The prescription drug deductible is not covered in current law. It is combined in the Smith-Allard plan. There is no deductible in the Democrat plan and the House plan.

The average supplemental insurance premium under current law is $1,611. Under the Smith-Allard plan, this comes to $1,061. This remains the same under both the Graham-Kennedy and House GOP plan.

Prescription drug premium: Under current law, there is no coverage. Under the Smith-Allard plan, the prescription drug premium would be zero. Under the Democrat plan, the monthly charge that is talked about as $25 a month, this amounts to a $300-a-year premium, and the House GOP plan, which is $30 a month, amounts to an annual premium of $420.

Total annual premiums and deductible: Under current law, we stay at the $1,611 level. Under the Smith-Allard plan, it is $1,736. Under the Democrat plan, the Graham-Kennedy proposal, it is $1,911. And the House GOP plan is $2,281.

Let's look at the 10-year cost to the Medicare Program. Obviously, we do not have anything under current law. The Smith-Allard plan would remain at zero. The 10-year cost of the Medicare Program to the taxpayer is zero.

The Graham-Kennedy plan gets up to $600 billion, and some estimates are running between $400 billion and $800 billion; $600 billion is the number we use on this chart.

The House GOP plan comes in at $350 billion. Some are estimating $370 billion currently.

Who provides the drug benefit? Under current law, it is not covered. Under the Smith-Allard plan, Medicare provides that drug benefit. In the Graham-Kennedy bill, Medicare provides it. And under the House GOP, it is provided by the private insurance industry.

What is the comparison of drug coverage? Currently, there is no coverage. In the Smith-Allard plan, there is 50 percent coverage of all drugs up to $5,000. In the Graham-Kennedy plan, the senior pays $10 for generic drugs and $40 for brand name drugs. Then in the House GOP, there is 20 to 30 percent coverage up to $1,000 the senior pays, and then 50 percent between $1,000 and $2,250, and 100 percent over the $2,250, up to $5,000.

Let's look at the catastrophic coverage under these various plans. Under the Smith-Allard proposal, it is optional. Seniors can decide whether they want to take it or not. Coverage could be provided with savings if they decide to take that optional provision. In the Graham-Kennedy plan, it is over $4,000, and in the House GOP plan, it is over $5,000.

The nice thing about the Smith-Allard plan and one reason I am presenting it to the Senate today and have introduced the legislation with Senator SMITH is because it provides another option, and it is compatible with these other drug plans, particularly the first one we talked about, the tripartisan plan, with an Independent, Democrats, and Republicans supporting the plan. Our bill is very compatible with that kind of a plan.

The amendment I will be offering with Senator SMITH is simply to provide seniors with an option so that as we move forward with this, it may be they do not want to pay the $25-a-month premium or the $30-a-month premium. They can say: I will offset that by increasing my deductibles in Part A and Part B on Medicare. I think it is the kind of choice we ought to offer seniors. It will balance any of the plans that happen to pass the Senate, and we ought to pass it in the Senate in order to give seniors some choice.

I am pleased the Senate is working to pass a prescription drug benefit for Medicare's 40 million enrollees. The Senate should be pleased that many Members have worked hard in recent years to add a drug benefit. We should be pleased that we are debating various proposals now. But our efforts are in vain if we do not pass a drug benefit this year. Our efforts are in vain, I repeat, if we do not pass a drug benefit this year. I urge my colleagues to set aside politics and pass a Medicare prescription drug benefit now.

I yield the floor and 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. KYL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. KYL. Mr. President, I ask unanimous consent to speak until the hour of 11:20 a.m. in morning business.

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

AMERICA'S SENIORS NEED PRESCRIPTION DRUG COVERAGE

Mr. KYL. Mr. President, I want to talk about the delivery of prescription drugs to America's seniors. It is a subject that Senators have been talking about pretty much all week long, but people tuning in might wonder whether we are really making any progress toward getting a bill passed. That is what I would like to address this morning.

For quite a long time now, we have appreciated the fact that when Medicare was created, treating people with medications was not the preferred or first or primary method of treatment. So much of what Medicare covers today is the cost of invasive surgery, and the cost of just about every other kind of treatment except treatment through the use of medication or prescription drugs. Over the last 25 years, it has become increasingly common for physicians first to treat with medications, if possible. It seems second nature to us now. When Medicare was first established, that was not the case. As a result, most prescription drugs were not covered as part of Medicare.

