next decade. The inflation rate for prescription drugs will continue at an annual double digit pace as well. Our members and indeed all Americans simply cannot afford these costs. We look forward to working with you and Senators Graham and Miller to enact a comprehensive Medicare prescription drug benefit as soon as possible.

Sincerely yours,

EDWARD F. COYLE
*Executive Director.*

---

Mr. GRAHAM. Madam President, what does our plan provide? Our plan will require of seniors who voluntarily elect to participate a $25 monthly premium to do so. There will be no deductible. There is an easy-to-understand copayment system, which is $10 per prescription for generic medication and $40 per brand name, medically necessary drug.

I will pause at this point and point out the connectedness of this plan and this structure of benefits to the underlying legislation we have been discussing throughout the week to make it easier for all Americans to gain access to generic drugs.

Our legislation has a strong incentive for the use of generic drugs by having the $10 copayment for generics, $40 for brand names. To the extent that more generics are available, which, of course, is the purpose of the underlying bill, we will reduce the cost of this program and make it even more affordable to senior Americans.

We set a maximum out-of-pocket expense of $4,000 per year. Above that, all of the senior's drug cost, including copayments, will be covered. This is the so-called catastrophic coverage.

Seniors with incomes below 135 percent of the poverty level will pay no premiums, and beneficiaries with incomes between 135 and 150 percent of poverty will pay reduced premiums. We want all senior Americans to be able to participate in this program.

Our plan uses the same delivery model that America's private insurance companies utilize. It happens to also be the same model used by the Federal Employees Health Benefits Plan, a plan that covers virtually everybody in this Chamber.

We use pharmacy benefit managers, or PBMs, to deliver and manage prescription drug benefits, just as they do in virtually every major private and public sector employee health insurance plan. PBMs are companies that negotiate with pharmaceutical companies to get discounted prices based on their volume purchase.

We would allow all seniors a choice of which PBM to join. This would give choice to seniors, and it would give them the opportunity to shop among the PBMs that are competing for their business so that they, the senior, can decide which PBM best meets their particular needs, including factors such as the availability of mail order delivery and access to local pharmacies.

PBMs would be accountable to the Medicare Program and to all taxpayers. They would be required to demonstrate their ability to keep costs down through effective purchasing practices and provide quality service in order to win and keep a Government contract.

CBO has given us an estimate of our plan today. CBO estimates that our plan through the year 2010 would cost $421 billion. Taking into account, in addition to the base cost, the benefits that would flow by the adoption of the underlying generic bill, that figure is reduced to $407 billion through the year 2010.

That date is important because part of our legislation is a required reauthorization by the Congress in 2010. In much the same way as we are now reauthorizing Welfare to Work after it has been in place for 6 years, we would require the reauthorization of this prescription drug benefit so we can take into account the experience we will have gained and make an assessment as to what kind of prescription drug benefit we want to carry into the future.

If the program is extended, then the 10-year cost of the plan through the year 2012 would be an additional $173 billion.

Because this prescription drug benefit would represent the largest expansion of the Medicare Program in its 37-year history, we believe it is important for Congress to review the program to see how well it is working and whether it has given seniors the coverage they need.

Madam President, our good friend and colleague from Utah has introduced legislation which has a similar objective to the one we are proposing; that is, to assure that seniors would have access to a comprehensive, universal, affordable prescription drug benefit.

I have comments to make about the plan which has been introduced. I will defer those comments, however, until Monday.

To conclude tonight, I want to say we are still hearing the background noise that all of this is theater, that there is no real commitment to passing a prescription drug benefit in the year 2002, as there was not in 2001, 2000, and on for the many years which seniors have been promised by different people seeking office that if elected they would deliver on a prescription drug benefit.

What we are committed to today—and I believe this feeling also carries to my good friend from Utah and those who have joined him in his legislation—is we are not interested in election year posturing. We want to actually accomplish a result. We want to be able to say to our senior Americans, we have turned the corner. No longer are you participating in a sickness program, but you are now participating in a program which has as its primary commitment assuring that all senior Americans can live in the highest state of good health.

Our Nation's seniors have waited too long for the help they need to purchase their prescription drugs. An unconscionable number of these people are forced every day to choose between filling a doctor's prescription for a needed medication and paying for other basic needs. These people are not numbers in a statistical database. They are not strangers. These people who have been waiting and waiting are our parents and our grandparents. They are our neighbors. They are the people we used to work with. They are our friends. They are the Americans of the great generation.

We now have a challenge, an opportunity, a responsibility to respond to this great need that they have of some assistance in paying for what has become the fastest growing segment of our health care costs—prescription drugs. If we do not act on the prescription drug benefit this year, I fear the American people will lose confidence in the Congress and our ability to make the tough choices necessary to address our country's priority domestic issues.

Certainly, I do not claim that our bill is perfect, but I do suggest that it is as good as our collective efforts have been able to make it at this point. I believe this amendment justifies the support of our colleagues, as it has already received the support of virtually every major organization which represents the interests of America's seniors.

So I look forward to a full discussion and debate in the best tradition of this great deliberative body. I hope at the end of that debate we not only will have a better understanding of the options before us, but we will have reached a conclusion that will command the votes of a sufficient number of Members of this Senate that we can tell our senior constituents we have heard their long call for assistance in paying the costs of increasingly expensive prescription drugs; that we understand the importance of that call, and that we are now responding to that call. That is the challenge and that is my hope of what will be the conclusion of this debate.

The PRESIDING OFFICER (Mr. DAYTON). The Senator from Utah.

Mr. HATCH. I want to express my appreciation to my colleague from Florida. He is an eminent member of the Senate Finance Committee. He is a very serious, reflective Member. He has worked hard to come up with his bill. I respect him for it, and I wish him well with it. However, I will say a few things about Senator GRAHAM's bill before I finish.

