earn a living making that stock as valuable as it is.

I am also troubled by the Secretary of the Army, Thomas White, who testified before the Commerce Committee last week about his role as vice chairman of Enron Energy Services. Those who observed his testimony can only be disturbed by his performance. Memos written by Enron lawyers in the year 2000 suggest that the division of Enron led by Secretary White at the time overstated the demand for power so that another division could benefit from artificially higher prices. As a result, Enron raked in obscene profits while consumers paid billions of dollars in excess.

It was all phony accounting, a manipulation, by an organization led by the Secretary of the Army.

Enron's manipulation of California's energy markets affected the entire western United States. It affected Nevada adversely, driving Nevada's utilities to the brink of bankruptcy and forcing consumers to pay skyrocketing rates.

Secretary White received approximately $50 million while at Enron—he, personally—and he made an additional $12 million after he joined the Bush administration by selling Enron stock following 77 phone calls to his former colleagues at the company.

During the questioning by Senator BOXER and others he claimed: Well, I was just seeing how my friends were doing.

He made $12 million, made 77 phone calls. It just doesn't look right.

The New York Times reported that last December the Army, which of course reports to Secretary White, granted a sweetheart deal to KBR, a division of Vice President CHENEY's former employer Halliburton, ''despite being a reputed bill-padder and the target of a criminal investigation.''

I don't know what Secretary White's total involvement in these dealings might be. I hope neither he nor any of the administration officials being investigated is guilty of any criminal wrongdoing. But it is obvious that he cannot be an effective leader if he doesn't have the confidence of the American public, the airline steward or stewardess or the nurse. It would be in the best interests of our country and the administration if he resigned.

We in Government not only have to avoid what is wrong but also what looks wrong. With the Secretary of Army it looks wrong. With the head of the SEC, Harvey Pitt, it just doesn't look right.

The PRESIDENT pro tempore. The senior Senator from Utah, Mr. HATCH, is recognized.

THE ECONOMY

Mr. HATCH. Mr. President, I have been listening to the assistant majority leader. I was very interested in his remarks. This President has been in office less than a year and a half. It does seem to me that the problems we have in America are problems for everybody—not one party and not one President. They are problems for all of us.

I have to say I think this President is doing everything he possibly can to try to stabilize this economy and get us through these difficulties. Certainly the economy is doing well. We have 3-percent productivity growth, which is better than the whole time between 1980 and 1995. There are a number of other things which show that we have a strong economy.

But this underlying illness that afflicts the stock market is hurting everybody. I suspect part of that comes from what has gone on over the last 10 years or so and not just in the last year and a half. There has been a lack of confidence in our business community because of those who have been committing these heinous acts of misrepresentation and fraud in some of these major corporations in America. There have been relatively few. And I see that other corporations are scrupulously going over their books to make sure they are toeing the line in meeting the needs of the American stock market.

I suspect we are going to come through this within the next couple of weeks, and when people start to realize that our economy is good and that we are going to come through this, we will be OK. But I think it may be a little unfair to suggest that it is basically all this President's fault or that it is all one party's fault. We all have things we could have done better. We all have some responsibility.

I believe our current President is doing an excellent job. As everybody knows, I stood up for the prior President when I thought he was right.

GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS ACT—Continued

Mr. HATCH. Mr. President, today we are discussing the Medicare prescription drug bill, which is basically the two bills we will be voting on tomorrow.

I rise this afternoon to take the opportunity to share my thoughts on Medicare drug coverage. Today and tomorrow, we will be debating two Medicare prescription drug bills—the Medicare Outpatient Prescription Drug Act of 2002, introduced by Senators GRAHAM, MILLER, KENNEDY and CORZINE, and the 21st Century Medicare Act introduced by the Senate tripartisan group which includes Senators GRASSLEY, JEFFORDS, BREAUX, SNOWE, and myself.

There is no question that all of us have the same goal in mind—to provide beneficiaries with Medicare prescription drug coverage, this year. But, unfortunately, we do not agree on how this coverage should be provided. Senators GRAHAM and MILLER believe it should be provided through the Federal Government. On the other hand, the Senate tripartisan members believe drug coverage should be provided through the private market.

During the next day and a half, you will hear about the merits of both bills. You will also hear criticisms of both bills. While these matters certainly need to be debated by the Senate, both of these bills, which will impact the lives of millions of Americans, should have been considered by the Senate Finance Committee before being debated on the Senate floor. I have heard my colleagues on the other side of the aisle saying that the Senate Finance Committee has debated this issue for the last 5 years and the American people are tired of waiting for the Senate Finance Committee to act. I take issue with that argument. Actually, we have had 37 years to fix Medicare. We just celebrated its 37th birthday. And don't forget what happened when we passed a Medicare prescription drug benefit the last time. We repealed it the very next year. So we need to proceed with caution and consider any prescription drug bill very carefully before passing such a measure by the U.S. Senate. We do not want to make the same mistake twice.

Let me just say that making any changes to the Medicare program is not an easy task. I have been in the Senate for over 26 years and I find the Medicare program to be one of the most complicated programs in the Federal Government. There was a recent quote by former Secretary of State Madeleine Albright in the Washington Post, July 20, 2002, where she said, ''being Secretary of State is the best job in the world. Better than being President, because you don't have to deal with Medicare.''

I think she may have hit the nail right on the head.

The point I am trying to make is simple. We need to spend quality time drafting and debating a Medicare prescription drug benefit. We should not be considering such important legislation on the Senate floor without the Senate Finance Committee having a mark-up. That is just not right and it is downright irresponsible.

We should have let the Finance Committee do its job. But as I said all last week, politics is dictating policy. So here we are, debating one of the most important issues of the 107th Congress without even a Finance Committee hearing on the legislation being considered by the Senate today and tomorrow.

I am extremely disappointed in the way this has been handled by the Democratic leadership. I believe that the Finance Committee members could have approved a bill out in the Committee. It just wasn't the bill that the Democratic leadership wanted to have passed out of Committee.

On that point, I truly believe that we could have reached a consensus in the Finance Committee if we had been given a chance. When Senator KENNEDY and I authored the Children's Health Insurance Program in 1997, there were not more different Members of the Congress. But we did it, and we got the bill

through the Congress and had our CHIP bill signed into law in 1997 as part of the Balanced Budget Act.

In fact, it was the glue that held the first balanced budget act in over 40 years. It was the glue that got that CHIP bill signed into law as part of that particular act.

Senator KENNEDY and I reached consensus. Where there is a will, there is a way.

The same thing could happen with the Medicare prescription drug legislation. But there must be a willingness to get something done this year. And I am sensing that there is a lot of political game playing on this issue which says to me that there is not a willingness to get something signed into law this year.

Our tripartisan bill has the votes to pass both the Senate Finance Committee and the Senate. But we will not be given the opportunity to bring our bill before the Senate Finance Committee because, in my opinion, the majority leader does not want our bill to pass the Senate Finance Committee. Again, that is just a shame that we have to resort to such political game playing on an issue so important to our seniors and to our country. We finally have a bill that can be approved by the Committee and the majority leader refuses to have it go through the proper channels. Let me just say that I am extremely disappointed by his decision. I, for one, am still willing to do the work to get a Medicare prescription drug bill signed into law this year. I only hope that the majority leader is willing to work with us.

We have talked a lot about both bills in the last week and, at this time, I would like to talk about the tripartisan Medicare prescription bill. It is the only bill with support of both Democrats and Republicans being considered in the Senate. It provides Medicare beneficiaries three key elements—affordable drug coverage, choice in health coverage, and quality health care. All three elements are important and all three elements are included in this bill.

According to CBO, spending on drugs for seniors over the next decade will grow at an astronomical rate. CBO says that the only way to contain the cost of a drug benefit is to ensure that drugs are delivered efficiently. In turn, CBO says that the only way to have drugs delivered efficiently is to have true competition.

True competition, according to CBO, requires two things:

No. 1. Private plans that assume at least a limited degree of risk—that is, if they are efficient, they will make money, and if not, they will lose money.

No. 2. That those plans be able to compete by varying the premium they charge, and varying the benefits they offer. The tripartisan bill allows plans to vary both premiums and benefits.

CBO says that if all plans offer the same premium and same benefits, as under the Democratic leadership bill, that is simply not true competition. Accordingly, the CBO score of any such approach will be extraordinarily high.

Some have suggested a dual system, with competitive and non-competitive plans operating side-by-side. Unfortunately, CBO has made it clear that it would give such dual systems the same high score as a totally non-competitive system, because all plans would choose to be non-competitive. A dual system simply doesn't achieve cost containment and is also flawed because it is government run.

Our tripartisan drug plan is a voluntary and permanent program. It does not sunset like the Graham bill. In addition, all Medicare beneficiaries may participate—those in traditional Medicare, Medicare+Choice or the new enhanced Medicare fee-for-service program.

The monthly premiums are $24 per month, which is the lowest premium amount of any drug plan that has been introduced in the Congress, and one that I think would be more acceptable to our people out there rather than causing us to run into the difficulties we had when we had to repeal the catastrophic bill a number of years ago.

The deductible will be $250 and the beneficiary coinsurance, except for the low-income seniors, is 50 percent once they reach the deductible and up to $3450 in drug expenditures. Our drug plans are based on actuarial equivalence, which means that we permit Medicare drug coverage to respond to consumers' demands. These actuarial equivalent plans will meet consumers' needs. The Government will determine which plans are actuarially equivalent, and, CBO has determined that the five standards that the plans must meet in order to be actuarial equivalent reduces a lot of variation between the standard benefit.

The five standards for actuarial equivalence are:

No. 1, the Medicare benefits administrator must approve any actuarially equivalent coverage, and may terminate or disapprove any benefit design intended to discourage enrollment of high risk individuals.

No. 2, the actuarial coverage value of the total alternate coverage for the entire benefit must be equal to the standard benefit.

No. 3, the unsubsidized value of alternate coverage must equal the unsubsidized value—that is, 35 percent which is subsidized—of the standard coverage.

No. 4, the alternate coverage must be based on actuarially representative patterns of utilization to provide payment, with respect to costs incurred that are equal to the initial coverage limit under the standard benefit.

No. 5, catastrophic protection must equal the precise dollar amount, which is $3,700, the same as the standard benefit package.

So the arguments that our bill allows plans to raise the deductible to $500 or that our premium would be significantly higher than $24 per month are just wrong.

In 2005, when the drug plan is first established, Medicare beneficiaries have a 7-month open enrollment period from April 1 through November 30.

Every senior would have a choice between two prescription drug plans, and that includes rural areas across the country. This is required by the legislation, and the Congressional Budget Office agrees that there will be two plans in each coverage area. These coverage areas could be nationwide but they must be, at minimum, at least the size of a State. Before being offered to seniors, the drug plans must be certified by the Department of Health and Human Services. Seniors will receive information about the available prescription drug plans each year before selecting their coverage.

The drug benefit begins in January 2005. CBO estimates that 93 percent of Medicare beneficiaries will participate in the Medicare prescription drug program, 6 percent will keep their current prescription drug coverage and 1 percent will not be eligible because they do not participate in Medicare Part A and/or Part B.

An actuarially sound penalty would be imposed on seniors who decide to participate in the drug plan once the enrollment period is over. This is almost identical to Senator BOB GRAHAM's late enrollment penalty.

The Government will be covering 75 percent of the value of the Medicare drug benefit equaling $340 billion over the next 10 years, providing a tremendous incentive for plans to participate. The tripartisan bill allows private sources of drug coverage to supplement the new Government coverage by providing a strong base benefit—50 percent drug coverage after a $250 deductible up to $3,450 and price discounts on all drug purchases. The result is that 80 percent of beneficiaries in 2005 will not have drug spending beyond that basic benefit.

We also include low-income protections in our legislation by providing low-income seniors with additional subsidies so they, too, can afford to pay for their drugs. The tripartisan group's goal was to put an end to people having to choose between buying food and buying their medicine by providing additional help to those seniors who need it.

