so I will not support it. But what is really interesting is that many of those who oppose this bill are actually supporting a proposal that is significantly more costly to the taxpayers. So I suggest people take a look to see who votes against this bill on the basis it exceeds the amount of money we have set aside by $70 billion and then perhaps votes for a bill that is $700 billion, $800 billion, $900 billion—or a trillion dollars—perhaps twice or three times the cost of this bill.

My point is a number of my colleagues could find themselves in the position of voting against one bill because it costs too much only to turn around and support a competing bill that is two or three times more costly.

Beyond cost to taxpayers, there are other important policy differences between the two Medicare drug benefit proposals. I believe the most important is that the tripartisan bill stretches Federal dollars further than any other proposal and provides a permanent, comprehensive drug benefit that's affordable for seniors and taxpayers. This is a critical achievement.

And, the bill does even more. It provides seniors with the option of an expanded fee-for-service plan, including drug coverage, that will serve as the first modernization of the scope of benefits under Medicare since the program was created almost 40 years ago.

Lastly, while Medicare managed care plans—known as Medicare Plus Choice plans—are not serving Wyoming, millions of seniors across the country made the ''choice'' to enroll in those plans, and this bill makes long overdue improvements to how those plans compete for seniors' business. My colleagues from more populous and urban states undoubtedly know that seniors who have Medicare Plus Choice plans as an option now want to keep that option and want to see it expanded and improved.

All of this sounds like a lot. And it is. But I won't stand here and tell my constituents in Wyoming that this is everything they might dream of in a prescription drug benefit. It is a giant step forward and it will absolutely reduce the drug costs seniors bear today. It won't make those costs disappear, but it will dramatically reduce them. And, it's a benefit we can afford to enact for seniors today and keep our promise to implement it in 2005. The proponents of the Daschle bill are also making seniors promises about a great new drug benefit. Except we can't afford it, so it's a hollow promise.

The opponents of the tripartisan bill will say that our bill doesn't provide a real benefit to seniors. Well, here's the skinny on our bill and what it will save seniors in out-of-pocket costs. The Congressional Budget Office (CBO) determined that Medicare beneficiaries will spend an average of $3,059 per year on drugs in 2005. If enacted, this bill would cut those costs by 53%—a savings of over $1600. That is real money. CBO also determined that the bill would cut costs for lower-income beneficiaries at or below 135% of poverty by 98%, a savings of $2,988! The estimated out-of-pocket cost per prescription among the 50 most-prescribed medications would be $21. And, every beneficiary would have at least 2 drug plans to choose from when selecting the plan that best fits their health care needs.

The Democrat bill, on the other hand, has a statutorily prescribed cost sharing for all drugs that the government decides to include in the plan, and every senior must participate in that one-size-fits-all plan. That's a concerning and very significant difference from the tripartisan bill. All of us in this body have numerous choices of health plans both at and above the standard benefit package under the Federal Employees Health Benefit Program. I do not believe seniors should be—by law—without a choice in their own health coverage. Unlike the tripartisan bill, the Daschle bill completely misses the opportunity to improve Medicare through expanded choices for seniors when selecting the right drug coverage.

To restate another distinction I raised earlier, the tripartisan bill has been officially scored by the CBO to cost $370 billion over 10 years. The sponsors of the Daschle bill have not provided us with an official score, but the unofficial scores are as high as $1 trillion over 10 years. More importantly, the drug benefit is not permanent under the Daschle bill. It would sunset in the year 2010. That is to hold costs down as much as possible. There are rumors of a 4th iteration of the bill that would not sunset the benefit, but that bill has not been introduced and will be much more costly.

Since I'm talking about the cost of the Daschle bill to taxpayers, I would be remiss if I did not talk about the cost of the bill to seniors themselves. Because the bill would cement in Federal law fixed co-payment amounts for all drugs, seniors will actually pay more for certain drugs than they would if the bill allowed drug plans to offer lower co-payments. The CBO analysis and score of the tripartisan bill proves that it employs this logic and essentially proved that drugs will be provided in a more cost-effective way under the tripartisan model.

I have mentioned it before, but I just want to say again that, in addition to the very high profile issue of needing to provide a drug benefit, Medicare has many other shortcomings. It is crying out for updating and improvements. No one in this chamber can possibly be satisfied with the program's status quo. Every day—literally—I either meet with or hear from my constituents who interact with the Medicare program or beneficiaries. They are all complaining, and rightly so. The program was created with the best of intentions. But since that day some 40 years ago, the rest of the health care world has evolved and improved, from standards of care to technology to disease management. Not to mention how providers are reimbursed and empowered in the delivery of health care services. I question whether any of this progress has penetrated the morass of the Medicare program. In fact, all I seem to hear from my constituents is that things are pretty bad with Medicare right now. That is before the new program is started.