Tonight, I introduced an amendment that is called the tripartisan bill. I introduced it on behalf of Senator GRASSLEY for himself, Senators SNOWE, JEFFORDS, BREAUX, COLLINS, LANDRIEU,

HUTCHINSON, DOMENICI, and myself. We believe this tripartisan bill is the only nonpartisan bill being considered by the Senate at this time. It is a very important effort by people of goodwill on both sides and, of course, the only Independent in the Senate.

I want to take this opportunity to talk a little bit about the tripartisan bill. Many of these points were raised two nights ago, when I spoke on the Senate floor about our tripartisan proposal. Tonight, I will raise them again because I believe that all of them are extremely important and worth listening to again.

While drafting this legislation, we tried to reach out to everyone who has an interest in this issue. We have taken this very seriously, and we have worked on it for well over a year. This has required many hours of meetings, among all of the sponsors of the bill and our staffs along with other interested parties. Let me assure everyone that this has been a unified effort, one which has required some give and take from all of us.

We have worked with CBO to come up with a cost-efficient solution. The Congressional Budget Office has told us that our bill will cost $370 billion over 10 years. As far as I know, the Daschle-Graham-Miller bill, S. 2625, does not have a CBO score, but I suspect that it is extremely expensive. The distinguished Senator may have some idea of what that score is because he has indicated that the amendment that he just introduced will cost around $600 billion, if I understand it, over 10 years. The prescription drug program in the Graham legislation would include a sunset at the end of 2010, which is one of the problems with this legislation.

On the other hand, there are no sunsets within our bill. Our tripartisan bill is a permanent solution, not a temporary solution. CBO informs us that once our bill is implemented, 99 percent of all seniors will have drug coverage. That would be truly remarkable. And that is CBO, not us.

Again, this is a nonpartisan approach to providing prescription drugs to Medicare beneficiaries. On the other hand, the Daschle-Graham-Miller bill sunsets after 2010. So in my opinion, that bill is only a temporary solution.

Does a temporary solution truly help seniors in the long run? I do not think it does. Our tripartisan bill provides all Medicare beneficiaries with affordable prescription drug coverage because we let competition determine the prices, not Government bureaucrats. That is how we keep prices of drugs down. It is not a good idea to let the Government set the price, which is what I predict will happen if the Daschle-Graham bill becomes law.

We also provide additional subsidies to low-income seniors so they, too, can afford to pay for their drugs. I find it absolutely appalling that there are people in our country who have to choose between buying food and eating, and having prescription drugs. The tripartisan group's goal is to put an end to that. Through our bill, we will provide additional assistance to those seniors who need it. For example, the 10 million beneficiaries with incomes below 135 percent of poverty will have 95 percent of their prescription drug costs covered by this plan with no monthly premium. They will not have to pay a monthly premium. In addition, these seniors are exempt from the deductible and will pay well under $5 for their brand name and generic prescriptions. Finally, these beneficiaries who reach the catastrophic coverage limit will have full protection against all drug costs, with no coinsurance.

The 11.7 million lower income beneficiaries with incomes below 150 percent of the poverty level are also exempt from the $3,450 benefit limit. Enrollees between 135 percent and the 150 percent of the Federal poverty level will also receive a generous Federal subsidy that on average lowers their monthly premium to anywhere between 0 and $24 a month. The beneficiary's monthly premium will be based on a sliding scale, according to his or her level of income.

It also cuts in half their annual drug bills. All other enrollees will have access to discounted prescriptions after reaching the $3,450 benefit limit and a critically important $3,700 catastrophic limit which protects seniors from high out-of-pocket costs. It is also important to note that 80 percent of Medicare beneficiaries will never experience a gap in coverage.

Let me take a few minutes before we finish this evening to talk about my views on S. 2625, the Daschle-Graham-Miller Medicare Outpatient Prescription Drug Act of 2002. I understand that a new Graham bill has been filed and we are currently reviewing the details. We have not been able to review it very thoroughly, but we have a quick preview of it, and perhaps I can express my thoughts this evening just so people will have something to consider over the weekend.

Again, I commend my good friend, a person I admire greatly, Senator BOB GRAHAM, for his bill. I know he has worked hard. I know he has tried his best. I know he is representing his people in Florida very well and he has worked long and hard on this issue. I respect him for that. I respect him personally. He knows that. He, like those in the Senate in the tripartisan group, has the same goal: To provide Medicare beneficiaries with prescription drug benefits. But that is where the similarities end.

My biggest concern with the new version of the Daschle-Graham bill is still the cost. My understanding is that this bill costs close to $600 billion, over a 10-year period. We all agree a Medicare drug proposal will cost a lot of money, but the Daschle-Graham-Miller bill is, in my opinion, too expensive to both current and future generations because of the magnitude of its costs.

And bear in mind, this bill is still not a permanent program. It sunsets. It sunsets after 2010, which makes it a less than 10 year benefit for approximately $600 billion. That is if I am right on the scoring. I believe having the sunset on such an important bill just to get a decent score from CBO is not being as fiscally responsible as I would like to be. I understand there is some window-dressing language that attempts to address the sunset, but to me that is all it is—window dressing.

Having said that, I am absolutely astounded that the AARP has come out and ask its members to support a bill that does not have a permanent benefit. That is just irresponsible on the part of the AARP. They are, in my opinion, not looking out for the best interests of seniors by asking their members to support this type of a bill. I am very disappointed in the AARP for making what I believe is a poor judgment call.

Again, one of my top concerns with the both versions of the Graham bill is the cost. It is not going to get better as drugs become more expensive and more and more baby boomers retire. I remind my colleagues, our Government is in a Federal deficit. Figures from last week reveal that the Federal deficit could be as high as $150 billion for fiscal year 2002. Passing a bill that I believe could cost well over $600 billion over 10 years is going to increase our deficit. That is, in my opinion, a step in the wrong direction.

The new Graham bill is still a one-size-fits-all bill that very well could lead to having the Federal Government set drug prices, although I know that is not the intention of my dear friend and colleague from Florida. That is, in my opinion, the wrong direction, as well. And why on earth should the Federal Government be making coverage decisions for seniors? I trust senior citizens to make their own decisions about their health coverage. Apparently, the authors of the Daschle-Graham-Miller bill do not agree and that is why they continue to put the Government in charge.