For example, the 10 million beneficiaries with incomes below 135 percent of poverty will have 80 to 95 percent of their prescription drug costs covered by this plan with no monthly premiums. These seniors are exempt from the deductible and will pay well under $5 for their brand name prescriptions and/or their generic prescriptions. And beneficiaries at this income level 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. Those beneficiaries between 135 percent and 150 percent of the Federal poverty level will also receive a more generous Federal subsidy that, on average, lowers their monthly premium to anywhere between zero and $24 a month on a sliding scale. This also reduces their annual drug expenses by more than half.

All other Medicare beneficiaries will have access to discounted prescriptions after reaching the $3,450 benefit limit, and the critically important $3,700 catastrophic benefit, which protects seniors from high, out-of-pocket drug costs.

I now want to take some time to discuss the Medicare coverage provisions in the tripartisan legislation.

Under our bill, we offer two choices for Medicare coverage, traditional Medicare and a new, enhanced fee-for-service plan which offers benefits similar to those provided in private health insurance. Medicare beneficiaries may choose one or the other. If a beneficiary wishes to remain in traditional Medicare, he or she may do so. If a beneficiary opts for the enhanced fee-for-service plan, then changes his or her mind and wants to go back to traditional Medicare, that is fine, too. For the first year, beneficiaries may go back to traditional Medicare without a penalty. Afterward, an actuarially fair penalty will be imposed on them for switching back and forth. This is similar to the penalties for late enrollment into the Medicare Part B program under current law. But no one is stuck in one coverage plan. Beneficiaries may change their minds and switch back to traditional Medicare if they are not happy with the enhanced fee-for-service plan.

Now, I would like to take just a few minutes to discuss the details of the new, enhanced fee-for-service option with my colleagues.

As far as enrollment is concerned, the rules for the enhanced fee-for-service benefit, Medicare Part E, are modeled on current Medicare enrollment policies. Those who are already enrolled in Medicare Part A and Part B as of 2005 will stay in traditional Medicare unless they decide to enroll in the enhanced fee-for-service option. Those who become eligible for Medicare in 2005 or later will automatically be enrolled in the enhanced fee-for-service option unless they indicate that they want to be enrolled in the traditional Medicare program. All beneficiaries will have a 7-month period to make their initial coverage decision. This is similar to Medicare Part B.

In addition, beneficiaries will be given information about the coverage options included under the enhanced fee-for-service option. This information will compare the benefits under the traditional Medicare program to the benefits provided under the enhanced fee-for-service option. That way, Medicare beneficiaries will be able to make a coverage decision that really is best for them.

Benefits covered under the Medicare enhanced fee-for-service option include better hospital inpatient cost-sharing. Instead of the current extremely high Medicare Part A hospital deductible, which will be $920 in the year 2005, and high copayments for long hospital stays, the Medicare enhanced fee-for-service option offers a single hospital copayment of $400 per admission. This is similar to the benefits provided to individuals through private health insurance. In addition, it avoids penalizing those who are ill enough to have long hospital stays. It is also simpler and more rational than the current system and all other plans on the table, including the Graham plan. The enhanced fee-for-service option also replaces the current limits on hospital coverage with 365 days per year, lifetime coverage.

I would like to give you an example of how this would work.

Beneficiaries who are hospitalized have to pay an extraordinarily high Part A deductible of $812 in 2002, rising to $920 in 2005. Unlike private health plans, Medicare today imposes its Part A cost-sharing per spell of illness, not per year. As a result, beneficiaries could be exposed to the deductible, copayments and coverage limits repeatedly in a single year. I just don't think that is fair to the beneficiary who is a victim of frequent hospitalizations within a year.

Under current law, after the Part A deductible, $812 in 2002 per spell of illness, is satisfied, there are copayments for those who have long hospital stays. In 2002, $0 for days 1 through 60; $203 per day for days 61–90; $406 per day for days 91–150 this specific coverage, for days 91 through 150, is available only once per lifetime.

In other words, Medicare provides no coverage at all for inpatient care beyond 150 days per spell of illness. And, for additional hospitalizations after the first one per lifetime, inpatient hospital coverage ends after the 90th day. Our enhanced fee for service option would change that, once and for all. The $400 copayment per hospital admission would replace both the Part A per spell of illness deductible and the copayments imposed on beneficiaries after being hospitalized longer than 60 days.

As far as preventive benefits are concerned, for those who choose the enhanced fee-for-service option, preventive benefits would not be subject to any deductibles or coinsurance. Currently, Medicare imposes deductibles and coinsurance, usually around 20 percent, on most preventive benefits. We in the tripartisan group believe that the current Medicare policy on preventive benefits makes beneficiaries reluctant to seek out preventive services that may identify health problems and prevent more expensive care later.

Therefore, the enhanced fee-for-service option eliminates all copayments and deductibles on Medicare preventive benefits.

The enhanced fee-for-service option also includes a unified deductible of $300 per year for all services. Today, in the current Medicare program, the Part A deductible in 2002 is $812 per spell of illness. In 2005, it will be much higher, $920 per spell of illness, while the Medicare Part B deductible will still be only $100 per year.

The enhanced fee-for-service option offers seniors a choice: their current coverage that emphasizes protection against relatively predictable and routine Part B costs, or new coverage that emphasizes protection against unpredictable but potentially devastating Part A costs in the event of serious illness. Seniors would have a choice, which they do not have today.

Medicare's irrational, two-deductible system is unheard of in private insurance. Beneficiaries are used to a single deductible from their prior employer-based plans. It is true that in a given year, relatively few beneficiaries use Part A hospital services.

However, the picture changes if one looks across multiple years. A recent survey found that 17 percent of beneficiaries were hospitalized each year. Over a 6-year period, more than half, 56.4 percent, were hospitalized and 36 percent were hospitalized more than once. These hospitalizations may result in ruinously high out-of-pocket costs for seniors, and the enhanced fee-for-service option offers protection against such costs for those who choose this coverage plan.

In addition, the enhanced fee-for-service option would protect seniors with serious illness. Today, Medicare has no limit on a beneficiary's out-of-pocket expenses in a year, creating the potential for crippling costs in the event of serious illness. Our tripartisan bill would limit beneficiaries' exposure to out-of-pocket costs for Medicare-covered services, other than prescription drugs, to $6000 per year. Beyond $6000, Medicare would pay 100 percent of any costs incurred by the beneficiary.

In a given year, it is estimated that 2 to 3 percent of Medicare beneficiaries may have costs that reach $6000. If beneficiaries want peace of mind that would come from such catastrophic protections included in the enhanced fee-for-service option, they should have that choice.

Contrary to popular belief, Medicare supplemental policies do not offer catastrophic protection. The standardized Medigap plans fill in the cost-sharing in the existing Medicare benefit package, but they do not offer serious illness protection. Since virtually all employer-sponsored health plans offer serious illness protection, it is something that many beneficiaries have come to expect.

In addition to those with serious illnesses, this protection would also benefit those with severe, chronic conditions, which are inadequately covered by Medicare today. All spending by or on behalf of the beneficiary, including by third parties, such as Medicaid, employers, or Medigap plans would count toward the serious illness threshold of $6000. This differs from the drug benefit stop-loss because CBO indicated that counting only a beneficiary's own spending toward the Part E limit would reduce participation in the enhanced fee for service option a concern that CBO did not have about the drug benefit in the tripartisan bill.

As far as home health benefits and skilled nursing facilities are concerned, those who choose the enhanced fee for service option would have to make home health copayments of $10 per visit, on only the first five visits of a 60-day episode. A Medicare beneficiary would only have to pay $300 in home health copayments per year. Home health care is one of the only Medicare benefits for which there is no beneficiary cost-sharing. Medicare's average payment per home health care episode is $2300, so a maximum total copayment of $50 per episode would cover only about 2 percent of the program costs, in contrast to the typical 20 percent cost-sharing on Medicare Part B benefits.

Both CBO and Med PAC indicate that even a modest copayment is critical to making beneficiaries consider cost when deciding whether or not to use home health care. CMS projects a 12 percent growth in home health care spending in 2003, even if the 15 percent cut scheduled in current law takes place. Beneficiaries with serious enough conditions to need more than five visits per episode receive those additional visits without additional cost-sharing. Those who cannot afford these modest copayments are protected, because current law includes cost-sharing protections for the low-income beneficiaries, Medicaid eligible and QMBs are maintained.

For skilled nursing facilities, the enhanced fee for service option would include a copayment of $60 per day for the first 100 days. Under Medicare today, beneficiaries currently pay copayments beginning on day 21 of a skilled nursing facility stay. Medicare imposes no cost-sharing for the early days of a skilled nursing facility stay, days 1 through 20, and then Medicare imposes very high beneficiary cost-sharing for longer stays. In 2005, when our bill goes into effect, those copayments will be $115 per day for days 21 through 100.

As a result, Medicare's current skilled nursing facility cost-sharing unfairly penalizes those who are sick enough to need a longer stay, while allowing those who aren't as sick to have free days of care, with no incentive to consider costs. Influenced by the 20 days of free care, then prohibitive cost-sharing policy, the average length of stay in a skilled nursing facility is approximately 24 to 26 days, according to CMS.

We believe that since skilled nursing facilities already collect copayments beginning on day 21 of the beneficiary's stay, these facilities will already have administrative structures for cost sharing in place.

To be honest, I am not enthusiastic about imposing home health or skilled nursing facilities copayments on Medicare beneficiaries. But, as I said earlier, this legislation required a lot of give and take from all of us. If Medicare beneficiaries do not want to make home health or skilled nursing facility copayments, they may stay in the traditional Medicare program. If they go into the enhanced fee for service option and don't like the coverage because they end up having to make copayments for home health care or skilled nursing facilities, they may switch back to traditional Medicare. It is that simple. We are not imposing copayments on anyone who does not want them. The enhanced fee for service option is just that a coverage option.

These are some of the key elements of the new, Medicare enhanced fee for service option that our bill will provide to Medicare beneficiaries. I hope that my explanation cleared up any questions that my colleagues may have had on this component of the tripartisan bill.

Our tripartisan bill also includes provisions concerning the Medicare+Choice program. In 2005, our legislation takes modest steps to improve Medicare+Choice plan participation by introducing a competitive bidding system under which the plans will compete with each other, but not with the government-run, fee-for-service program, for beneficiaries. This competitive approach to Medicare+Choice payments, based on a bipartisan model supported by the Clinton administration, will result in fairer and more accurate payments to plans. Today's bureaucratic pricing system sets arbitrary and inaccurate rates that discourage plan participation.

At this point, I would like to take a few minutes to rebut some of the arguments my friend and colleague Senator KENNEDY made against our bill last week on the Senate floor. He obviously has not read our bill very carefully. I wish he had taken the time to read the tripartisan legislation before making statements that were not completely true on the Senate floor about our bill. Now, there is some confusion about our bill and I would like to set the record straight, once and for all.

First, Senator KENNEDY criticized our plan's assets test for low-income beneficiaries. Our tripartisan plan provides additional subsidies for low-income seniors which everyone agrees is only fair. I believe I am correct in saying that everyone, on both sides of the aisle, believes that additional subsides for our low-income seniors is completely justified. My good friend is trying to make it appear that we are picking and choosing which seniors would be eligible for this additional assistance. Nothing is further from the truth.

I want to be clear that we have done nothing different on this issue than what has been the accepted practice and policy for many years when it comes to programs that provide assistance to those with lesser means. In fact, the tripartisan bill adopted an assets test similar to the Medicare bill proposed by President Clinton in 1999.

Under current law, Medicaid includes an assets test. States have the flexibility to waive the assets test at their discretion.

Our tripartisan proposal ensures that the flexibility found in current law is retained in the Medicare drug benefit program. The assets test ensures the seniors who need the most assistance are provided with the most protection. We want to provide the most generous assistance to those who truly need it.

Also, let me clarify that current law specifically excludes from the assets test an individual's home and its land; household goods; personal effects, including automobiles; the value of any burial space; and other essential property. So I hope this clarifies any questions that Senators may have had on the tripartisan proposal's assets test. Hopefully, I have made it clear to my colleagues that the tripartisan bill adopted a widely accept and common practice for determining which lower income seniors are eligible for higher subsidy for their prescription drug benefits.

Another issue raised by my good friend, Senator KENNEDY, is the design of the tripartisan proposal's prescription drug benefit. He wanted to know how our prescription drug benefit design permits creation of competitive plans that would provide quality coverage to all Medicare beneficiaries.