Over the years, people learned how to receive supplemental drug coverage through Medigap insurance and other ways to pay for prescription drugs, but the combination of the fact that Medicare itself did not set out to cover those drugs and, second, that the cost of drugs has obviously increased over the years has made it more difficult for some seniors to be able to pay for their prescription drugs, especially since, again, this is what their physicians are prescribing as the best way to treat them in many cases.

Add to that the fact that people are, fortunately, living longer today, but that the longer one lives, the more likely they are going to need to take various kinds of drugs, and we have a situation in which clearly it is time for Congress to respond with an inclusion of a Medicare drug benefit for all of America's seniors. We have been working on that now for quite a long time.

I find it interesting that on the Republican side there are three or four very good, somewhat different, ways of approaching this because Members on our side have been working hard to try to fashion a set of benefits we can afford and which will also provide the kind of care we want for our senior citizens, and now we have a number of options.

I sit on the Finance Committee. Last year, when Senator GRASSLEY chaired the Finance Committee, we began working legislation through the Finance Committee to try to bring to the Senate floor so we could provide a prescription drug benefit to Medicare. Then the control of the Senate changed.

Toward the end of last year, Republican members continued to meet and, in fact, began reaching across the aisle to meet with the Democratic members of the Finance Committee and also with the Independent Member of the Senate, Senator JEFFORDS, who had left the Republican Party and caucused with the Democrats but is identified as an Independent, and over the months, representatives of the Republican Party, the Democratic Party, and Senator JEFFORDS have come together on an approach that has now acquired the name, the tripartisan approach—because it is not just the two parties but, it is actually three parties—an approach that actually will deliver a very good prescription drug benefit to our seniors and a plan that actually is unique among all of the different ideas that have been brought to the floor because it can actually pass the Senate.

It has more than 51 votes in the full Senate, we believe, and it could pass the Finance Committee. Senator BREAUX is one of the leaders in this coalition, and he has been a leader in the Finance Committee in support of this. So a great deal of work has been done to try to develop the kind of reform that is necessary to provide prescription drugs to our seniors.

Then why the discussion on the Senate floor and what is going to happen next week? Well, at the early part of next week, we are finally going to have a chance to vote on some alternatives. There will be at least two. One will be this tripartisan plan I mentioned that has been offered by Senators GRASSLEY, HATCH, SNOWE, JEFFORDS, BREAUX, and others, and the other will be a competing plan brought by some members of the Democratic Party, led by BOB GRAHAM from the State of Florida. The two proposals approach the prescription drug issue in fairly different ways. I am hoping we will have a good debate about the difference between those two approaches.

There are also approaches from other Republican colleagues who are even more different and in some ways provide a very direct benefit to seniors at a much lower cost than either of the two bills I just described. The problem is that at the end of next week, it is doubtful the Senate will have passed any of these bills.

How can that be if, as I said, there is majority support at least for one of the bills? I fear the problem is a political one, that there are some people who would rather have an issue than a bill, a problem rather than a solution, because of course the problem can continue to be talked about in a campaign context. I would rather have a bill that provides the benefit we can all take credit for, but if politics is the primary motivation, then clearly doing something is a good way to appeal to voters. But of course the whole point is it is the right thing to do.

It is past time that we provided a drug benefit to our seniors. Why is it that my prediction is what it is? Ordinarily, if the Finance Committee brought a bill to the floor, we would vote on it and the majority would prevail. It either wins or it loses. But in this case, even though the Finance Committee has been working very hard under the chairmanship of Senator BAUCUS's and Senator GRASSLEY's leadership on the Republican side, we are close to being able to mark up the bill in the Finance Committee and bring it to the floor. It is clear that the Senate majority leader has, according to Senator BAUCUS, indicated the bill would have to be acceptable to him in order for it to come out of the Finance Committee and brought to the floor. That was not the case with the so-called tripartisan bill. The legislation that has been brought to the floor by the majority leader is not legislation that would have come out of the Finance Committee.

Why is that important? Because a point of order lies against legislation that does not come out of committee. In practical terms, that means you have to have 60 votes on the Senate floor to pass it.