I look forward to the debate on Monday where we can discuss these issues more fully. If I am wrong on some of these suggested interpretations of my friend's bill, I would like him to set me straight on Monday when we debate this bill even further. I would like to know why anybody believes a sunset is necessary. That means the drug benefit ends. I hope we will have a CBO cost estimate we may review regarding the Graham legislation.

Again, I wish to point out that I continue to be concerned that under both versions of the Daschle-Graham legislation, the drug benefit is run by the Federal Government. I don't think that is a good idea, to let the Government run a drug benefit because the Government will end up setting prices for drugs. Keep in mind, Canada sets prices for drugs, and where is their pharmaceutical industry today? They have to look to us because we do not set prices for drugs and we have a competitive

system. Yes, some say it has flaws, but it is the best in the world, bar none. Frankly, with whatever flaws there are, we should be very proud of the system we have in our country.

In the tripartisan Medicare drug bill, we allow Medicare beneficiaries to make choices for themselves. They decide whether or not they want drug coverage. As I mentioned earlier, we allow Medicare beneficiaries to choose from at least two drug plans, and it maybe more, but at least two, competing plans, allowing them to select a plan that best suits their own personal needs.

Another difference between the Daschle-Graham bill and our Tripartisan bill is that we include reforms to the Medicare program and they do not. The current Medicare benefit package was established in 1965. While the benefits package has been modified occasionally, it now differs significantly from the benefits offered to those in private health plans. Our plan gives seniors a choice in their Medicare coverage seniors may remain in traditional Medicare or they may opt for the enhanced Medicare fee for service option which is similar to private health insurance. We do not force seniors to enter into the new enhanced fee for service plan. It is just an option. If beneficiaries want to stay in traditional Medicare that is fine.

We need to give seniors choices concerning their health care coverage. Seniors must be given improved health care choices through the Medicare program. It is extremely unfortunate that the Daschle-Graham-Miller bill does not recognize that the Medicare program needs to be improved so seniors can take advantage of the benefits that are offered by private health insurance. Keep in mind, our bill only costs $370 billion as scored by the Congressional Budget Office. Yet we still reform Medicare in addition to providing high quality prescription drugs to our people. There is nothing in the Daschle-Graham-Miller bill to improve the Medicare program. It just tacks on a prescription drug program and ignores the larger problem. Medicare beneficiaries deserve better.

Senator BREAUX deserves an awful lot of credit for our bill in this area. He has wanted to reform Medicare for a long time and has come close from time to time. This is the best opportunity to do it. I think he sees the value of what we have tried to do. He not only sees it, he helped implement it.

The larger problem is the overall Medicare benefits package which is outdated, inefficient and it does not provide seniors with decent health care options. Let me give you an example. Today, Medicare beneficiaries do not have any serious illness protection. Beneficiaries who are seriously ill end up paying a lot of money out of pocket for their health care coverage each year. In our Tripartisan legislation, if a beneficiary is covered under the new enhanced fee for service program, once that beneficiary reaches a catastrophic limit of $6000, the Medicare program pays 100 percent of any costs incurred by the Medicare beneficiary. I feel that is only fair. Those Medicare beneficiaries with serious health conditions should be offered a choice in benefit coverage so if they want serious, illness protection, they may have it. The Graham-Daschle-Miller bill does nothing to assist Medicare beneficiaries in these types of situations. The Daschle-Graham-Miller bill's answer is to provide seniors with a government-run prescription drug benefit that is extremely expensive, and, isn't even permanent. That just is not enough.

These issues that I have raised about the Daschle-Graham-Miller should have been debated by the Finance Committee. I admit the issues we have raised by the Tripartisan bill should have been debated by the Finance Committee. Who knows, maybe we could have come to some resolution. Maybe the authors of the Tripartisan bill and the Daschle-Graham-Miller bill could have come to some agreement through the Committee mark-up process. Maybe not. Sadly, we will never know because the majority leader wouldn't even give us an opportunity to mark-up a prescription drug bill in the Finance Committee.

I have been here for 26 years and, trust me, it is rare for the full Senate to be considering such an important bill before it is even considered by the Committee of jurisdiction. I am bitterly disappointed at how much the Senate has changed.

At the beginning of the 107th Congress, we all talked about working together in a bipartisan spirit because that is truly what the American people want from us. What happened to that bipartisan spirit? Why are we on the floor debating a bill that will affect the lives of over 33 million Medicare beneficiaries and millions of future beneficiaries without a Finance Committee mark-up? I just do not understand why members of the Finance Committee were not even given that opportunity and, in fact, completely excluded from the process, other than that we can file whatever bill we want to, which we have done.

I want to do everything I can to pass a Medicare prescription drug bill into law this year. But it appears that election year politics are more important than passing a well-thought out prescription drug bill which is extremely unfortunate.

I stand ready to work with my colleagues so that we can provide affordable prescription drug coverage to our Medicare beneficiaries this year. We need to have Medicare available for today's seniors, our children and our grandchildren. So let's stop playing politics and start working on getting a Medicare prescription drug bill signed into law this year. I have no doubt if the distinguished Senator from Florida and I could sit down together we could just work it out—I have no doubt about that. Unfortunately, it has gotten embroiled in some political aspects.

Again, I call attention to the tripartisan bill which has Democrats, Republicans, and the sole Independent. I believe that bill literally could provide an affordable drug benefit for Medicare beneficiaries, although it is still expensive. It could do what we really need to have done—not only on the prescription drug benefit aspect of this matter but also on the Medicare reform as well—and Medicare+Choice as well. To me, that is very important.

I look forward to working with my colleague from Florida and others on the floor and hope we can come to a resolution this year, so the millions of American citizens will have the benefits that we really should be delivering to them and which they need and which are right and just.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. Mr. President, as I indicated, I restricted myself this evening to discussing the essence of our proposal and what I think are the six principles against which every proposal should be evaluated. I defer until Monday a close evaluation of the legislation that has been introduced by our good friend from Utah and others. One of the things I do not want to do is to create a poisoned environment which will make it difficult, if not impossible, to do what I think seniors want, which is to arrive at a reasonable compromise that will provide them with a prescription drug benefit.