Let me explain why we took this approach. First, we believe that Medicare beneficiaries deserve a quality drug benefit that meets their individual needs. The Graham-Miller proposal does not allow any variation in cost-sharing or premiums and is a ''one-size-fits-all'' plan which, in my opinion, will fail to address the individual prescription drug needs of seniors.

So, with that in mind, it is important that Medicare beneficiaries are provided a quality drug benefit at an affordable price. Our tripartisan plan strikes the right balance to give Medicare beneficiaries access to prescription drugs they need at the lowest possible price. Any plan that wants to offer a Medicare drug benefit will be required to receive the approval of HHS according to strict standards specified in law. This approval process will be an interaction between any prospective plan and the Federal Government to ensure that Medicare enrollees receive the best quality coverage possible at an affordable price.

There are five strict standards of actuarial equivalence in our bill which

the CMS Administrator is required to certify that a plan meets before the plan is offered to Medicare beneficiaries. The plans themselves will not be determining what is actuarially equivalent; only the Federal Government will make that determination. If the Government determines that a plan is not equivalent to the standard benefit, its proposal will be rejected and it will not be permitted to participate in the Medicare drug benefit. End of Story. In fact, CBO has told us that our standards of equivalence are strict enough that Medicare Drug Plans will have little room to vary premiums or cost-sharing. That little room to allow some variation, however, is critical to the success of a Medicare prescription drug benefit.

Under the Graham-Miller bill, Medicare drug plans operating in the same area will be forced to charge the same monthly premium and the same cost-sharing. While Senator GRAHAM claims that his proposal includes competition, I do not understand how Medicare plans will compete if they are required to offer identical premiums and identical cost-sharing across the country. If drug plans wanted to lower their cost-sharing or lower their premium in order to attract Medicare enrollees, Congress would have to pass legislation.

On the other hand, the tripartisan bill ensures that the innovation of the private sector is not stifled by a micro-managed, ''one-size-fits-all'' drug benefit run by the Federal Government.

Another issue raised by my friend Senator KENNEDY is whether or not the prescription drug benefit under our proposal guarantees that seniors will have access to benefits. Let me assure you that if this were not true, I would not be standing here today, speaking in favor of this legislation.

Let me clarify that the tripartisan bill guarantees two Medicare prescription drug plans to every Medicare beneficiary. If the beneficiary lives in an area where there are Medicare+Choice plans, then even more choice will be available as the presence of drug coverage under Medicare+Choice does not count as one of the two choices that would be guaranteed in law under our plan.

The Medicare prescription drug plans are not determining their own service areas. The Federal Government will make that determination. And let me emphasize that the service areas must be—at a minimum—the size of a state. The government will be covering 75 percent of the value of the Medicare drug benefit equaling $340 billion over the next 10 years.

The last issue that my good friend from Massachusetts raised is whether or not employers will be encouraged to continue to provide retiree health benefits with prescription drug coverage. I believe that we have worked hard to protect both employers and retirees on this issue. The tripartisan bill provides employers the same full subsidy to offer drug benefits to their retirees as any other qualified provider of prescription drug benefits.

The Graham-Miller legislation provides a disincentive for employers to continue offering retiree health coverage for prescription drugs by giving employers only two-thirds of the value of the government drug benefit to retain their retiree coverage. So in other words, the Graham-Miller plan would encourage employers to end their coverage of prescription drugs in order to encourage their retirees to enroll in the Government plan and receive the full Government subsidy.

I do not understand how my friend can make the argument that our plan is bad for employers. Currently, employers receive no assistance whatsoever in paying for drug costs for their retirees. Employers today are paying the full price and taking all of the risk for covering retiree prescription drug costs.

The subsidy policy in the tripartisan proposal will allow employers who are offering a drug—benefit at least as generous as the standard benefit—to receive the full value of the standard benefit.

Again, our policy targets dollars where they might do the most good, and our employer subsidies recognize the value of employer-sponsored retiree drug coverage.

I would like to take some time to share my thoughts on the Graham-Miller Medicare outpatient prescription drug amendment which was offered at the end of last week.

As I have said throughout this debate, Senator GRAHAM deserves a lot of credit for his hard work and dedication to this issue. His staff, too, has worked long and hard on this issue. Senator GRAHAM, like those of us in the Senate tripartisan group, has the same goal—to pass Medicare prescription drug legislation into law this year.

I have had a chance to review Senator GRAHAM's amendment over the weekend and I would like to raise some issues regarding his new legislation. I understand that the Congressional Budget Office has scored his legislation as costing close to $600 billion over 10 years. While GRAHAM says that any potential saving from the underlying legislation should be counted against the cost of his amendment, I disagree. We do not know whether or not the underlying bill will be approved as proposed, amended or defeated altogether. Therefore, we obviously cannot assume any savings from that bill when discussing either Medicare prescription drug amendment—the Graham amendment or the tripartisan amendment.

Quite honestly, I am still extremely worried about the expense of the Graham-Miller legislation. In fact, I believe that the true 10 year cost of the Graham-Miller drug benefit could be closer to $1 trillion.

Another concern is that this bill is not a permanent program. It sunsets after 2010 and, quite frankly, I believe that having a sunset in such an important bill just to get a decent score from CBO is fiscally irresponsible. The way I read the Graham-Miller bill, it is a temporary benefit, which lasts for 6 years. On page 78 and 79 of the Graham-Miller amendment, it states that ''no obligations shall be incurred . . . and no amounts expended, for expenses incurred for providing coverage of covered outpatient drugs after December 31, 2010.'' That is a mouthful to read. But the translation from Government-speak is simple: no funding at all, zero, for the Medicare drug benefit after 2010.

I also read in the Graham-Miller bill that there is an attempt to provide prescription drug coverage after the Medicare prescription drug program sunsets. On page 79, the amendment states that ''the Secretary shall make payments on or after January 1, 2001, for expenses incurred to the extent such expenses were incurred for providing coverage of covered outpatient drugs prior to such date.''

I think what the sponsor of this legislation is attempting to do, although I am really not sure, is say if there is additional, left-over money from the drug benefit, that money may be used to provide drug coverage after December 31, 2010. That language is very confusing to me. Like I said the other night, it seems more like window dressing to me than an actual extension of the sunset.

I am interested in Senator GRAHAM's comments on this specific provision and the broader issue of why he and his bill cosponsors believe that a sunset is necessary in the first place. I just think it is plain wrong to give Medicare beneficiaries a Medicare drug benefit and then take it away six years later. I cannot believe that the AARP would actually tell its members to call their members of Congress to express support for this bill. I cannot figure out how a temporary Medicare drug benefit helps seniors in the long run.

Another serious concern I have about the Graham-Miller legislation is that the drug benefit is run by the Federal Government. I do not think it is a good idea to let the Government set the price for drugs which is exactly what will happen if the Graham-Miller bill becomes law. And that will be catastrophic, in my opinion.

The Graham-Miller bill has a one-size-fits-all drug plan that is offered to Medicare beneficiaries. That approach will lead us down a dangerous path. I have said this more than once but I am going to say it again, before you know it, the Federal Government, not the private market, will be setting drug prices, mark my words. And I do not believe it is a good idea for the federal government to be making coverage decisions for seniors—I trust senior citizens to make their own decisions about their health coverage. Apparently, the authors of the Graham-Miller bill do not agree and that is why they put the Government in charge.

If you do not believe me, read the language on page 41 of the bill. It states that if only one drug plan meets all the conditions set by the Secretary of Health and Human Services, and the Secretary can set any conditions he pleases, then the Secretary can simply decide that Medicare beneficiaries will get coverage through that one prescription drug plan. Period.

And while there are laws to protect Medicare beneficiaries, and in fact all Americans, against the government doing something that arbitrary, the bill waives all of those laws. Let me summarize for my colleagues what is included in the Graham-Miller legislation on this topic.

Page 42, line 18 through 21 reads as follows:

In awarding contracts under this part, the Secretary may waive conflict of interest laws generally applicable to federal acquisitions * * *

In other words, not only is there no judicial or administrative review of the Secretary's decisions allowed at all, but even the Government's conflict of interest laws are waived.

The other primary difference between the Graham-Miller bill and our tripartisan bill is that we include reforms to the Medicare program and they do not. Keep in mind our bill is $370 billion in contrast to their proposed $600 billion bill. 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.

We need to give seniors choices concerning their health care coverage. It is extremely unfortunate that the Graham-Miller bill does not recognize that the Medicare program needs to be improved so seniors can have similar benefits offered by private health insurance. There is nothing in the Graham-Miller bill to improve the Medicare program. It just tacks on a prescription drug program and ignores the larger problem—the overall Medicare benefits package which is outdated and inefficient. Medicare beneficiaries, in my opinion, deserve better. We do not shove the larger issue under the rug in our bill.

Another serious concern I have about the Graham-Miller legislation is that only two brand-name drugs are covered in each therapeutic drug class, and, plans are permitted to cover just one drug.

For all other drugs, ''the beneficiary shall be responsible for the negotiated price of the treatment'' which means in plain English, no coverage at all.

Let me give an example.

Let's say Bob, a Medicare beneficiary in his early 70s, takes Mevacor to lower his cholesterol. His new Government prescription drug plan only covers Lipitor.

Bob's wife, Bev, takes Celebrex for her arthritis. Her Government drug plan only covers prescription strength Advil.

What happens to Bob and Bev? They are both out of luck because their Government drug plan does not cover the prescription drugs that they have been taking for their chronic health conditions.

Even worse, according to CBO, the Graham bill does not lower drug prices for drugs that are not covered. Unless a beneficiary is awfully lucky to be on the one or at most two brand name drugs that the government plan decides to cover, he or she will get nothing.

I think of people suffering from depression. There are a number of antidepressant drugs, and they all work in just a little bit different way. Where Prozac may not work, Zoloft might, or Paxil might work, or some other antidepressant drug. Why should they be limited to only two drugs when the two they are limited to might not be helpful to them? It just does not make sense to me.

If a Medicare beneficiary believes that he or she needs a specific prescription drug, not the one or two drugs that the Government plan decides to cover, the beneficiary may be able to get coverage if the beneficiary and his or her physician go through a ''medical necessity'' certification process. This certification process is then followed by an internal and external appeals process—and guess what—all run by the Government.

I simply do not believe that Medicare beneficiaries want the Government to make drug coverage decisions for them. Supporters of the Graham-Miller legislation say, ''Don't worry, trust the Government, you will have choices of drug coverage.'' Tell that to Bob and Bev who will not have their prescriptions covered through this Government-run plan or to somebody suffering from depressive illness where the two drugs that are in the Government plan are not the ones that help them. Or in any number of other illustrations where you have a whole variety of drugs but you are limited to two. When the Government says ''trust us,'' it is time to pay attention.

In addition, the way I read the Graham-Miller legislation, the Secretary of HHS is given the authority not only to decide what constitutes therapeutic classes but also the ability to determine when such a drug fits into such a class. I do not understand why the sponsors of this legislation believe the Secretary of HHS should be making such important decisions. In addition, why should the Secretary of HHS, instead of physicians and pharmacists, be given authority to decide what constitutes preferred and non-preferred classes of drugs and, on top of that, determine when a particular brand name drug fits into such a class? It does not make any sense.

Because the Graham-Miller amendment now does not cover non-preferred drugs, at all, I am deeply concerned about the impact this could have on Medicare beneficiaries with cancer or AIDS or other chronic illnesses that require many prescriptions. I have a feeling that people with chronic or terminal illnesses will be getting the short end of the stick if the Graham-Miller bill is signed into law.

Furthermore, how are the doctors, who may know that one drug may be much more beneficial than another drug, protected? How are the doctors protected from medical liability under those circumstances? Already we are finding that obstetricians in Nevada can no longer get insurance coverage for medical malpractice, and that is going to happen all over the country if they do not watch it because litigation is driving these costs higher and higher.

If a doctor cannot prescribe what is necessary for the patient, that doctor is subject to medical liability even though the Government is the one dictating what two drugs should be provided. By the way, that is under the Graham-Miller bill.