What has been set up is a process that is set up to fail. By not allowing the Finance Committee to bring its bill to the floor and be voted on by a majority of 51, we are setting up a requirement that any bill has to pass with 60 votes because it did not come out of committee; 60 votes will be very difficult to achieve because the Senate is divided roughly 50/50 among the two parties.

We have different approaches to this solution, this problem. The only bill that likely would pass is the so-called tripartisan compromise. But if it has to have 60 votes, that is a stretch, as well. I am not sure we can get 60 votes.

At the end of the day, by virtue of the process that has been created, we are not likely to end up with any legislation at the end of next week. Then what will we do? Point fingers: It is your fault. No, it is your fault.

The bottom line will be that the American people end up the losers. Our seniors will not have a prescription drug benefit because the Senate decided to operate in a way that guaranteed that conclusion.

The House of Representatives has passed a bill that is a good bill. It is not exactly what I would do, but it is a good start. The Senate should act in the same way.

Let me describe a little bit about what this tripartisan bill does. Even though it is not a bill I would have written, I am willing to support it, primarily because it does have a number of good ideas, and it can be passed and we can move on, get a bill to conference and to the President for signature to begin providing Medicare drug benefits for our seniors.

The tripartisan plan is a comprehensive plan. It is a permanent plan with respect to providing drugs to all Medicare beneficiaries. It also has another feature that the other plans, by and large, do not, in that it provides reforms of Medicare that will ensure that as the program continues on out into the future, it will actually work. The problem with both Social Security and Medicare today is without serious modernizations neither one can provide the benefits that have been promised. Those are commitments that we should be ensuring we can keep.

Under this plan, Medicare beneficiaries will have a new drug benefit option. They can keep their current Medicare plan and do nothing, or they can buy into the new drug plan provided for them. If they sign up for the new plan, it is completely voluntary on their part. If they sign up for the new plan, they will have choices so that they can pick what best suits them. They would pay a premium that is estimated to be about $24 a month, very similar to the monthly premium seniors now pay for Medicare Part B. They would be able to choose between competing plans. The plans would compete for their business and therefore would offer the best possible arrangements for each individual senior. The plans generally would have an annual deductible of $250. This is similar to the Part B deductible seniors now pay which is currently $100.

A key difference is after $3,700 in out-of-pocket drug spending by the beneficiary, the Government would pay 90 percent of the costs, and the beneficiary would only pay 10 percent. As Medicare beneficiaries know, traditional fee-for-service Medicare does not have this type of important stop-loss coverage for the benefits it provides; stop-loss meaning after you pay a certain amount you do not have to pay anymore, the Government would begin paying the bulk at that point. It is important to protect the beneficiaries from high drug costs, particularly those who have a significant illness, or a longstanding illness that will require them to pay for drugs over a long period of time.

Another important aspect of the proposal is it is affordable. The CBO has estimated the cost, what we call scoring, will be $370 billion over 10 years. Given it is estimated the alternative offered by the House Democrats cost in the neighborhood of $800 billion to $900 billion over 10 years, and the Graham-Miller proposal will cost almost $600 billion over 10 years, we clearly have an inability to fund that kind of a program. I believe the tripartisan plan is a much more affordable and practical plan.

In an artificial attempt to keep down their costs, the Graham-Miller plan sunsets after just 6 years. The proponents of this plan claim the reason they sunset their legislation after 6 years, in the year 2010, is they want the ability to look to see whether changes are necessary. The fact is, it is a very expensive plan, about $600 billion over 10 years, if enacted on a permanent basis, making it undesirable from a political point of view. That is one of the reasons that plan should not be supported.

Let me also say we can examine legislation at any time, whether or not it sunsets, and we can review legislation every year and propose amendments to it. We do not need to sunset this legislation.

I mentioned the fact that traditional fee-for-service Medicare does not have the stop-loss provision so people can continue to pay for high-cost drugs on and on. Under the tripartisan plan, beneficiaries will have a chance to join this new fee-for-service option instead of joining Medicare Part A and Part B, as they do now. It would have a combined deductible, instead of two separate deductibles that beneficiaries have to deal with today.