They have heard us too many times, as candidates, place in their living rooms on their television screens ads that pronounce our commitment to a prescription drug benefit for senior Americans.

Now is the time to deliver. I recognize that in a democracy that means we have to have at least a majority, and probably under the rules of the Senate not just a majority but three out of every five Senators be prepared to vote for a single piece of legislation.

Therefore, I reach my hand out across the aisle to two of my favorite colleagues, the Senator from Utah, who is now being joined by the Senator from Iowa, with whom I worked on many issues in the past, to say we look forward to engaging in that compromise.

I do want to have printed in the RECORD, and I ask unanimous consent to do so, the CBO estimate of our bill.

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

*Democratic Drug Bill—Preliminary CBO Estimates*

[In billions of dollars]

| | |
|---|---|
| Full Score (2005–12) | |
| Gross estimate | 594 |
| Score with % drug reduction from GAAP[1] | 584 |
| Score with Federal GAAP savings[2] | 576 |
| Score with Contingency (2005–10) | |
| Gross estimate | 421 |

| | |
|---|---|
| Score with % drug reduction from GAAP[1] | 415 |
| Score with Federal GAAP savings[2] | 407 |

[1] CBO estimate of Democratic drug bill assuming lower drug prices for Medicare beneficiaries that would result from enactment of the GAAP bill (S. 812).

[2] Estimate of Democratic drug bill assuming lower drug prices for Medicare beneficiaries that would result from enactment of the GAAP bill (S. 812) and savings from lower costs associated with prescription drugs that the government current pays for under the Medicaid, veterans, and other programs.

Mr. GRAHAM. Mr. President, the estimate of our bill is that, in conjunction with the underlying generic drug bill, if that passes and makes generic drugs more available, our bill, which would only charge a $10 copayment for generic drugs as opposed to a $40 copayment for brand name drugs—our bill would have a cost over the next 8 years of $407 billion—not $600 billion, or $800 billion, or, as some have even said, $1 trillion—and over the next 10 years would have a cost of $576 billion.

I might point out that this is the same program for 8 years that will cost $407 billion, and for 10 years will cost $576 billion.

That differential is a reflection of how significant two factors are: One, inflation of prescription drug costs; and, second, the change in the demographics of Medicare beneficiaries.

I happened to have been born in 1936. I was 65 years old on November 9 of last year. I belong to the second lowest birth rate year in the 20th century. Only 1933 had a lower birth rate than 1936. Therefore, there are not very many people my age. We are not putting a particular demand on Medicare or on the Social Security Program. But, in 10 years, it will be the people who were born in 1946—not 1936—which was the beginning of one of the greatest demographic revolutions in America history.

We are going to begin to feel the impact of that revolution at the outer years of the 10 years. We are now calculating the cost of this program. It is my judgment that it is critically important that we now get started on this prescription drug benefit so that we can learn as much as we possibly can about what the implications are of delivery systems, of methods of providing benefits, and how to attract healthy, older citizens to participate in a prescription drug benefit—all the things that will be critical to the long-term stability of a prescription drug benefit. We need to start that process today when the demand is relatively low—not 5 or 10 years from now when the demand will begin to rapidly escalate.

We have before us two different visions of how to get to the same destination. The Senator from Utah has outlined a number of issues of concern to him. I look forward to having a full debate on Monday. Hopefully, we can frame each one of these issues, such as the relative benefits of using the Medicare system as a means of delivering prescription drugs, or delivering it through subsidized private insurance policies—the relative benefits of having what I call a ''defined benefit plan'' where seniors would know what they are buying as opposed to a defined contribution plan where there would not be that assurance.

Those are all legitimate issues for us to debate.

I suggest to my colleagues that they might take the time over the weekend to read the letters of endorsement from groups such as the AARP, which clearly has no interest other than representing the best interests of their millions of members—most of whom are part of this 39 million Americans who are Medicare participants because they are over the age of 65. There is no reason to suspect their motives, or that they have some hidden agenda other than what they think is in the interest of senior Americans.

I recommend reading their rationale for reaching the conclusion of their support for our proposal.

I conclude tonight with a sense of optimism. We have gotten further this week than we have gotten in a decade in terms of closure on providing our older Americans with a key but missing part of their health care coverage; that is, assistance with their prescription drug costs.

I hope next week we can complete this by the passage of a prescription drug bill recognizing that we have to negotiate with the House, and then secure final passage, and hopefully gather in the Rose Garden where I suspect that the President will, with great enthusiasm, be there to sign this bill into law and provide what America's older citizens have so long sought, an affordable, comprehensive, and universally available prescription drug benefit.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I am surely glad that this debate has begun. It is too bad we could not have started the debate on this bill on Monday or Tuesday of this week when the majority leader led us to believe that we would be doing nothing but prescription drugs until we got it done.

I am glad that we now have Senator GRAHAM's alternative before us.

I thank Senator HATCH, who took the position as manager, while I was on the CNN program just a few minutes ago, to introduce the tripartisan bill on my behalf. That bill is a comprehensive prescription drug bill that represents a year of hard work by dedicated members of the Finance Committee, the committee that has jurisdiction over Medicare.

We have Senator GRAHAM's bill that you have heard about tonight. Then we have this tripartisan bill. People wonder what the term ''tripartisan'' means. It means three Republicans, one Democrat, and one Independent in the Senate, but it also implies bipartisanship, or across-party cooperation that must be done to get any bill passed in the Senate.

Our legislation is called the 21st Century Medicare Act. It makes essential improvements to Medicare by adding the comprehensive prescription drug benefits, and a new Medicare fee-for-service option to the 1965 program. These are all first improvements in Medicare since it was introduced in 1965.

As I indicated to you, I have been honored to work with a top-notch group of Senators on this bill. That tripartisan group is OLYMPIA SNOWE, a Republican; JOHN BREAUX, a Democrat; JIM JEFFORDS, an Independent; and ORRIN HATCH, a Republican. The group has dedicated countless hours to this effort.