These issues that I have raised about the Graham-Miller should have been debated by the Finance Committee. Who knows, maybe we could have come to the same resolution, but I doubt it. We could have come to some resolution and it would be better than what is in the Graham-Miller bill. Maybe the authors of the tripartisan bill and the Graham-Miller bill could have come to the same agreement through the committee markup process. Maybe not. Sadly, we will never know because politics, not policy, is more important.

Last Thursday night, I asked what happened to the bipartisan spirit that we all talked about at the beginning of the Congress. This legislation is not being considered in a bipartisan manner and, in fact, the way this entire debate has been handled has really created some hard feelings, especially among members of the Senate Finance Committee. Why are we on the floor debating a bill that will affect the lives of millions of Medicare beneficiaries and millions of future beneficiaries without a Finance Committee markup? I do not understand why members of the Finance Committee were completely excluded from the process other than whatever little they can do on the Senate floor.

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.

I stand ready to work with my colleagues, like Senator BOB GRAHAM, so that we pass an affordable prescription drug benefit for our Medicare beneficiaries this year. I think he and Senator MILLER are trying to the best they can, and I have respect for both of them, but I believe their bill falls far short of the tripartisan bill and has a lot less chance of bringing us together than the tripartisan bill does. I truly believe that we can work something out that will be approved by the Senate before we adjourn in the fall. This is an

important issue, too important to politicize so we should stop playing politics, once and for all. Let the Finance Committee do its work so the Senate can pass a Medicare prescription drug bill which can be signed into law this year.

I yield the floor.

THE PRESIDING OFFICER (Mr. JOHNSON). The Senator from Hawaii is recognized.

Mr. AKAKA. I thank the Chair.

(The remarks of Mr. AKAKA pertaining to the introduction of S. 2767 are located in today's RECORD under ''Statements on Introduced bills and Joint Resolutions.'')

Mr. HATCH. I yield 15 minutes to the Senator from Nevada.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I rise today to speak in support of the Medicare Prescription Drug Discount and Security Act of 2002, coauthored by myself and Senator HAGEL with the help of Senator GRAMM. This legislation provides an overdue and much needed prescription drug benefit to the Medicare Program.

We are going to be voting on two different bills tomorrow; following that, we will be taking up our legislation. We bring this legislation to the attention of our colleagues. We need to offer a responsible solution to make medicine more affordable for those seniors who need it the most. This offers immediate help to our Nation's seniors in the form of a bill that is voluntary, reliable, and it gives seniors options. It complements, rather than replaces, the private prescription drug coverage that two-thirds of retirees have now.

Many seniors like their current prescription drug plans and should not be forced to abandon them. The cost of prescription drugs is a major concern for many of my constituents, especially those who rely on only their Social Security benefits for their total income.

Let's look at a typical senior. We will call her Mary. Mary has worked hard her entire life, makes $55,000 a year, and is about to retire in 2004—coincidentally, the same time our program goes into effect.

Mary has never been much of a saver, so she will be relying almost solely on her monthly Social Security check to make ends meet. She can expect to get about $1,300 per month in benefits. Mary has diabetes and has to take six different prescription drugs every day to keep her healthy. The total cost of these drugs per month comes to about $475, about one-third of her income. Considering her other expenses, such as rent, food, and other monthly bills, Mary needs some help paying for her prescription drugs. The bottom line is Mary should never have to compromise her health by having to choose between buying prescription drugs or buying food for her table.

Our legislation provides immediate, affordable, and permanent help so that seniors like Mary never have to make that choice. This legislation has two parts:

First, all seniors would be protected from unlimited out-of-pocket drug expenses by instituting caps on their private expenditures. Once those caps are reached, the Federal Government would step in and cover the rest of the cost, minus a small copayment.

Second, all non-Medicaid seniors could enroll in a discount drug card program that would give them access to privately negotiated discounts on prescription drugs.

Let me now focus on the heart of our plan which protects seniors from unlimited out-of-pocket expenses, with the greatest protection going to those who need it most. Negotiated discounts on prescription drugs would be worked out through the private market, while Medicare would pay for drug costs after out-of-pocket expenditure caps have been met. This means, to our friend Mary, saving hundreds, possibly thousands, of dollars every year on prescription drug costs.

In this chart, we see how our plan works as far as the various income categories are concerned. Mary fits in the category below 200 percent of poverty. For an individual who makes less than $17,720 a year, which is about 50 percent of the senior population today, we cap their out-of-pocket expenses at $1,500. After they have paid $1,500 out-of-pocket, the Government will then pay for the rest of their prescription drug expenses.

Now remember, before they even start paying toward that cap, they have the prescription drug discount card. That saves them money, as well, on their prescriptions.

Continuing with the catastrophic coverage, if an individual's income is between 200 percent and 400 percent of poverty, they are capped at $3,500. If their income is between 400 percent and 600 percent of poverty, they are capped at $5,500. For seniors above 600 percent of poverty, individuals would be covered after they pay what is equal to 20 percent of their annual income.

The Hagel-Ensign plan has no monthly premium. It was said earlier that the tripartisan plan has the lowest monthly premium of any of the plans out there. Well, our plan has no monthly premium. What we do require is a $25 annual fee which is waived for those below 200 percent of poverty. Our $25 premium is used strictly for administrative costs.

Additionally, participants would also pay a small copayment of no more than 10% per prescription after they reach their out-of-pocket limit. We believe the copayment system is important because it not only keeps costs low by forcing pharmaceutical benefit managers to compete for business, but more importantly to the consumer, in this case the senior buying prescription drugs, back into the accountability loop.

The second part of our plan, the discount drug card program, works according to practical principles. According to a study conducted by the Lewin Group, one of the country's most respected health care actuaries, this approach would achieve significant discounts from full retail price between 30 percent and 39 percent. Here is how it works:

First of all, the card is completely voluntary, for both seniors and drug manufacturers. Drug manufacturers, through pharmacy benefit managers, would compete for business on the basis of their discounts and services, ultimately offering seniors the lowest price for their prescriptions. Seniors could choose from among any number of competing drug card plans. If they became dissatisfied with their plan, they could enroll in a different plan the following year. The Federal Government would not be fixing or negotiating prices for prescription drugs. The program simply allows seniors, such as Mary, to receive the same kind of privately negotiated discounts on drugs that are available to those enrolled in private health insurance plans.

Our plan also encourages the use of generic drugs whenever possible, in a couple of different ways. It requires the drug discount card issuer to include incentives in its program to use generic drugs whenever possible.

Mr. President, could you remind me when there is about 3 minutes to go?

The PRESIDING OFFICER. The Chair will do so.

Mr. ENSIGN. It also requires that each beneficiary who buys a drug through the discount card program be made aware of generic drug alternatives at the time they purchase the drug.

It is crucial to make prescription drugs affordable for seniors, which our program clearly does. However, it is also important to make sure Medicare's prescription drug program is affordable to the American taxpayer, which our plan also does.

According to actuarial analysis, our proposal would cost approximately $150 billion over ten years. We are waiting for the final score from CBO, but that is where we believe our plan will come in. This is markedly less than any of the other plans out there, even the tripartisan plan. It is less than half of what the tripartisan plan would be.

We must not only enact a responsible outpatient prescription drug program for our seniors, we must also do so without bankrupting the overall Medicare system.

Another reason our program is the best fit for seniors is that it takes effect at the earliest date. Our program takes effect on January 1, 2004, a full year earlier than any of the other plans. Our program is also permanent, unlike some of the other proposals which sunset after a period of time. So, our plan is an immediate step that can be taken to help seniors until comprehensive Medicare reform can be enacted.

I want to now compare our plan to the tripartisan plan and to the major

Democrat plan that Senators MILLER and GRAHAM have proposed. These are real life examples.

James is a 68-year-old, has an income of $16,000 per year, and is being treated for diabetes. He is taking these six different medications. His total monthly costs for these prescription drugs are around $478. His total annual costs are more than $5,700. Under the Graham-Miller approach, James would pay $2,940 out of his pocket. Under the tripartisan plan, he would pay $2,341.65 per year. Under the Hagel-Ensign plan, he would pay about $1,923.65 per year.

As you can see, the Hagel-Ensign proposal would save James over $1,000 annually when compared to the Graham-Miller proposal, and over $400 annually when compared to the tripartisan proposal.

Example No. 2: Doris is a 75-year-old, has an income of $17,000 per year, and is being treated for diabetes, hypertension, and high cholesterol. She takes Lipitor, Glucophage, Insulin, Coumadin, and Monopril every day. Her monthly cost is about $300, or about $3,650 per year.

Under the Graham-Miller proposal, her out-of-pocket expenses would be $2,220.00; under the tripartisan plan, $2,086.36; and under our plan, about $1,714.84.

The Hagel-Ensign proposal would save Doris over $500 annually when compared to the Graham-Miller proposal, and over $300 annually when compared to the tripartisan proposal. For those who are the sickest, who need the help the most, the Hagel-Ensign plan actually benefits them more than any other plan.

In comparing our plan to others—just to point out what other people may point out as a supposed weakness of our plan—for those who pay $1,000 or $1,200 per year for drug costs, the other plans will help them more, and we readily admit that. But for a majority of the senior population who has high drug costs and needs help paying those costs, we think our plan works best.

The PRESIDING OFFICER. The Senator has 3 minutes remaining.

Mr. ENSIGN. Betty is 66 years old, has an annual income of $15,500, and is being treated for breast cancer. She is still receiving low-dose radiation therapy and taking the following 6 medications: morphine sulfate, Paxil, Dexamethasone, Aciphex, Trimethobenzamide and Nolvadex. Her total monthly cost comes to around $670 and annually to about $8,000. Once again, to compare the plans with real life examples: under the Graham-Miller approach, she will pay $3,180.00 per year; under the tripartisan plan, she will pay $2,570.00 per year; under our plan, she will pay $2,152.00. So our plan is less, once again, than either of the other two major competing plans.

Under our bill, those who need it the most will get the most help. For those moderate- and low-income seniors, our plan will benefit them the most, and—we cannot emphasize this enough—our plan is the most responsible to the taxpayer. We cannot afford to say to the young people in America, you are going to be paying for this huge prescription drug program that probably will not be there for you in the future, but you have to pay for it anyway. We have to think about the next generation, so we must enact a plan that is fiscally responsible.

Our proposal says that we are going to give seniors—those who truly need it—the help that they need and ultimately deserve. But to the taxpayer, we are also saying we are going to be responsible to you.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. I yield myself 15 minutes.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, how much time—how much time remains between now and 6 o'clock?

The PRESIDING OFFICER. The majority has 92 minutes, the minority has 50 minutes.

Mr. KENNEDY. We have 90 minutes. I thank the Chair.

Mr. President, tomorrow in the early afternoon the Senate will have an opportunity to vote on which vision is the best vision for our seniors and for others who need prescription drugs. This will be the first opportunity we have had in the Senate to take that vote.

The absence of a prescription drug benefit from the Medicare Program is a glaring failure of the Medicare Program that every family understands in America today. It is not the fact that we have not had prescription drug programs that have been advanced to the Senate—we have. But they have been kept bottled up in the committees over the period of recent years.

I introduced, more than 5 years ago, prescription drug coverage into the committee. It was referred to the Committee on Finance, and it never saw the light of day.

We heard last week, and have heard now that somehow the majority leader has circumvented the Finance Committee and now we have the legislation out here. I applaud his efforts. So should all seniors applaud those efforts. We hear now the committee was prepared to move—but we waited and waited.

Our friends on the other side of the aisle had control of the Senate for 4 of the last 5 years. They controlled the Finance Committee for 4 of the last 5 years, and we never had an opportunity to have a debate on the issue of prescription drugs. Now we do. Now we will have a vote.

I think it is important for the American people to understand that we have been denied that opportunity for the past 5 years. Now we will have that opportunity. It is a tribute to leadership of Senator DASCHLE, who understands the importance of this issue to families in this country. We are enormously grateful to him for his leadership, and we are extremely hopeful that we will have a strong vote tomorrow that will reflect what is in the best interests of our seniors.

I was here in 1965 when we actually passed Medicare. We passed physicians' services and hospitalization but not prescription drugs. Now we all know that if the Medicare Program had been considered on the floor of the U.S. Senate, we would have included prescription drugs. It is as important as physicians' services and hospitalization. It is perhaps even more important in a number of different instances.