Additionally, it would eliminate the beneficiary cost sharing for preventive benefits, such as breast cancer screening, prostate cancer screening, and screening for glaucoma. This allows Medicare beneficiaries to receive these benefits without having to pay a so-called copay.

One of the important aspects of the new option is the ultimate $6,000 stop-loss coverage, especially important if a Medicare beneficiary has a long hospital stay. As I said, there are those

who have serious illnesses that simply cannot afford to pay more than that. This new option is a complete benefits package as opposed to just a prescription drug package. Instead of just trying to address the issue of providing drugs, the tripartisan bill puts it into a new option in the traditional Medicare Program that currently exists so people will know what they have a comprehensive plan. They can make an intelligent choice and know that it is all there for them together.

I will comment on another important part of the plan, and that is that it uses the current market system that seniors are familiar with to deliver the benefits. The alternative is a strictly Government plan that has to be run by Government bureaucrats. They will make the rules. They would establish exactly what the benefits are over time and what the costs of those are. By using the market that is currently used, there is competition to provide the product that is the best for seniors at the lowest cost, so that seniors' needs will actually keep the costs down and keep the benefit structure positive, as opposed to the Government bureaucrats making those decisions.

The tripartisan plan includes coverage for drugs within all therapeutic categories and classes, and provides timely appeals if there is any denial of drug coverage in a particular case. This allows the beneficiary to continue to have access to the needed drug and to call on outside experts to review any decision that would deny them those drugs.

The plans that participate in the program will have to meet access and quality standards that are decided by the Department of Health and Human Services, including pharmacy access standards. We want to make sure in the rural areas Medicare beneficiaries have access to pharmacies they can go to and get good advice. In rare cases, where beneficiaries may not have a choice of at least two of these plans, the legislation guarantees they would have an option of a fallback plan.

Providing affordable drug coverage is the goal of the tripartisan plan. That is why it subsidizes private plans to provide this drug benefit. Using this delivery method, as I said before, will both provide competition to hold down the costs and maintain the kind of program benefit that seniors are used to at the present time.

The CBO has told the authors of the tripartisan plan that using this delivery method not only ensures Medicare beneficiaries access to the new drug plans but also the most effective use of taxpayer dollars. We know the plan will become more expensive over time. Seniors care just as much about taxes as anyone else and they want to know it is affordable. The more affordable it is, the more likely they can expand the benefit to seniors. So that is in their interests, as well.

In contrast, the Graham-Miller plan uses government contractors to administer their drug benefit. These contractors would have little interest in holding down the cost of prescription drugs for Medicare beneficiaries. We all know what the ultimate result of this would be: the federal government would establish price controls on prescription drugs to hold down the costs. This would have a devastating impact on prescription drugs. Let me offer a real life example of what will happen here.

In some major cities today you have price controls, or rent controls on housing. We all know what happens when you have these rent controls. The bottom line is the prices either go up or the conditions of the tenements go down because the people who own them are no longer in a position to continue to upgrade them because they cannot make a profit on them.

What happens is that a severe shortage of housing is created and most people who do not have access to rent controlled housing have to pay very large amounts just to live in a small apartment. We are familiar with this in the area of housing.

The same thing would happen with respect to drugs. If you use the alternative plan, which will ultimately lead to an attempt by the Government to control the prices—whenever you try to control the price of something, you get less of it. That is exactly what would happen here. People who do not have access will pay extremely high costs. Just as there is no incentive to build new rental housing units in areas with price controls, there will be no incentive to create new prescription drugs. After all, if you cannot make a profit with a new drug that you create, why would you go to the effort and expend the money to try to develop that new drug and put it on the market? It is just not worthwhile to spend the amount of money necessary to create a product when you cannot even cover the costs when you sell it.

If we just think about price controls, if they had existed on prescription drugs over the last 20 years, you are probably not likely to have seen the creation of the fantastic new drugs we all have the benefit of today—to control cholesterol levels, like Lipitor; to help people with allergies; to help people with diabetes; and the list goes on. This could be the result of the Democratic alternative which would try to impose price controls without providing an incentive to create these new drugs. Over time, that will result in inferior medical care because fewer and fewer drugs are being brought to market that will help seniors as well as everyone else.