I am astonished that only one of the two major bills—the tripartisan bill—tries to address the other problems with Medicare. The foundation of the program desperately needs reinforcement; simply building on its weak foundation the way the Daschle bill does is dangerous and falls short of our obligation to do our best for seniors where all of their health care is concerned. Where the tripartisan bill has an enhanced fee-for-service option and improvements to the existing Medicare Plus Choice option, the Daschle bill is eerily silent. Such an absence of reform will only cost seniors more money in patch jobs down the road.

I guess I have come full circle. This debate is all about giving seniors additional coverage options and saving them money. Many seniors currently lack drug coverage. All of the bills will give them coverage and cost them less out-of-pocket than what they pay right now. But only the tripartisan bill will give them flexibility in their coverage choices and buy them and taxpayers the most that a dollar will buy. That takes competition and modernization. The tripartisan bill has both. The Daschle bill prohibits competition in its statutory language and does not entertain even modest improvements to the rest of the Medicare program.

The choice is clear to me and, I imagine, will be crystal clear to the American people. For that reason, Mr. President, I would ask unanimous consent that I be added as a cosponsor of the 21st Century Medicare Act.

The PRESIDING OFFICER (Mr. CORZINE). Without objection, it is so ordered.

Mr. ENZI. Mr. President, I yield the floor.

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

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

The Senator from Colorado is recognized.

Mr. ALLARD. Mr. President, I ask unanimous consent that I be allowed to speak for 20 minutes in morning business.

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

THE SENATE HAS NOT PASSED A BUDGET

Mr. ALLARD. Mr. President, I wish to express to the Senate my sincere

disappointment that we have not passed a budget. It has been 27 years since we have had this budget process in place in the Senate. This is the first time we have not had a budget plan passed out of the Senate.

If we are going to begin to talk about the need for various programs, it would certainly be helpful if we had some idea of where our limits were. I happen to believe we need to work to eliminate our deficit spending. We need to work to make sure we are trying to hold down the growth in our total debt.

MEDICARE PRESCRIPTION DRUG BENEFIT

Mr. ALLARD. Mr. President, I think it is vitally important that the Senate pass a Medicare prescription drug benefit plan now. Our seniors need it, our seniors have been waiting for years for it, and our seniors deserve it now.

Medicare is a health care entitlement program for the elderly. Since Medicare was established in 1965, Congress has considered adding a prescription drug benefit to the program. In the 106th Congress, the Senate got serious about enacting a benefit but was unsuccessful in their efforts.

I hope the Senate is successful now. I am concerned, however, that the legislative process has been derailed. The majority leader decided to bring to the floor S. 812, the Greater Access to Affordable Pharmaceuticals Act. This legislation did not proceed through the Committee on Finance. In order for a revenue measure to not face a Budget Act point-of-order, legislation must proceed through the Committee on Finance. S. 812 did not. As a result, the Senate is left with assuming budget points-of-order against any and all revenue legislation as we continue debate this week.

This is unacceptable. Seniors need drug coverage now. But the Senate majority has stalled the process. I hope seniors across the United States realize what has happened. This faulty procedure is robbing seniors of their drug benefit, which Congress and the President support but which the Senate is denying. Politics is superseding policy and that is simply unacceptable.

Because S. 812 did not proceed through the Committee on Finance, next week the Senate will take up the Graham-Miller, tripartisan, Hagel-Ensign, and Smith-Allard amendments in an attempt to provide a prescription drug benefit. We can only hope that the Senate will waive the budget point-of-order raised against these measures.

I have serious concerns about the legislation introduced by Senators GRAHAM and MILLER. Graham-Miller would be a temporary drug benefit, without secure financing. Graham-Miller would raise drug prices significantly, and Graham-Miller would not be able to be implemented as proposed. Graham-Miller would have an immeasurable and possibly unlimited cost.