The fact remains that this is going to become even more important because we are now in the life sciences century. We are going to see extraordinary breakthroughs. We now see the mapping of the human genome and progress in so many important areas of research. It is virtually unlimited in what we will be able to achieve over a period of years.

It should be important to find ways of taking the progress being made in the labs and getting it to the patients who need it. They need it today. And we have a program that will do it.

I have listened with interest to those who support the Republican proposal, as they outlined at least what they consider to be the advantages of the Republic proposal and the disadvantages of our proposal. I hope in the 50 minutes they have remaining today or in the time prior to the vote tomorrow they will cite at least one, two, three, or four senior citizen groups that support their program. Because there are not any. Do we understand that? There are not any. The senior citizen groups that know the importance of prescription drugs have gone through these various programs in careful detail for those they are representing. And do you know what? They endorse the Graham-Miller proposal. They are behind the Graham-Miller proposal. They support it completely and wholeheartedly.

They appreciate the fact that our Republican friends over here are at least giving lip service to a prescription drug program. But if we are talking about which particular version is best for senior citizens, there is no competition. There is no question about it. You never heard in the earlier claims this afternoon the senior citizen groups that support their program because they are not there. This is one of the key reasons this is so important, and—I am hopeful—what this tomorrow vote is about.

I listened to my friend and colleague from Utah talk about premiums. On page 26 of the Graham-Miller proposal, our premium is listed at $24; for 2005, $25. I searched all weekend to find out where the $24 premium was in their bill that they have been talking about for the past few days. You can't find it in there. It is an estimate.

Ours is printed right here. Every senior citizen knows what that premium is going to be.

Theirs is an estimate. They all say: We have one that is $24—lower than the Miller program. But that is an estimate of what they are going to charge the insurance companies over a period of time. That is the difference.

I want to take just a few minutes to review with our colleagues what this program does not do and why the seniors have been so distressed about their program.

Actually, between 2005 and 2012 the seniors in this country are going to spend $1.6 trillion on prescription drugs. Their program is $330 or $340 billion. It is a lot of money. But if you figure that out, that is only about 20 cents on the dollar.

They are trying to say they are really going to be able to do something for the seniors. It just doesn't measure up.

I want to take a few moments of the Senate's time to go through the facts of the program itself. This chart over here is the Republican program, and this line is the percent of seniors. The next line is the drug costs; beneficiary payments; Medicare benefits; and then the percent of costs paid by the senior citizen. That is what we are concerned about.

The fact is, to address the extraordinary escalation of the costs of prescription drugs, we have an underlying proposal which will create momentum to get a handle on that escalation of prescription drugs—the excellent proposal introduced by our colleagues, Senators SCHUMER and MCCAIN. It was reported out of our committee with bipartisan support, which we welcome.

But 18 percent of seniors spend $250; the beneficiary payments will be $538. That is what they are going to pay in terms of their premium and their deductible in order to sign up for this program. For 18 percent of our senior citizens, they turn out to be losers, because 100 percent is going to be paid by senior citizens.

We take what the premiums are going to be, estimated by the Republicans, and also add the deductibles and the copays. You have another 18 percent that spend $1,000. Again, you add up the premium, deductibles, and copays. It will be $913 and beneficiary payments of $87. The senior citizen, 91 percent—some help and assistance.

Together, 36 percent of all the seniors, and one part of them, are going to pay 100 percent. They are not going to get any help, and the other group will pay 91 percent of the cost.

You come down here to the $2,000. This is where you really begin to get some help. The seniors are still going to spend 71 percent. If you come into the $3,000 to $4,000 range, 23 percent, they are going to be spending 67 percent.

Finally, 7 percent at the very high end. They will still be paying 74 percent.

These are the figures that are the expression of the program advanced by the Republicans. If you are a senior citizen and are hard-pressed today, you will find that your help and assistance in this program is a lot of rhetoric and very little action. That is what the result will be.

This is why, perhaps more than any other reason, seniors do not support the Republican proposal. And there are features in the Republican proposal that we find absolutely extraordinary.

I have heard a great deal from those on the Republican side talking about how this is going to help really the poorest of the poor of the seniors. We know the extraordinary average income is maybe $14,000. You can mention the handful of people who we read about who are billionaires. But the fact is, when you are talking about a group of our fellow citizens, the people who fought in the wars and brought us through the Depression, you are talking about this group here—basically, about $14,000 in income.

What is really in the Republican program are assets tests for the very, very poor. We heard from the other side, well, if they really fall down to 135 percent of poverty, they are going to have their premiums taken care of, and they won't have to worry about anything else. Right? Wrong. Wrong. Wrong. They will get them taken care of, if they don't have anything more than $4,000 in savings because we have an assets test, a pauperization test, for our seniors.

If they have more than $2,000 in furniture and personal property—maybe a wedding ring, an heirloom, something that has been passed on—if it is worth more than $2,000, they are in real trouble. If they have burial assets of more than $1,500, it counts against them, and if they have a car worth more than $4,500.

What do we have for $4,500 for our seniors in our part of the world, the Northeast, where it is cold in the wintertime; or how about in other parts of the country, where it is steaming hot in the summertime? Do we want them to risk their car breaking down, as they are trying to get their prescription drugs?

Go down to most of the car lots and find out what you can get for $4,500 and how dependable that car would be, whether you would want your mother or grandmother riding around in it in the cold of the winter or the heat of the summer, wondering if they can get to their destination.

If there are any more of those values, it adds up. And when it hits $4,000, they are excluded from the program.

Think of the demeaning aspects of this for our senior citizens, who are part of the greatest generation, who fought in World War II and lifted this country out of the Depression. They are in their golden years and have a few bucks—not very many—and they have to go down and fill out that form in order to qualify. It seems to me that is such a demeaning requirement.

I am surprised. I am surprised that our Republican friends have included that—saving the few bucks that it would—in their particular program. I am deeply surprised.

Our seniors deserve much better treatment. There are ways of making an evaluation as to what the assets are. No one is talking about trimming on this. We do not want people to trim—and they should not trim—but there are better ways of doing it than this particular way.

Finally, because of the time, I will mention one other feature that I am very perplexed about. I do not understand why they developed this kind of program. Their program is going to effectively take 3.5 million senior citizens who are now receiving a good drug program through their employers and drop them back to this program, which will provide a lesser benefit than they are now receiving, by and large, from their employers. This aspect of their program is very different from the Graham-Miller which would help and assist the small businesses and the medium-sized businesses continue to fund a good program.

I yield myself 3 more minutes.

The PRESIDING OFFICER. The Senator has that right.

Mr. KENNEDY. According to the CBO—this isn't our estimate; it is a CBO estimate—3.5 million seniors who are getting decent drug coverage through employers will be dropped from the list.

They wonder why the senior groups are not in support of this.

This is an enormously important debate and discussion that we will have. We will have an opportunity to have an expression on the proposal. As Senator GRAHAM and Senator MILLER have pointed out, we have what is called the first-dollar coverage. We do not have the doughnut, the loophole, that exists there. It will be within the ability of our seniors. It will be dependable. It will be affordable. It will be reliable. And it will be built upon existing programs, programs which have the confidence of our seniors and on which they can rely. It will be a very effective program. It will meet the kind of human needs that we believe our seniors need and deserve.

I reserve the remainder of our time.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, before I yield to Senator DOMENICI, let me say, I do not know where he is getting his figures. But we take care of low-income senior citizens. We have 100 percent of subsidy for those under 135 percent of poverty or less. For those up to 150 percent, that subsidy ranges from 100 percent down to 75 percent. And everybody above 150 percent has a subsidy of 75 percent.

On the assets test, they are not quite accurate. I will not go into the differences right now. But we will go into them later.

Mr. KENNEDY. Will the Senator yield on that point?

Mr. HATCH. No. I yield to the distinguished Senator from New Mexico.

Mr. KENNEDY. He does not choose to yield—on my time—to explain it?

Mr. HATCH. I will be happy to.

First of all, let's take the car benefit of $4,500. If it is necessary for medicine or for daily use or for their job, they could own a Rolls Royce according to our bill. But the fact of the matter is, no car would be taken from them. Now, if it isn't essential for that, then it would be limited to $4,500.

Mr. KENNEDY. We are not talking about taking the car from them. We are talking about disqualifying them for all of the funds over $4,500.

Mr. HATCH. They would not be disqualified.

Mr. KENNEDY. Excuse me, Senator. Excuse me, Senator. For money over the $4,500—up to $4,000—the value of the car and above that, it works to disqualify them from the coverage.

Mr. HATCH. If the car is necessary for daily use, if it is necessary for their job or if it is necessary for a medical purpose——

Mr. KENNEDY. What about personal property?

Mr. HATCH. For personal property, we have——

Mr. KENNEDY. I will go back. You yielded the time. I will go back. And I hope you have read your book because——

Mr. HATCH. I have read it. And you are misrepresenting what is in our bill.

Mr. KENNEDY. You included the assets test. And it is just as I identified it.

Mr. GRAMM. Will the Senator yield? Senator HATCH, will you yield?

Mr. HATCH. Let me——

Mr. GRAMM. Just 1 minute.

Mr. HATCH. One minute.

Mr. GRAMM. I am a little bit perplexed. Senator KENNEDY is going on and on about the assets test for Medicaid, when he helped write the bill.

I would say, Senator, if you are so unhappy about it, why did you write it that way?

Mr. KENNEDY. Senator, I am trying to get it out.

Mr. GRAMM. Hold it. I am on my 1 minute.

Mr. KENNEDY. OK.

Mr. GRAMM. We are not talking about Medicaid here. The Senator is talking about the assets test under Medicaid. I was not here when all that happened. It seems to me that it is an interesting point to make, but to suggest that has something to do with the Republican plan—it is a wonderful speech, and I am sure everybody enjoyed it, but it has little to do with the subject we are talking about. It has little to do with the Senator's plan. I am not for his plan, but I think to try to say that somehow it is responsible for the assets test in Medicaid just doesn't make any sense.

The PRESIDING OFFICER. The Senator has used 1 minute.

Mr. HATCH. Mr. President, it has everything to do with the Social Security Act, which none of us on the floor, except for Senator KENNEDY, I guess, had anything to do with.

Now, it is nice to moan and grown about these figures, but he is wrong.

Mr. KENNEDY. Will the Senator yield on my time?

Mr. HATCH. On your time, I am happy to.

Mr. KENNEDY. If the Senator would refer to page 71, line 14, and I would ask the Senator from Texas to refer to those as well: ''Meets the resource requirements described in 1905.'' That is the assets test, included in the prescription drug program which we will be voting on tomorrow.

Thankfully, we dropped that from the Graham proposal. It is in the Republican proposal, that provision, on page 71, lines 14 and 15.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, I can see why some seniors would want a trillion-dollar program—no question about it—as long as they think it is free. But it isn't going to be free. Neither is their program going to be free. We have to face some realities around here. Ours is $370 billion. That is a lot of money. We do more with ours than they do with theirs in their alleged $600 billion price tag. The fact of the matter is, that 75 percent of everybody's prescription drug coverage will be covered by our bill.

I yield 10 minutes to the distinguished Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. I thank the Senator. If I can get through sooner, I will.

First, I want to make sure everybody knows what bill I am talking about. I hear the word ''Republican.'' I am for a bill that has as cosponsors Senator BREAUX, who is a Democrat, Senator JEFFORDS, who is an Independent, and Senators SNOWE, HATCH, and GRASSLEY, who are Republicans. That is the bill I am for, and that is the bill I am going to be talking about.

I rise as a cosponsor of the bill that is being called the 21st Century Medicare Act, a bill which will provide our Nation's seniors with a much needed prescription benefit. I believe this bill is the best hope we have for enacting a prescription drug benefit into law this year.

If there are those who do not want a law, because they do not think they are going to get what they want this year, that is another story. Either of the other two might suffice, but it won't become law.

This bill has a chance because it is similar yet less funding than the House bill, similar in the way it is structured and the like. I believe it could get out of conference, and the seniors could have something that would be worthwhile.