I must express my disappointment that the Senate Finance Committee has not had an opportunity to consider legislation as part of the committee process. I trust that Senator GRAHAM of Florida will feel the same way. However, the bottom line is America's seniors have waited too long—and too long already—for Medicare prescription drug coverage.

The House has acted in their fashion. The Senate must act as well. We cannot afford to waste a single day.

I look forward to debating this important issue over the next few days and hope that the same bipartisan spirit of cooperation and compromise that guided the tripartisan group over the last year to write this bill will guide all Senators in this Chamber to an agreement that will give long overdue help to our seniors.

Since the tripartisan bill is now introduced, since we have the Democrat version, and Senator GRAHAM's bill is introduced, and since there is some misunderstanding of the differences between the two, I will take just a little bit of time to go over those. I also will take just a little bit of time to express some differences between the bill that passed the House of Representatives because some people have alluded to that bill as something just exactly like the tripartisan bill, which it is not.

In regard to differences between Senator GRAHAM's proposal and the tripartisan proposal that I have offered, the first would be cost.

The sheer magnitude of Federal spending in the Senate Democrat bill—an amount that is obscured by a sunset provision that kills the benefit in 2010—threatens Medicare's long-term stability. As such, the Senate Democrat bill gives seniors temporary help, not a permanent entitlement.

By contrast, the Congressional Budget Office official estimate concluded that the tripartisan 21st Century Medicare Act totals $370 billion over 10 years, a figure that guarantees permanent, affordable drug coverage without breaking the Medicare bank.

There is also the issue of choice that separates the tripartisan plan from the Democrat plan. The Democrat plan relies on the Government to pick one standard prescription drug plan for over 40 million seniors with Medicare. The one-size-fits-all approach means seniors cannot shop for a prescription drug plan that best suits their needs.

Under the tripartisan 21st Century Medicare Act, seniors are guaranteed to have at least two competing prescription drug plans in their community, even in rural areas, using local pharmacies as well. Seniors will have the choice of picking plans on the basis of cost, benefits, and quality. All plans will be required to meet Federal quality standards and to provide a standard benefit package, or its actuarial equivalent, including a $3,700 cap on out-of-pocket drug expenses for seniors.

There is a difference in drug pricing. Because the Democrat plan is overly bureaucratic and excessively generous, that plan does nothing to curtail or even slow skyrocketing prescription drug costs. That is why it is essential that any new prescription drug benefit contain cost management controls that moderate growth in price.

While guaranteeing a comprehensive drug coverage for all citizens, the tripartisan 21st Century Medicare Act imposes reasonable cost-sharing obligations on beneficiaries and promotes competition among prescription drug plans. And with competition being promoted in the bill, that then leads to a better overall effect on drug prices. And that, again, is according to the nonpartisan Congressional Budget Office that does policy analysis and scoring for the Senate.

The other issue is affordability, affordability for seniors. Under the Senate Democrat plan, seniors face fixed copayment amounts that, in many instances, mean they will actually pay more for many of the most commonly prescribed drugs than they would under a system that gives prescription drug plans more flexibility to offer lower cost copayments.

That flexibility is a feature of the tripartisan 21st Century Medicare Act because it gives plans the freedom to offer copayments and deductibles that save seniors more money. Moreover, the tripartisan proposal has a lower average premium than the Democrat plan, and that would be $24. Again, this is according to a Congressional Budget Office estimate.

We have Medicare enhancements in the tripartisan bill that the Senate Democrat plan does not have because that plan leaves current Medicare as it is and simply dumps a massive entitlement expansion, which would be the prescription drug plan, into the old 1965 model.

The tripartisan 21st Century Medicare Act takes long overdue steps to strengthen and improve Medicare's basic benefit package. In addition to adding prescription drug coverage, the bill offers seniors a new enhanced option, including catastrophic protection and free—let me emphasize, free—preventive care; in other words, adopting the principle that an ounce of prevention is worth a pound of cure.

This entire enhanced option is voluntary. If seniors like what they have had since 1965, they do not have to sweat it. They do not have to do it. They can keep what they have. Even 50 years from now they will still have that same choice, but they can also have the enhanced coverage as well. So it is voluntary. And Medicare, as we know it today, will always remain available to seniors who prefer to keep what they have, if they like it.

Improvements are made to yet another coverage option. That coverage option exists today. Medicare+Choice plans are also included. Beneficiaries need not elect the enhanced option in order to have access to the drug benefit plan.

I will finish, then, with a short description of why what the House of Representatives passed has nothing to do with the tripartisan plan.

The tripartisan plan was adopted on principles and pricing and costs, the way the five of us decided to do it. For instance, the House bill has a higher average premium. This is according to the CBO estimate. The average premium under the House bill is $34 per month. The average premium under the tripartisan 21st Century Medicare Act is substantially more affordable, at just $24 per month.

We have a much better benefit. The House bill limits the initial prescription drug benefit to $2,000 before exposing seniors to a gap in coverage. The tripartisan 21st Century Medicare Act basic drug benefit is better and is richer than that in the House bill. Seniors will have drug coverage under the tripartisan plan worth 50 percent of their drug spending up to $3,450 after the deductible is met, and that is $1,450 more than what the House bill offers, even in its initial benefit.

We have greater protection for low-income seniors in this Senate version. The tripartisan 21st Century Medicare Act steps in to give more help to low-income seniors where the House bill does not. It provides full assistance with premiums and substantial assistance with cost sharing for seniors below 135 percent of poverty with no gaps in coverage. For seniors between 135 percent and 150 percent of poverty, assistance with premiums and cost sharing is provided on a sliding scale, also with no gaps in coverage. This critical additional coverage for our most vulnerable seniors is an important distinction that reflects the tripartisan commitment to universal, affordable drug coverage for all.