Senator GRAHAM's bill does not even have a CBO score. That is another concern I have. Preliminary estimates are that it would cost at least $400 billion to $800 billion over only 6 years. With two-thirds of seniors already obtaining their prescription drugs independent of Government, the Graham plan, frankly, is too generous at a time when Social Security solvency is at risk. According to CBO, Medicare beneficiaries will utilize $1.8 trillion worth of drugs over the next 10 years. But $1.1 trillion of this $1.8 trillion will be paid by third parties, such as employers, States, and Medicare+Choice plans. Drug benefit proposals should focus on reducing the $700 billion that will be paid by beneficiaries, not shifting the remaining $1.1 trillion to the Federal budget. Seniors and taxpayers need a plan that provides a benefit that does not blanket seniors with costs completely covered and that does not break the Nation's bank. Graham-Miller's cost alone is reason to oppose it.

Other Senate drug proposals are less expensive. The tripartisan 21st Century Medicare Act of 2002, introduced by Senators GRASSLEY, SNOWE, BREAUX, JEFFORDS, and HATCH, is estimated to cost about $350 billion from the years 2005 to 2012. For days, weeks, and months, the Senate Finance Committee members and staff have worked tirelessly to write a bill that expands drug plan options for seniors and refines and enhances Medicare+Choice, Medigap, and other programs. This tripartisan bill will establish a universal, voluntary prescription drug benefit with affordable premiums and special protections for low-income seniors. The tripartisan bill would add a new voluntary fee-for-service option to fit modern health benefit packages, and it will strengthen another drug option under Medicare+Choice.

I am pleased that this tripartisan group of Republican, Democrat, and Independent Senators have joined together to provide a Medicare prescription drug benefit. The tripartisan plan expands drug options for seniors so they can choose a plan that fits their needs.

I also laud the work of Senators HAGEL, ENSIGN, GRAMM, and LUGAR who introduced the Medicare Prescription Drug Discount and Security Act. The Hagel-Ensign plan would offer beneficiaries a voluntary drug discount card that they could use to purchase prescription drugs. The bill would cover catastrophic drug costs for beneficiaries under 600 percent of the Federal poverty level, so that seniors making less than about $53,000 will pay no more than $1,500 to $5,500 in out-of-pocket expenses. The bill also does not require monthly premiums, deductibles, or benefit caps. This bill is fiscally responsible, costing about $150 billion over 10 years. I commend Senators HAGEL and ENSIGN for their work in offering this voluntary plan for seniors who need it most.

Senator SMITH and I also have introduced an amendment to S. 812 that would provide a Medicare prescription drug benefit. Under our plan, the voluntary Medicare prescription drug plan, a Medicare beneficiary already enrolled in Medicare Parts A and B will have the option of choosing a new, voluntary prescription drug plan called Rx Option. This would cover 50 percent of their prescription drug costs toward the first $5,000 worth of prescriptions that the senior purchases.

Currently, Medicare Part A has a $812 deductible and Part B has a $100 deductible. The Smith-Allard plan would create one deductible for Part A and Part B of $675 that would apply to all hospital costs, doctor visits, and prescription drug costs. Once this $675 deductible is met by the Medicare recipient, Medicare will pay 50 percent of the cost toward the first $5,000 worth of prescription drugs that the senior purchases.

In addition, there is no benefit premium that would be required. Our plan is revenue-neutral. It is voluntary and will lower Medigap premiums by $550 per year.

According to the National Bipartisan Commission on the Future of Medicare, the Federal Government pays about $1,400 more per senior if the senior has a Medigap plan that covers his Part A and Part B deductibles. This generally is attributed to the fact there is overutilization of hospital and doctor visits by the senior because no deductible is required under Medigap, and seniors are more inclined to visit the hospital or doctor without having to pay a deductible.

The Smith-Allard plan would require seniors pay a deductible. As a result, Medigap utilization will decrease and savings are achieved. In other words, there is an incentive created for the senior to go to the doctor when he needs to and not simply because it cost him nothing.

The Smith-Allard plan would work as a stand-alone drug benefit or as a complementing, additional drug benefit in conjunction with the other drug options about which I talked earlier. Our plan has a number of features that both the Graham-Miller plan and the House-passed Medicare Modernization and Prescription Drug Act do not have.

I would like to take a minute to go over a chart I put together on Smith-Allard. This is the Smith-Allard proposal as compared to current law, as compared to the Democrat plan referred to as Graham-Kennedy, and as compared to the House GOP plan for prescription drugs.

This is assuming the senior has Medigap supplemental insurance. Under current law, there is no deductible with the doctor or the hospital when they have Medigap insurance coverage.

With the Smith-Allard plan, there would be a $675 deductible that would combine for both Part A and Part B of Medicare. Under the Democrat plan, there is no deductible, and in the House plan there is no deductible.