It isn't the highest benefit, and certainly, if you are expressing a wish, you would like the highest benefit. But I would like to discuss with you the fact that the seniors of this country are somewhat worried about the young people who are going to be paying the bills for a long time. They are somewhat concerned about whether we can afford at this particular time the benefit that one party is talking about versus another.

If we pass the bill I am talking about, I believe it will reach agreement in conference with the House and we can send it to the President. Then finally, after years of talking, our seniors will get a prescription drug benefit they need.

The tripartisan bill provides a generous prescription drug benefit that will help all of our seniors with their drug costs. It does so in a responsible manner. In the budget resolution I put together with other Members of the Senate last year, the only budget resolution currently in effect in the Senate—in other words, that is the budget resolution that assumes we can afford the things that are enumerated in it, Senators GRASSLEY, SNOWE, GORDON SMITH, and others on that committee called the Committee of the Budget—set aside $300 billion over a 10-year period for Medicare modernization and a prescription drug benefit. This $300 billion was to cover the period from 2002 until 2011.

The tripartisan bill is estimated to cost about $370 billion over a 10-year period from 2003 to 2012.

We are debating a prescription drug amendment with costs based on the Congressional Budget Office current projections. Yet we are enforcing points of order from a budget resolution that is based on the Congressional Budget Office projections for last year.

Now, as we are all aware, the budget situation has changed dramatically over the past year. As a matter of fact, when we said it will be prudent and good for America to spend $300 billion, we were in the black. It was one of those years when we actually had money in the bank, were applying money to the debt, and it looked as if the American economy and our fiscal policy would be sound and strong.

As I stand here and speak, we have gone from that position to a debt in the budget of $165 billion. It will be there for anywhere from 3 to 5—maximum 8 or 9 years—if we do things right.

The attacks on our Nation, the war on terror, the economic slowdown have all resulted in a reduction of these surplus projections. Yet the Senate leadership has been unwilling or unable to produce a budget resolution for this year; that is, the Democrats will have us operate, including passing a Medicare Program, without a budget.

We don't know, with an official stamp of approval, what the budget is going to look like for the next 8 or 10 years, but here we are passing a Medicare Program that in one instance is two and a half times the amount we said was fiscally prudent for all Americans, not just the seniors, just 2 years ago when we were running a budget that was in the black.

An updated budget resolution could have an update on our spending estimates, and we would be debating these prescription drug amendments to the current Medicare Program in a more honest and transparent way.

Last year during the debate on the budget resolution, every Senator in this Chamber voted for funding of either $300 billion or $311 billion over 10 years. Those were the two chances to vote. They voted on them, every single one. They said, with a better American fiscal policy, they were more concerned about the future than they are now with a debt, and they all voted on between 300 and 311. The Democrat proposal, I believe, is up around $600 billion.

I don't believe, had we been voting on a budget instead of saying we don't need a budget, let's don't vote on one, had we been voting on one, the Senate would have put a budget before us on Medicare that would have been far less than $600 billion, if you are required to get a majority of the Senators as you would on a budget.

Here again, it has worked to the American people's disadvantage. By not having a budget resolution, we are probably going to overspend or we are going to kill the chance to get a Medicare prescription drug benefit package out of both Houses and before the President to sign.

From my standpoint, we can continue to argue and make like we are going to give the seniors the best program; that is, the most costly one, not the middle of the road one which we can really afford, and then we say, of course, the seniors want it. But if you presented to the seniors of America all the other problems we have in the next decade and asked them which they would want—do you want to say the one just for us or do you want to say one that would be good for everybody, I believe the triparty one before us will be good for everyone. But most importantly, from the practical, not political standpoint, you will get a prescription drug benefit program this year, effective next year, under the plan that is before you that is called triparty. You won't, if you proceed with the idea that the Democrats have the best plan and the bipartisan, triparty one should not be considered because it doesn't provide as much money.

I believe the seniors of this country want a plan that will pass, that can become law now. I believe they want one that is good for America, not just good for them. I believe they want one that is fiscally sound.

We are all worried about the American economy. The man who knows most about it says the one thing we ought to be frightened about is spending too much money while we are in this rather fragile situation. Yet we are here arguing that the plan we ought to vote on is the one that spends the most money. It seems to me that the House will stand in the way of that program. The President won't have to pass on it, and we will get nothing. We will have a vote. Those who are for the Democratic plan can go home and say: We voted for the most expensive one, the one we think will give the seniors the most. Whether it ever becomes law or not, we voted for it. We will put that up on a television screen. We voted for it.

Somebody is going to be asking: What happened to the law? Well, it never passed. Why didn't it pass? Because the House wouldn't approve it, because many Republicans and some Democrats wouldn't approve it. You got nothing.

That is what I think the end product is going to be—nothing. We ought to sit down and think about which plan would be adequate and which plan might, in fact, become law this coming year for the seniors.

Mr. HATCH. Mr. President, I yield 10 minutes to the distinguished Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. GRAMM. Mr. President, I thank the Senator for yielding.

I remind my colleagues that the best chance we have had to give prescription drug benefits to seniors occurred on March 16, 1999. We had a Bipartisan Commission on Medicare. JOHN BREAUX was the chairman of that Commission. We had set the Commission up by law. The leadership in the House and the Senate appointed members, and President Clinton appointed members. We met that day to vote on a plan that would have reformed Medicare.

One of the incentives to induce people to move out of the current Medicare system, where there are no incentives to contain cost, where Medicare pays for a walker three times as much as the Veterans Administration pays—not an agency especially noted for its efficiency, was to give them prescription drugs.

When the roll was called, the four Clinton appointees—Altman, Tyson, Vladeck, and Watson—all voted no. And while we had a majority, 10 of 17, to make an official recommendation, we had to have 11. On that day, March 16, our chance of modernizing Medicare and providing prescription drugs died on a straight vote, where every Clinton appointee voted no.

Then we started a process of bidding. I really believe much of this is more about the next election than it is about Medicare and the next generation. I want to remind people of this bidding. I say to Senator HATCH that the bill he supports would have outbid the Democrats last year, but it will not outbid them this year.

In 1999, Bill Clinton said that if you gave him $168 billion, he would provide a Medicare prescription drug program second to none. Then, in the year 2000, Senator Robb's bill bid that up to $242 billion, and last year, the Baucus amendment to the budget called for $311 billion. I have quotes that go on for 4 pages, where every member of the Democrat leadership says: If you will give us $311 billion, we can provide a fine prescription drug benefit. Now, this year, they are saying that $370 billion—which we do not have—will not do it and that what is being offered by this tripartisan group is chintzy, when, in fact, it provides more money than the Democrats were asking for last year.

This year, the Democrat's budget proposal provided $500 billion, and the Graham-Kennedy plan—which doesn't start until 2004 and ends 7 years later to try to hold down costs—costs up to $600 million. If you funded it for the whole 10 years, it would almost certainly cost a trillion dollars.

How did this cost explode? Well, it exploded because each year the two political parties bid against each other for votes, and the Democrats are never outbid. As Senator KENNEDY said, groups are for his plan because whatever it takes to get them to be for it is what he is going to offer. The current offer, on a 10-year basis, is really about a trillion dollars. There is only one problem: We don't have any money.

Let me say this about the plan that has been offered by the Democrats. Let me make it clear that this is Graham from Florida, not Gramm from Texas. Currently, we are spending about 2 percent of gross domestic product on Medicare. Because we have not reformed and modernized Medicare and because its costs are exploding, by 2030 that number is going to be 4 percent. Under current law, we will have to double the payroll tax, from 15 percent of income to 30 percent of income in 2030, to pay for Medicare and Social Security.

The Graham-Kennedy plan, which Senator KENNEDY was talking about, would raise that to 6 percent of gross domestic product and raise that payroll tax to a figure approaching 45 cents out of every dollar earned by every working American making a moderate income level. Does anybody really believe that people can pay those taxes? I don't think so. But when Senator KENNEDY is touting endorsements, those are not endorsements from people who are going to be paying for the program; they are from organized groups that claim to represent people who are going to be benefitting from the program.

The Kennedy bill, when you have it for 10 years, is a trillion dollars. We don't have a penny, much less a trillion dollars, in terms of funding this new benefit. We are going to have to double the payroll tax to pay for the program we have right now. The tripartisan plan is superior to that program because the Kennedy plan relies on the same inefficient Medicare Program run by a bureaucracy that tries to hold down cost with Government regulation. At least the tripartisan plan tries to bring in competition and efficiency.

The problem is, when you fill up this so-called donut in the tripartisan plan—where the government provides a

benefit up to a point, and then there is a gap where you pay $1,850 alone, before you get the Government benefit again. When you fill all that up, the tripartisan bill costs somewhere between $700 billion and $800 billion over a 10-year period. I think, in the end, that is unaffordable.

I am supporting the Hagel-Ensign bill for two reasons: One, we can afford it. It is within the budget we have, which is $300 billion. It is the only plan that is going to be offered where a budget point of order cannot be raised against it because it spends too much money. On the other two plans, a budget point of order can and will be raised.

There is another point of order because it didn't come through the Finance Committee, but that was a decision made by the Democrat leadership to not bring it through the Finance Committee.

The second advantage of the Hagel-Ensign plan is it is efficient. It helps the people who need the help most; that is, people with moderate incomes and very high drug bills. What the Hagel-Ensign bill basically says is, after you spend roughly $100 a month, and you have a moderate income, you are going to get Government help in buying your pharmaceuticals, and you are going to then pay only a very nominal copayment. That is help that people can understand. It doesn't start in 2005; it starts sooner in 2004 and doesn't end in 2012, it goes on forever.

As your income goes up and you are able to pay more for pharmaceuticals, the amount you have to spend before you get Government assistance goes up. That is a perfectly rational policy because what is a crisis to one family is not a crisis to another.

Finally, immediately, under the Hagel-Ensign plan, you have a choice among companies with which you will contract that will go out and try to buy your pharmaceuticals at the lowest possible cost. Estimates have been made by outside groups that this, by itself, could cut prescription drug costs by as much as 40 percent.

So under the Hagel-Ensign plan, you have a plan that, A, is within budget, costing less than $300 billion; and B, gives a lot of help to low or moderate income people who have high drug bills. If you have higher income and low drug bills, you don't get any help.

Senator KENNEDY would say: But it doesn't help all Americans. That is true, it doesn't; it doesn't help all Americans. It will not help Gates or Perot, but they don't need help. It will help people with moderate incomes and very high drug bills, and those are the people we need to help.

Is the Chair telling me my time is up?

The PRESIDING OFFICER (Mr. KENNEDY). Regrettably.

Mr. GRAMM. We are going to be in session next year, and we can build on this beginning. I urge my colleagues, if the Kennedy bill does not get the budget point of order waived, and if the tripartisan bill doesn't get the budget point of order waived, please look at the Hagel-Ensign bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. JOHNSON. Mr. President, I rise in support of the Graham-Miller legislation that is on the floor today. I note that Senator DASCHLE deserves great credit. For years, many of us have been trying to bring a prescription drug bill to the floor of the Senate, and we have been blocked. We would be blocked year after year if Senator DASCHLE had not become majority leader in the Senate this past year. We have an opportunity for a bipartisan debate and hopefully the successful passage of legislation will at last break the blockade that has been imposed against us for so long relative to providing prescription drugs under Medicare.

I believe the contrast is absolutely stark between what we have an opportunity to pass in the Graham-Miller legislation versus what our friends on the Republican side have been proposing as an alternative.

I think it profoundly says a great deal when we find out who are the supporters of the legislation on our side versus who supports the legislation of the other side of the aisle.

We are talking about an expansion of Medicare. We are not talking on our side about some form of privatization of the Medicare Program, some form of taxpayer subsidy to the insurance industry in the hopes that somehow the insurance industry will come up with stand-alone prescription drug policies which they will then offer and somehow people will find ways, then, to buy those policies.

We are talking about an actual strengthening of the Medicare system, an effort that is supported by AARP, by the National Committee for the Preservation of Social Security and Medicare, and by Families USA. Senior citizen groups across the board are in support of our legislation.

Who supports the alternative? The pharmaceutical industry. What does that tell you? What does that tell you about price control? What does that tell you about who is going to benefit by these alternative pieces of legislation?