And then, lastly, I will speak about our enhanced option to which I have already referred. The House bill leaves the 1960s-style Medicare largely as it is today. It does provide $30 billion in additional funds to Medicare providers, but it does little to strengthen or improve Medicare's basic benefit package.

Rather than addressing provider payment issues, the tripartisan 21st Century Medicare Act addresses Medicare's benefit flaws. It offers seniors a voluntary enhanced option, including catastrophic protection, free preventive care, and better Medigap plans.

The new option would be offered alongside current fee-for-service Medicare and a strengthened Medicare+Choice. Seniors can keep what they have if they like it or choose the new option. In all three settings, access to affordable prescription drug coverage would be guaranteed.

I just mention the difference, that the House bill does not have a new and improved and modernized Medicare option that we have in the tripartisan bill.

(Mr. JEFFORDS assumed the Chair.)

Mr. GRASSLEY. Since the distinguished Senator from Vermont has now come to the chair to be the Presiding Officer of the Senate, it gives me an opportunity to say that this provision in the tripartisan bill, of improving Medicare, bringing Medicare from a 1965 model to a 21st century model, improving it beyond the prescription drug provisions, was very much a concern of the Senator from Vermont, the Independent member of the Senate, Mr. JEFFORDS. I thank him very much for his contribution to that.

It really has probably done as much for Medicare as the prescription drug provisions will, as we look to the day when we have baby boomers going into transition from their employer's health plans to Medicare. There will be a smooth transition if they choose the enhanced option; whereas all the other plans, including the Republican plan in the House of Representatives, including even the President's plan, Medicare will still be a 1965 model. And for baby boomers going from their modernized employer's health plan to the 1965 model of Medicare, if that is the only choice they had, it would not be a very good day for those baby boomers going into retirement.

It has been such a pleasure to work with Senator JEFFORDS on this whole package, but most importantly, to have his leadership on this part that deals with the enhanced option, the new and improved and strengthened Medicare.

Mr. KENNEDY. Mr. President, I ask unanimous consent to have printed in the RECORD this letter to Mr. Carl Feldbaum of the Biotechnology Industry Organization.

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

U.S. SENATE,
*Washington, DC, July 18, 2002.*

Mr. CARL B. FELDBAUM,
*President, Biotechnology Industry Organization, Washington, DC.*

DEAR MR. FELDBAUM: I was surprised to receive you letter of July 15, 2002, opposing S. 812. The Greater Access to Affordable Pharmaceuticals Act (the GAAP Act or Schumer-McCain). The record is abundantly clear that the pharmaceutical industry is exploiting loopholes in our Hatch-Waxman drug patent laws to block less costly generic drugs from coming to market. As our hearings revealed, these actions hurt millions of American patients who are burdened with rising health care costs.

The exciting new cures brought forward each day by America's biotech companies are paving the way for what I believe is the new

century of the life sciences, and I remain a proud champion of the biotechnology industry in Massachusetts and across the nation. It is important, therefore, as an industry concerned about the health of all Americans, for BIO to acknowledge the harm to American patients and consumers caused by today's Hatch-Waxman abuses. Clearly, collusive agreements between brand-name companies and generic companies to block cheaper generic drugs from coming to market do not serve the public interest. Similarly, patients are harmed when generic drugs are stymied year after year by unfounded patent evergreening for brand name drugs. I would strongly encourage BIO to be part of the solution to these challenges.

The Schumer-McCain legislation addresses these abuses and restores the balance intended under the Drug Price Competition and Patent Term Restoration Act of 1984 (the Hatch-Waxman Act). As your letter expresses concerns about the legislation, this letter describes in further detail the Committee's intent in addressing them,. The issues you raised include incorrectly listed patents or patent information with the Food and Drug Administration (FDA), use of patents to trigger multiple thirty month stays that delay effective approval of generic drugs, collusive agreements between brand and generic pharmaceutical companies to block subsequent generic applicants from gaining effective approval of their drug products and litigation attacking FDA's bioequivalence regulations that have delayed entry of generic versions of drugs.

THE 45 DAY PERIOD TO ASSERT PATENT RIGHTS

You express concern that a patent owner's rights will be forfeited under Schumer-McCain. I want to reassure BIO that this is not the case.

Section 4 of Schumer-McCain says that a patent owner that does not sue within 45 days of receiving notice that a generic drug applicant has challenged its patent will be barred from suing that generic drug later.

This provision provides the patent owner with the opportunity to protect its patent rights. It also clarifies those rights in relation to the generic drug product at issue if the patent is not defended, thereby enabling the generic drug product to be marketed immediately. The 45 day period may be thought of as a statute of limitations, and Congress has plenary authority to establish statutes of limitations for federally created rights such as patents. In addition, comparable periods of time for claiming or defending property rights have been upheld by the Supreme Court.

This provision does not eliminate the patent owner's rights against the generic drug applicant and its generic drug product. Rather, it specifies the time within which the patent owner must assert those rights against that applicant and its drug product.

I cannot overemphasize that the bar on enforcing the patent right under this 45 day rule applies only to the particular generic product of the particular generic company that has challenged the patent in its generic drug application. It does not affect the ability of the patent owner to enforce its rights with respect to any other generic company, or with respect to a licensee who strays beyond the bounds of a licensing agreement under which the patent owner has licensed use of the patent.

That being said, I also point out that the bar does protect downstream distributors of the particular generic drug product, such as wholesalers and pharmacies, as well as doctors and patients who will use the generic drug product for treatment.

ENFORCEMENT OF THE PATENT LISTING REQUIREMENT

Seciton 3 of Schumer-McCain says that a patent owner cannot enforce its patent against a generic drug company, or a person who manufactures, develops, uses, offsets to sell, or sells a generic drug, if the patent owner has failed to list the patent information at FDA. This provision provides an effective enforcement tool for a current requirement.

Drug companies are required currently to list patents at FDA, and I am not aware of any complaints about this requirement from the brand pharmaceutical industry. We understand that now companies generally comply with this requirement because patents can trigger 30 month stays of the effective approval of generic drugs.