This is another reason we should support the tripartisan plan that essentially builds on the system we have today, that gives seniors at least two types of choices. Medicare beneficiaries can either continue in the existing Medicare system or get to choose the new options. If you get into the new options, you are going to have at least two plans to choose from. So there is a lot of choice at the same time that it is also very similar to the current system private employees and federal workers have to receive their health care.

Let me finally talk about how much the Government is paying Medicare providers to serve Medicare beneficiaries. It is a very serious concern. At some point we are going to have to deal with it. In the House of Representatives there was, I think, $30 billion added to their prescription drug benefit legislation to ensure that physicians and hospitals and other providers would receive the money they need literally to stay in business.

We have emergency rooms around the country that are closing because they are not being paid. It is going to be necessary for us to provide some supplemental funding to the hospitals and other health care providers literally to continue to provide the benefits we are promising through programs such as Medicare and Medicaid. If there are not doctors and hospitals to serve people, we can pass all the laws we want, but it is not going to do people any good. So we are going to have to address this issue, whether it is on this legislation or legislation down the road.

My colleagues may appreciate that by Federal law, under the Medicare Program, physicians will receive a 17-percent cut over the next 4 years in what Medicare pays them to see a Medicare patient. Since private plans frequently base their reimbursements on what the Government Medicare plan reimburses, the effect is, for virtually all physicians, that they are seeing this kind of drastic cut in what they are reimbursed, either by the Government—which provides about 50 percent of the health care—or by the private plans, which provide the remainder.

According to a March 12, 2002, New York Times story, 17 percent of family doctors are not taking new Medicare patients because of this problem. They are simply not getting paid enough to cover their overhead costs.

Last year, Senators JEFFORDS and BREAUX and I introduced legislation that would have partially fixed this problem. This legislation now has 80 cosponsors in the Senate. That means virtually everybody in the Senate has said we need to adopt this legislation. It would help to fix this problem of declining reimbursements for providers.

Additionally, Home health care agencies will be taking a 15-percent reduction in payments starting October 1, skilled nursing facilities will experience a 17-percent cut in some of their Medicare rates, and these are just a few of the examples of payment reductions. So we are not going to be able to provide quality care under Medicare if we are not able to sustain the experts who are providing that care today.

I am looking forward to working with my colleagues to ensure that through the reimbursements we will add, whether in this legislation or

some other legislation this year, we will be able to provide that supplemental help to them until we are able to straighten out the payment formulas under which Congress reimburses the hospitals and other providers that are providing care called for by Medicare.

Let me summarize the point about the difference between the two prescription drug proposals and how we are likely to pass a drug bill that will actually be signed into law. If we had been able to pass a bill out of the Finance Committee, we would only have to have a bare majority—51 votes. The tripartisan bill has support on both sides of the aisle, Democrat and Republican as well as Senator JEFFORDS, another cosponsor, to be able to pass. We could actually get together with the House of Representatives, make the changes, the compromises between the House bill that has already been passed and this bill, and get it to the President for his signature, and by the beginning of the fiscal year we could actually be implementing a new drug for our seniors that they do not currently have.

But because that does not fit in with the plans of the majority leader, we are now in a situation where any bill that is brought here is going to have to have 60 votes to pass. Because of the realities of the political environment in which we operate, it is unfortunately the case that it is going to be very difficult to get 60 votes for any plan.

The one that has the best chance is the tripartisan plan that I alluded to earlier. It is not the bill I would have written, but I am willing to support it because it is a good proposal that has the best chance we have to actually get something passed and deliver a real benefit to our seniors. We will have time to work the issues in the conference committee. We will have time to continue to modify the legislation after it is passed and signed into law. But we have to act, and every year we do not act is a year in which more and more seniors are denied the benefit that they need, that their physicians are prescribing for them and, unfortunately, many of them cannot afford.

It seems to me we should put ideologies and politics aside and try to do something good for the seniors of our country and lay those differences aside to the extent that we can actually pass a bill. It is a good bill. It is a very good bill in terms of providing the benefits. It is costly, but with the reforms in Medicare that are included within it, I think over time we will be able to afford these costs. After all, it is a commitment that we should be satisfying for our seniors.

I urge my colleagues, when the time comes early next week, to lay aside partisan differences, to support the tripartisan bill, the only bill that has a chance of succeeding here, and move on with the political process so we can work with the House of Representatives, pass it on to the President, who I am quite sure will sign it, and begin providing a prescription drug benefit to our seniors.