On our side, we are talking about a Medicare prescription drug coverage with a defined benefit. Every American of Medicare eligibility age will know precisely what the premium is in a voluntary program. If they choose to undertake this program—they certainly do not have to, but if they choose to take this program, they will know precisely what the premium is, they will know precisely what the benefit is, they will know precisely how the program works, and it will not depend on whether they live in Sioux Falls, SD, or Los Angeles or New York or anywhere else.

Every American will have the same program, and it will not be dependent upon whether the insurance industry happened to decide to come into their State or into their community. In my home State of South Dakota, the insurance companies increasingly are leaving the State and leaving people in very rural areas with too few options. That is not where we want to be with prescription drugs.

Every American deserves to have a strong Medicare Program, and I know there are those on the other side who have ideological qualms. They do not like the idea of more Government, so they would rather privatize Medicare and rather go in the direction of taxpayer subsidies to the insurance industry to the applause of the pharmaceutical industry but not to the applause of American seniors who want a stronger Medicare Program as the underlying basis for prescription drug coverage.

We talk about whether this would contain prescription drug costs. In our underlying bill, we have the generic incentives and promotion which will be enormously helpful. We have also passed by a large margin a very closely monitored and controlled reimportation provision. Also within the underlying Graham-Miller bill under Medicare, there would be opportunities to negotiate and use the leverage of that huge population base for negotiated prices, keeping in mind that the citizens of no other industrialized nation pay anything close to what American citizens pay for the cost of prescription drugs.

If you go to Canada, Mexico, Britain, France, Scandinavia, or Germany, it does not matter, you pay less than half what American citizens are expected to pay.

It is long overdue that we have a component in this prescription drug bill that not only affords every Medicare-eligible individual a cost-effective, efficient way of gaining prescription drugs, but it holds those costs down and that, in fact, is why the pharmaceutical industry has objected so much to what we are trying to do and is so supportive of what the other side is trying to do because they know that the effective way of cutting costs, which indeed comes from massive profiteering that has been going on in recent years, will take place in our version. It will not take place in the version coming from the other side.

It always stuns me somewhat, I have to say, that those who talk about the cost of these programs and who preach the loudest about fiscal responsibility when it comes time to figure out how we can best serve the Medicare-eligible citizens of our nation in the most effective and efficient way, do not seem to be bothered when it comes time to propose follow-on tax cuts, primarily for the billionaires of this society, to cost in excess of what we are talking about for a Medicare drug coverage program.

It seems to me we have some priorities we need to sort out in this institution. We need to talk about how to effectively make sure that every senior gets the drugs they need.

I talk to many, far too many, people as I go across my State of South Dakota—one of the lowest per capita income States in the America—who literally are choosing between groceries and prescription drugs. They are cutting pills in half and not renewing their prescriptions, and then they show up in emergency rooms with an acute illness and the taxpayer picks up the cost.

How much better for the long-term cost, how much better for the dignity of these people to keep them healthy in the first place with a prescription drug regime that they and their physician have chosen which can be secured through Medicare and not at the whim of the insurance industry and not to the applause of the pharmaceutical industry but to the applause of the senior citizens organizations. How much better would it be to follow that road in terms of the reforms we need to be doing this week.

I know this is going to be a difficult debate because of the parliamentary rules that may require 60 votes to pass legislation. I do not know if we have the 60 votes or not. It is certainly my hope that we will because the problems this Nation faces, the problems that my senior citizens in South Dakota face are not Republican or Democrat problems. They transcend that. They are the problems of our entire society in my State and across this Nation. They deserve to be dealt with aggressively and effectively, and we have that opportunity with the Graham-Miller legislation and the underlying generic legislation before the Senate today.

Mr. President, there will be few more important votes in terms of domestic policy that this Senate will take anytime during the 107th Congress. It is my hope that politics can be laid aside, that ideological qualms about opposition to Medicare and Social Security that some have can be set aside, and recognize that Medicare is, indeed, the commonsense vehicle for trying to address cost containment and access to prescription drugs in a uniform, consistent way across this Nation; that opposition can be set aside, and we will, in fact, have the bipartisan support this legislation deserves to have and that at long last the gridlock, the obstructionism that has gone on for so many years can be broken and we can go home to our respective States at the conclusion of this debate knowing that we have done the right thing; we have done the good thing.

I have always believed the best politics is good government; that is, doing the right thing for people. If this body supports this underlying legislation, it will be a cause of great celebration. Everyone can get whatever credit they choose to have, but it will be the right thing for America and the right thing for our seniors.

I thank the Chair.

The PRESIDING OFFICER. Who yields time? The Senator from Utah.

Mr. HATCH. Mr. President, I have been listening to the comments of the distinguished Senator from Massachusetts earlier and the distinguished Senator from South Dakota. I mentioned in the early debate, on the first day of debating these matters, the book ''The System,'' written by Haynes Johnson and David S. Broder. It is a failure of the Clinton health care program in part.

It is very interesting what they say in this book. Neither Haynes Johnson nor David Broder would be considered leading conservative spokespeople.

The PRESIDING OFFICER. Is the Senator yielding himself time?

Mr. HATCH. Yes, I am.

The PRESIDING OFFICER. Such time as he may consume?

Mr. HATCH. I am.

Neither of them would be considered conservative journalists. This is what they wrote on page 90 of ''The System,'' which was published in 1996:

> In the campaign period, Fried recalled, Clinton's political advisers focused mainly on the message that for ''the plain folks, it's greed—greedy hospitals, greedy doctors, greedy insurance companies. It was an us-versus-them issue, which Clinton was extremely good at exploiting.''
>
> Clinton's political consultants, Carville, Begala, Grunwald, Greenberg, all thought ''there had to be villains.'' Anne Wexler remembered, ''It was a very alarming prospect for those of us looking long term at how to deal with this issue. But at that point, the insurance companies and the pharmaceutical companies became the enemy.

That is what is being done here today.

The main difference between the two programs is that ours lives within at least some budget constraints. It is more than what the Democrats would have taken last year, $311 billion. This is $370 billion. No. 2, we provide some element of private sector competition so there will be competition in this matter. That is driving costs down. No. 3, we provide there will be a system that will work because one can have more than one program instead of a one-size-fits-all program. No. 4, we are not going to get to price controls by the Federal Government, which would destabilize research and development of pharmaceuticals in this country. To hear some people on the other side, it is the big bad pharmaceutical companies that are causing these problems.

Actually, I think if we look at our system, both the generic and the pioneer companies, the research companies, we have a pretty great system that is producing the greatest therapeutic drugs in the world today. The reason we do is that we do not have price controls.

Where is the pharmaceutical system in Canada? Where is it in many other parts of the world where they have price controls? They do not have it. We do. We have the greatest system in the world.

I think Haynes Johnson and David Broder are right on: ''When you cannot win the debate, start knocking the big companies; speak for ''the little people,'' as they have said. And this has been the tenor of this debate so far.

I frankly think we ought to talk about living within the budget, doing the best we can, having a system that works, that has some element of competition in it, that does not set price controls over drugs so that it ruins our domestic companies and research and development plans, so we can ultimately get drugs into generic form so that we can save money. That is what is really involved.

I yield such time as she may consume to the distinguished Senator from Maine, Ms. SNOWE.

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. How much time is remaining, Mr. President, on our side?

The PRESIDING OFFICER. Twenty-two and a half minutes.

Ms. SNOWE. Mr. President, first, I express my appreciation to the Senator from Utah, who has done a yeoman's effort on behalf of this legislation, working in this past year to develop what has been known as the tripartisan legislation to develop a prescription drug benefit program.

I am pleased we are able to finally begin the debate on this most critical issue. It is obviously a significant issue to seniors. I hope everybody understands that we, in attempts to draft this tripartisan legislation, had hoped to avoid developing a polarizing and politicizing of this issue before the Senate. I regret that the regular process of the committee has been bypassed because I think in so doing there was an obvious attempt to try to avoid building the consensus that is essential to passing this kind of legislation.

Obviously, through the disruption of this process, we are here today, and I hope this process does not give anybody the excuse or the rationale to vote against a prescription drug bill because I think in the final analysis each of us will be accountable for our failure to do so in this institution.

We have a chance—just maybe this is our year—to pass a Medicare prescription drug benefit after all. There is only one plan thus far that has bipartisan and tripartisan support. Senator BREAUX, Senator JEFFORDS, Senator GRASSLEY, Senator HATCH, members of the Finance Committee, and I began this effort more than a year ago in an attempt to draft a compromise proposal that bridges the differences between two sides in this debate, hoping to avoid the kind of scenario that has now unfolded on the floor. That is why we undertook this effort to craft this tripartisan solution, when partisan differences threaten to undermine any possibility of enacting a prescription drug benefit. We believed then, as we do now, that as seniors cannot afford to put off their illnesses, we cannot put off a solution to this problem. So we

crossed the political divide to develop an innovative program that could become the basis for action.

As I said, we had hoped we could start that process within the committee that could give us the best hope for developing and forging a consensus on this issue. We worked closely with the Congressional Budget Office for forecasting an accurate estimate of the cost of our legislation, working hand in hand with them up until the final days in introducing this legislation, to ensure that we had a stable, efficient, competitive program that would provide choices to the seniors in this country and at the same time give them the maximum benefits under any kind of prescription drug benefit that we could include as part of the Medicare Program.

I have personally been working on this issue for the last 4 or 5 years, imploring Members of this Senate to pass a prescription drug benefit. It has been 4 long years. We have made some progress certainly in terms of estimating the cost and providing the type of appropriations that would be essential to supporting a generous prescription drug benefit.

In 1999, as a member of the Senate Budget Committee, I worked with Senator DOMENICI, Senator WYDEN, and Senator SMITH of Oregon to include a reserve fund. At that time, then-President Clinton provided $28 billion in his budget. We went further and provided $40 billion to set aside for a prescription drug benefit over 5 years. Then we decided last year we would go to $300 billion because the prescription drug costs go up each and every year, as we well know. So on both sides of the political aisle, there was agreement again and the Budget Committee set aside $300 billion for a reserve fund. It was also acknowledged time and again in floor debate that $300 billion was where we needed to be to provide strong coverage for seniors in Medicare for a prescription drug benefit.

So now we are at the stage of $370 billion, the tripartisan proposal, and approximately $600 billion in the proposal offered by Senator GRAHAM from Florida.

Everybody recognizes we need to enact a prescription drug program as part of Medicare. It is long overdue. Frankly, I do not think there is any difficulty in developing the policy, if there is the political will to do it. That is the big question—whether we have the desire to enact this kind of coverage for seniors in this country.

We have two competing plans. I hope we can avoid a process that is designed to create a political showdown. I hope we are not going to go down that path this week, irrespective of the fact we have two votes tomorrow, one on each plan. Is that where it is going to end or is that where it is going to begin?

I hope this is not about this election. I hope it is for the determination to do what we ought to do, and that is to design a program for prescription drug benefit coverage. It will not happen without bipartisanship and tripartisanship. That is what we did through the legislation we introduced and have been working on for more than a year.

I would rather not spend my time talking about process. The process becomes important when we bypass the conventional means of consideration: Draft and amend legislation in order to create a consensus on a bill before it reaches the floor; at least it attempts to do what was done on the tax bill last year. No one could have predicted what the outcome would be in the committee, let alone on the floor, but it was through the amendment process, through debate and deliberation that we finally reached a consensus that yielded the 62–38 vote.

We are in danger of not completing prescription drugs because of the process of cloaking political motives. We are looking at the procedural gymnastics that have occurred in this legislation. We could almost write the headlines: The Senate fails to muster 60 votes for a prescription drug plan; issue put off for another year.

Is that what Members want? I do not want the Senate described in those terms. I do not want this issue put off another year. We have been putting it off year after year after year. I want to make headway, not headlines. That is why it is important people understand what is going on. I am the last person who wants to talk about inside the beltway gobbledygook, about the process. I am interested in talking about the truth and what deserves our attention in terms of policy differences, not designing the next political stroke.

It is a disservice to the more than 40 million Medicare beneficiaries that see their prescription drug costs rise every year to the tune of 17 and 18 percent in annual costs just over the last 4 years. That is why we try to work on developing a middle ground approach and analyzing what could be the best plan, under the circumstances, to maximize the benefit, particularly those in the low-income scale, from all ranges of the political spectrum that could offer a comprehensive drug benefit that is affordable, comprehensive and available to all seniors, that provides the most in terms of benefits to low-income seniors and those especially without drug coverage.