As you know, however, Section 4 of Schumer-McCain limits 30 month stays to one per generic application, and on only certain patents. The Committee's concern was that limiting 30 month stays in this way reduces the incentive to list patents. We therefore concluded that we needed to provide an effective incentive for compliance with the current requirement to list patents at FDA. Otherwise, we were concerned about increased abuses of the listing requirement.

Currently, under section 505(e)(4) of the Federal Food, Drug, and Cosmetic Act (the FFDCA), FDA can withdraw a drug from the market if the patent information is not filed after the agency gives written notice of failure to file the information. FDA has never used this enforcement tool, and it would not withdraw a drug from the market for this reason when the drug presumptively is being used safely for treatment of patients by health care providers. I believe that Section 3 of Schumer-McCain provides effective enforcement of the FDA listing requirement.

Your letter raises the real concern about situations in which a patent is not listed, or the information is incorrect, because of an oversight or a clerical error. But Schumer-McCain addresses this problem as well.

Section 3 of Schumer-McCain allows FDA to extend the date for listing patents if there are extraordinary or unusual circumstances. An honest administrative or clerical error is clearly such a circumstance. Because FDA publishes patent information immediately upon receipt, the drug company and the patent owner can promptly check that patent information is published and that it is correct. If there is an error, or a patent was not listed, the error can be spotted quickly and immediately corrected. Accordingly, Schumer-McCain allows patent owners to avoid the consequences of the inadvertent failure to list a patent with the FDA.

THE CAUSE OF ACTION TO DELIST OR CORRECT A PATENT

Your letter also raised questions about the cause of action in Section 3 of Schumer-McCain to delist patents from FDA's Orange Book or to correct patent information. In particular, BIO is concerned that generic companies will bring these cases unnecessarily, to harass a drug company or patent owner. I do not believe that this will be the case.

A generic drug company must certify to the patents listed on a drug when it files a generic drug application. A generic company must do so even if it intends to seek the correction or delisting of a patent.

If a generic wants to delist a patent or correct information, it will likely chose to make a paragraph III certification to the patent, saying that the applicant does not contest the patent and requesting that its drug approval be made effective when the patent expires. The generic applicant will then sue to have the patent delisted or corrected.

If it wins, the patent is delisted, or the patent information is corrected so that the generic applicant may make a statement that the applicant is not seeking approval for a use claimed in the patent. In either case, no certification is necessary and the paragraph III certification essentially goes away.

Should the generic applicant lose a delisting case, however, it will have to recertify and challenge the patent under paragraph IV. This could trigger a 30 month stay, and at a minimum would delay the resolution of the patent issues involved. It is therefore my view that there are strong incentives for generic applicants to bring these delisting cases only when there is strong merit to the case. Because this is the case, it is difficult to argue that delisting cases will be either unnecessary or harassing.

To the contrary, in such cases, the delisting of a patent, or correction of patent information, serves a public good. This is because a patent to which other generic drugs would otherwise have to certify is instead either delisted or corrected so that no certification is necessary. In such cases, generic drugs may get more quickly to market, to the great benefit of consumers.

BIOEQUIVALENCE

BIO requests that section 7 of Schumer-McCain be stricken in its entirety. I do not believe this provision raises the concerns that BIO thinks it does.

Section 7 allows FDA to amend its regulations, but it does not say that those amended regulations are legitimate exercises of authorities under the FFDCA. Only the current regulations are identified as continuing in effect as an exercise of authority under the FFDCA. Should FDA ever amend its bioequivalence regulations, they would be subject to judicial review under the Administrative Procedure Act.

Indeed, earlier drafts of section 7(a) covered the FDA's current regulations and successor regulations. But we did not intend to protect amended regulations from judicial review, so the language on successor regulations was removed.

Also, under section 7(a), the application of the current regulations in any particular case would be legitimate issues for judicial review under the Administrative Procedure Act. So FDA can be challenged if its application of those regulations will pose potential risks to patients or to public health.

Finally, BIO believes that section 7(c) is inadequate. This language, which we added in part in response to concerns from BIO, says that section 7 shall not be construed to alter the authority of the Secretary of Health and Human Services to regulate biological products under the Federal Food, Drug, and Cosmetic Act. Any such authority shall be exercised under that Act as in effect on the day before the date of enactment of this Act.

This language is very similar to a statement that Senator Jeffords and I made on December 3, 1997, in a letter to Michael Friedman, then Lead Deputy Commissioner at FDA. It makes it clear that we are not changing FDA's authority under the FFDCA over biological products—in particular that we are not making changes to newly authorize the approval of generic biologics under the FFDCA. That was good enough in 1997 and should be good enough today.

I remain committed to the reforms of the Hatch-Waxman Act provided for in Schumer-McCain, just as I remain committed to a strong and vibrant biotechnology industry, both in Massachusetts and throughout the nation. I believe that the adjustments to the Hatch-Waxman Act found in Schumer-McCain correct imbalances in and will stop abuses of the generic drug approval process that have arisen in recent years. I do not believe that these reforms will adversely impact in any way a company or patent owner

that diligently sees to its legal rights and obligations under Federal law.

I hope that this letter addresses your concerns, and I remain willing to work closely with my many friends in the biotechnology industry in Massachusetts and elsewhere as this legislation moves forward.

Sincerely,

EDWARD M. KENNEDY.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

## MORNING BUSINESS

Mr. REID. Mr. President, I ask unanimous consent that the Senate now proceed to a period of morning business with Senators permitted to speak for up to 5 minutes each.

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

## UNANIMOUS-CONSENT REQUEST—H.R. 3210

Mr. REID. Mr. President, I ask unanimous consent that the Senate proceed to immediate consideration of Calendar No. 252, H.R. 3210, the House-passed terrorism insurance bill; that all after the enacting clause be stricken, and that the text of S. 2600, as passed the Senate, be inserted in lieu thereof; that the bill, as amended, be read a third time, passed, and the motion to reconsider be laid on the table; that the Senate insist on its amendment, request a conference with the House on the disagreeing votes of the two Houses; and that the chair be authorized to appoint conferees on the part of the Senate with the ratio of 4 to 3; all without intervening action or debate.