Going all the way back to when Medicare was created, we treated people differently. Today we know medications are the primary method of treatment. We have to recognize that here in the Senate, something that all seniors understand very well. Let's recognize the reality, let's provide this drug benefit and really keep faith with the seniors we represent.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mrs. LINCOLN). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

PRESCRIPTION DRUGS

Mrs. LINCOLN. Mr. President, in all the rhetoric and grandstanding about who has the best prescription drug plan, I truly do not want us to forget who we are trying to help.

I cannot possibly forget the 436,000 Medicare beneficiaries in Arkansas who struggle every single day to pay for the prescription drugs to control blood pressure, their heart, and help them cope with chronic diseases.

Yes, some seniors are eligible for Medicaid. Some have Medigap. But most of them fall through the cracks. In Arkansas, we don't have the tools that other States might have to help our seniors pay for their prescription drugs. Medicare+Choice has left our State. Medigap plans cost a lot more than the national average—almost 20 percent higher, to be exact, a year.

Employer-sponsored retiree health plans are extremely rare. On top of that, 60 percent of our seniors live in rural areas. So how do our seniors afford their prescription drugs, which rise in cost absolutely every year? The sad fact is, they don't.

The best way to combat this problem is add a prescription drug benefit to the Medicare Program. That is why I am so disappointed that neither of the Medicare prescription drug plans we will consider this next week seem to have the 60 votes they need to pass.

I am disappointed we are at a standstill in the Senate, and I am disappointed we have been unable to forge a compromise in the Senate Finance Committee. As a member of that committee, I would prefer to be debating these plans in that committee. However, I understand that the urgency of the issue and the timing of the Senate schedule has brought us here today.

In years past, I have been a cosponsor of Senator BOB GRAHAM's Medicare prescription drug bill. My colleague from Florida has invested a tremendous amount of time and effort in designing a benefit that senior citizens desire. And he has done well. My constituents have told me how much they like the benefit package and the extra assistance for low-income beneficiaries. They like that the premium will be guaranteed at $25 a month and will not vary State by State or region by region. This is good because in States such as Arkansas, we usually—almost always—get the short end of the stick when that happens. They like that the benefit is stable and universal and that it does not have a gap in coverage and is straightforward and simple.

Although I favor this plan, I did not cosponsor the bill this year in the hopes that I could help my colleagues on the Finance Committee forge a compromise that would work for seniors and that would have enough votes to pass the Senate. Unfortunately, that effort seems to have failed. I commend my chairman, Senator BAUCUS, for his efforts to try to shape a compromise between these two competing plans that we have before us today.

I also thank my friend from Louisiana, Senator JOHN BREAUX. Senator BREAUX, through serving on the National Bipartisan Commission on the Future of Medicare in 1997 and shaping the debate in Congress, has played a leading role in the national effort to improve the Medicare Program.

I appreciate the many meetings we have had on this issue and hope we have the ability to continue to work in that bipartisan fashion, working to forge compromises as we move forward on the Senate floor, as well as in conference.

I also want to recognize the tremendous amount of staff work that has been done, particularly and especially by my staff, Elizabeth MacDonald, all of the staff on the Finance Committee, as well as the Members who have had plans.

However, despite the changes Senator BREAUX, Senator GRASSLEY, and others have made to the tripartisan bill, I believe the bill still fails to offer an acceptable model to deliver prescription drugs to seniors in rural States such as Arkansas.

I cannot in good conscience vote for a plan that relies on the untried, untested delivery system laid out in the tripartisan plan. The private insurer model will require significant taxpayer subsidies to attract insurers into a drug-only insurance market, something we have never tried before. The insurance companies have told me they are hesitant to assume the risk for this type of plan unless they are heavily subsidized, and I do not think this is a proper use of our taxpayers' dollars. Nor can I support a plan that does not entitle seniors to any particular drug benefit but, rather, only a suggested benefit.

Consider for a moment the story of Mrs. Mildred Owens of Havana, AR. Mildred is 70 years old, and she worked for 35 years before retiring 5 years ago. Now widowed, Mildred receives about $830 a month in Social Security and about $125 a month in retirement.