I have indicated I was going to propound this. I know there is no one present from the other side. I object on behalf of the minority, the Republicans. I do that with some reluctance because we have to move this legislation forward. It is important. I don't do this to embarrass anyone or to try to minimize what is taking place. In fact, it is just the opposite. We have to move forward on terrorism insurance.

I get calls in my office every day saying: Why can't you move this bill? The reason we can't move it is because we have an objection. I repeat what I said yesterday and the day before and the day before: We fought to get this bill on the floor. We were held up getting the bill on the floor. Once we got the bill passed, then we have fought to get conferees appointed.

The sad part about this is we were told initially: We don't like the ratio; the ratio is three Democrats to two Republicans.

We said: What do you want?

They told Senator DASCHLE: We want four Democrats, three Republicans.

We said: Fine, we will go for that.

They still won't let us clear this. It is my understanding the House is going out of session for the summer next Friday. So we have just a few days to do this. Everyone should understand why it is not being done.

The PRESIDING OFFICER. Objection is heard.

Mr. REID. I will put it back on my desk, and I will return with this in the future.

## TRIBUTE IN REMEMBRANCE OF DAVIS O. COOKE

Mr. THURMOND. Mr. President, I rise today to pay tribute to the late David O. Cooke, Defense Department Director of Administration and Management. I would like to offer my condolences to Mr. Cooke's three children, Michele, Lot and Davis, along with his other family members, friends, and coworkers. Mr. Cooke has truly imprinted an everlasting legacy on the American defense system and our great Nation. Although our Nation mourns for this tragic loss, we must remain strong in honoring such an outstanding individual. For six decades, David O. Cooke served the federal government distinguishing himself as one of the most exceptional and honorable civil servicemen of our time. He was truly a visionary, epitomizing the core values of exemplary public service. I ask unanimous consent to have printed in the Record an article from the Washington Post.

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

[From the Washington Post, June 27, 2002]

DAVID COOKE, 'MAYOR OF THE PENTAGON,' DIES

(By Graeme Zielinski)

David O. ''Doc'' Cooke, 81, the high-ranking administrative director who was known as the ''Mayor of the Pentagon'' for his work over six decades to keep the gargantuan complex humming, died June 22 at the University of Virginia Medical Center.

He died of injuries received June 6 in a car accident two miles north of Ruckersville, Va., when his vehicle veered off Route 29 and rolled over several times, Greene County Sheriff William Morris said yesterday. It wasn't known what caused the accident, Morris said.

Mr. Cooke had served at the Pentagon since the late 1950s and as its top civil servant had a hand in every major Defense Department reorganization during that time. He knew virtually every inch of the 20 miles of corridors in the building and was the department's highest-ranking career civil servant.

As Defense Department director of administration and management, he had a vast institutional memory and numerous friends spread throughout Washington's power structure. It meant that he had the ear and respect of flag officers, members of Congress and Cabinet officials—and not only because he dispensed office space and the Pentagon's 8,700 parking places.

In a 2001 edition of Government Executive Magazine, editor Timothy B. Clark called Mr. Cooke ''a force for good in the federal government.''

Mr. Cooke's many honors included seven awards of the Defense Medal for Distinguished Civilian Service. In 1999, he was given the President's Award for Distinguished Federal Service, the highest government service award.

Mr. Cooke called in some of his considerable chits in the late 1980s and early 1990s as he argued vociferously for a billion-dollar renovation of the Pentagon. Up until Sept. 11, it was scheduled for completion in 2004.

The hijacked airliner that slammed into the side of the building that day, killing 189 people, hit a wedge of the Pentagon that had undergone upgrading. Some of those features supported by Mr. Cooke have been credited with saving many lives.

''The steel that we used to strengthen the walls, the blast-resistant windows, the Kevlar cloth, all those things working together helped protect countless people,'' Walker Lee Evey, the program manager for the Pentagon renovation, said. ''Doc Cooke strongly supported all of these.''

Mr. Cooke also was a strong supporter of the government as an institution and was active in good-government groups and community service projects.

He served on the President's Interagency Council on Administrative Management and was a leader of the Combined Federal Campaign and an active member of the American Society for Public Administration.

In the early 1990s, he worked to create a Public Service Academy at Anacostia High School that has been credited with improving the school's graduation rates. He also was known in the Pentagon as a strong promoter of employment opportunities for minorities, women and disabled people.

Mr. Cooke was born and raised in Buffalo, where his parents were teachers. He began following their path, receiving a bachelor's degree from the New York State Teachers College at Buffalo and later a master's degree in political science from the State University of New York at Albany.

His teaching career was interrupted by World War II, when he served as an officer aboard the USS Pennsylvania, a battleship that saw action in the Pacific.

Mr. Cooke returned to teach high school in Buffalo in the late 1940s, but was recalled to the Navy during the Korean War. After getting his law degree from George Washington University in 1950, he served as a Navy attorney and instructor.

His Pentagon career began in 1958, when he was assigned as a civilian to a Defense Department reorganization sought by then-Secretary Neil McElroy.

Mr. Cooke retained his professorial ways throughout his career, but his humor often helped leaven the serious atmosphere in the Pentagon. Mr. Cooke was just as likely to quote a Greek philosopher as a pithy joke or homespun tale.

Evey, the Pentagon renovation manager, recalled an aside at a dedication ceremony last summer. ''He said that he took it as a sign that the building needed to be renovated when the fungus on the wall took the shape of Elvis,'' he said.

Mr. Cooke was not laughing when he argued in the 1980s for the renovation and for the Pentagon to be transferred from under the auspices of the General Services Administration to the Defense Department. He said it was a crucial step in rehabilitating the world's largest office building.

Mr. Cooke would make routine trips to Capitol Hill with what he called his ''horror board,'' a convincing collage of fallen asbestos or rotted piping from the Pentagon.

In 1998, Mr. Cooke testified before a federal grand jury about alleged leaks by then-Assistant Defense Secretary Kenneth Bacon of