It must be a fully funded, permanent part of Medicare that does not threaten the stability or the solvency of the Medicare Program for future generations. We offer in our plan the lowest premium of any plan introduced, $24 a month. It provides a 75 percent Federal subsidy. That is more than Federal employees have under their current health care coverage. That yields $340 billion in Federal support over the next 10 years.

People suggest the private sector will not be engaged in this process when the Federal Government provides an overall 75 percent Federal subsidy.

Seniors above 150 percent will see an annual savings on their prescription drugs of more than $1,600, which is a 53 percent savings. Those below 135 percent will see 98 percent savings on their prescription drugs. Ninety-nine percent of Medicare beneficiaries will be covered under our program; 93 percent estimated by CBO will participate in this program, and 6 percent will remain with their current coverage. That is extraordinary. Eighty percent will not even hit our benefit limit of $3,450.

We eliminate the so-called doughnut, the gap in coverage between the $3,450 benefit limit and catastrophic coverage of $3,700; 11.7 million beneficiaries with incomes below 150 percent are exempt from the benefit limit of $3,450. There are 10 million Medicare beneficiaries with incomes under 135 percent who will see 80 to 98 percent of prescription drug costs covered by this plan with no monthly premium, no deductible, and have average coinsurance of $1 to $2 per prescription and will have no cost beyond the catastrophic level. All other enrollees above 150 percent of the income level will have access to discounted prescription drugs after reaching the $3,450 benefit limit.

Everybody under Medicare will be protected against catastrophic costs. The drug benefit will be offered by the private drug plans. They accept part of the risk for managing this prescription drug program with the Federal Government accepting most of the risk. Seniors will have clout. They can vote with their feet. If they do not like the plan, they can select another plan. We believe, and CBO agrees, that the real competition will hold down drug costs and make this benefit more affordable for seniors and taxpayers.

Creating a new prescription drug benefit is absolutely essential to be part of our Medicare Program. AARP said in their testimony before the Senate Finance Committee, we need to have a dependable drug plan. That is exactly what we are providing. It is permanent and it is fully funded. That is a big difference from a plan that is sunsetted. I do not know how you explain to seniors in this country that the good news is you will have a prescription drug program starting in 2005, but the bad news is it expires in 2010. That is exactly the scenario established by the Graham-Daschle-Kennedy bill, which simply rides off into the sunset. It certainly will not be a happy new year on December 31, 2010 for any senior citizen who uses prescription drug coverage to learn their benefit has disappeared over the horizon—it is gone.

Is that the kind of stability, certainty, and predictability we want to give our seniors when it comes to one of the most vital benefits we could provide and need to provide?

You might wonder why it sunsets under the Graham legislation in 2010. That is a very good question. The answer is because they ran out of money. They knew if they continued, the sticker shock of their plan and the impact of their program, already facing

serious financial concerns, would cause more than a few to raise strenuous objections because of the ultimate impact it could have on the solvency of the Medicare Program.

Seniors have said they have two major priorities. One, they want to make sure the program is universal; two, it has the lowest monthly premium and at the same time it does not affect the financial stability of the future for Medicare.

That is a question about the choice we have tomorrow. Are we serious about providing a prescription drug benefit to seniors that will be sunsetted in 2010? That is a significant question that each Member must address in casting his or her vote in the Senate with the two competing plans. The plan we have offered was consistent with the priorities of seniors in this country, indeed the priorities of AARP, the major representative of seniors in America, that they wanted a dependable prescription drug benefit as part of Medicare. We offer it. It is fully funded, and it is part of Medicare in perpetuity.

There are other problems we have to address when we are looking at the Graham proposal. One is the issue of the nonpreferred drugs. In the original plan that was offered by Senator GRAHAM, there were the preferred drugs and the nonpreferred drugs. In fact, the copayments are lower under our plan. For the top 50 preferred drugs, we have lower copays under 39.

To put it the other way around the Graham proposal is higher on all but 11 of the top 50 preferred drugs—higher in copayments.

In the original Graham plan, there were the nonpreferred drugs. Again, we were lower in copayments in all categories except 1 out of the top 50.

Now, under the newly revised plan, none of the nonpreferred drugs is even covered—none, not one.

You might ask, what does that mean? That means it won't be available for seniors. That means, by virtue of the fact that the nonpreferred drugs are not covered under the Graham-Daschle-Kennedy plan, they are not going to be available to seniors. They will not have choices in the types of plans that include both the preferred and the nonpreferred. It means if your doctor prescribes a different brand prescription and it is not on the preferred list, you are out of luck because under Senator GRAHAM's proposal they will cover generics and only two brand names in every therapeutic category.

So here are a few examples of how the Government's strict limits on drug coverage under the Graham-Daschle-Kennedy plan would interfere with the drugs your doctor prescribes. The examples are taken from drug classes in the ''Physicians Desk Reference'' explicitly described in the bill as a model for determining the therapeutic classes in which only one or, at most, two drugs will be covered.

Let's take high cholesterol as an example. If you take Advicor, Baycol, Colestid, Lipitor, Mevacor, Pravachol, Tricor, WelChol, Zocor, or other drugs to lower cholesterol, and the Government plan says Lescol, you get no coverage at all. And even if you take Lescol XL, the more convenient extended-release form, then you get no coverage at all.

What about treatment for arthritis? Well, if you take Bextra, Cataflam, Celebrex, Clinoril, Feldene, Lodine, Lodine XL, Relafen, Tolectin, Tolectin SR, Trilisate, Vioxx, Voltaren, or Voltaren-SR for your arthritis, and the Government plan covers prescription-strength Advil, then you get no coverage at all, none.

You have high blood pressure? Well, if you take Accupril, Adalat, Aldoclor, Aldomet, Altace, Captopril, Cardizem, Cardura, Catapres, Corzide, Cozaar, Diovan, Diuril, Hyzaar, Lotensin, Maxzide, Minipress, Norvasc, Procardia, Tenormin, Toprol-XL, Univasc, Vasotec, Zebeta, Zestril, or any of dozens of other effective medications for high blood pressure that work best for you, and the Government plan covers Accuretic, then you get no coverage at all.

So it is far more restrictive than what the private sector offers today. Most private sector plans and the Federal employees plan would never consider being so restrictive as to provide no coverage at all for nonpreferred or off-formulary drugs. Moreover, to restrict covered drugs to no more than two in each class of drugs—generally these plans do the opposite, by providing some coverage for off-formulary drugs through tiered copays or off-formulary incentives.

What happens if I really need it? What happens if the doctor thinks that is the only option, the only drug that is going to be best for your treatment? It would require an explicit review and approval from the Secretary of Health and Human Services, right here in the plan that is offered by Senator GRAHAM, in order for the Government plan to offer a lower copayment or to provide coverage on additional drugs. Beyond these strict limits, the Secretary must determine that it will not result in an increase in expenditures by the Government.

Since when do we essentially decide we would rather have the Secretary of Health and Human Services writing prescriptions for American seniors? But that is what this comes down to.

Mr. HATCH. Will the Senator yield on that point?

Ms. SNOWE. I am delighted to yield to the Senator from Utah.

Mr. HATCH. Is the Senator saying that they claim for $600 billion, even in a bill that is sunsetted so they can keep the cost that low, that all of those drugs indicated on your chart in red letters ''not covered'' are drugs they do not cover?

Ms. SNOWE. That is correct.

Mr. HATCH. Yet in this $370 billion program that we have devised, all of those in yellow are covered?

Ms. SNOWE. That is correct. In fact, in our copays, on those that are covered, the top 50, we are lower or, the converse, in Senator GRAHAM's legislation their copays will be higher in 39 out of the 50 categories in terms of copayments. Then in the nonpreferred drugs, they are not even covered, and they are covered under our legislation because plans will be designed to include choices.

Mr. HATCH. I take it they are spending $600 billion or more—almost double what we spend—and not getting nearly the delivery of the drug as in the system we would give to the seniors. It seems to me it is pretty tough to be for the $600 billion program under those circumstances.

Ms. SNOWE. I would say to the Senator, that is correct. Obviously, the Government is going to make the determinations in terms of the types of drugs to be used, but the legislation already starts off in a very restrictive fashion. As a result, it will deny seniors their choices—not to mention that the whole program sunsets in 2010.

The PRESIDING OFFICER. The time of the Senator has expired.

Ms. SNOWE. Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Mr. President, I want to take a moment this afternoon to share a part of a letter I received from an 84-year-old gentleman in my home State of Washington. He writes to me:

> My income is limited to Social Security and a small amount of interest generated from the proceeds of the sale of my home. That doesn't leave much for anything but the basics. The highest of my monthly bills is for prescription drugs, the cost of which has skyrocketed for the past few years. Because Medicare provides nothing towards the exorbitant cost of these drugs—which are mostly for my heart—I pay upwards of $250 a month out of pocket.
>
> If Congress does nothing else this coming session, please let it be relief from the expense of the drugs I have to take to survive.

That is why I rise today in support of Medicare prescription drug benefits. This is an issue that Congress has talked about for years. It is a major challenge for seniors and the disabled every time they have to fill a prescription. And everyone agrees that we need to do something about it.

We have a bill that will address this problem in a responsible way, and I am in the Chamber today to help move it forward. I am very proud to be a cosponsor of the Graham-Miller-Kennedy bill, the Medicare Outpatient Prescription Drug Act of 2002.

This is not a new issue for me or for the people of my home State of Washington. Over the years, I have held many roundtable discussions in my home State where I have listened to doctors, seniors, the disabled, industry leaders, and health care providers. Like many people in my State, I am frustrated that it has taken us this long to finally reach this point in this critical debate.

Unfortunately, as we all know, the attacks of September 11 and the problems in our economy have delayed this critical discussion until now. During my time in the Senate, I have been very proud to work on prescription drug coverage, from helping to draft the MEND Act in the 106th Congress to working on the Budget Committee over the past 3 years to provide funding for prescription drugs.

In this Congress, I have been very proud to work with my Democratic colleagues to help ensure that the Graham-Miller-Kennedy bill meets our priorities of providing an affordable, voluntary, comprehensive, reliable benefit that is part of Medicare.

Health care has changed dramatically since Medicare was created, and it is time we update the Medicare Program to meet today's needs.

Decades ago, there was no big prescription drug issue. Back then, it was because prescription drugs played much less of a role in our health care. Today, prescription drugs are a key part of our health care. They help to prevent disease, and they help patients live longer.

As a result of these changes in health care, seniors now rely on prescription drugs more than ever. The average Medicare beneficiary fills 19 to 24 prescriptions each year.

Clearly, prescription drugs are more effective—and coverage is more needed—than ever before.

Unfortunately, it is getting more expensive—and more difficult—for seniors to get the medicine they need. Some seniors have drug coverage through their employers, but that number is shrinking. As costs rise, employers are cutting back on coverage.

In 1994, 40 percent of firms offered health benefits to their retirees. But by 2001, only 23 percent offered health benefits to their retirees.

Of those on Medicare, 38 percent have no drug coverage throughout the year. And even those seniors who are lucky enough to have coverage have seen increased premiums, deductibles, co-pays and greater restrictions. For those on Medicare, out-of-pocket payments for prescriptions—in just a two-year period from 2000–2002—have grown from an average of $813 to more than $1,000.

The lack of coverage—and the growing costs—are impacting health care today. Right now, an estimated 10–13 million seniors not have any prescription drug coverage.

To meet this need it has become critical that we update the program that seniors and the disabled rely on for their medical care. Updating Medicare is something we need to do very carefully. Back in 1997—when I first joined the Senate's HELP Committee—we faced the challenge of reforming and revitalizing the Food and Drug Administration's drug and device approval process. There were several competing demands we had to balance. On one hand, patients want new drugs and devices approved and available as soon as possible. On the other hand, the FDA has a responsibility to protect the public's health. We had to balance those two competing demands. And I am pleased that in the end—after months of debate—we passed a good bill that struck the right balance.

I mention that example to remind us that there are several competing demands when it comes to prescription drugs for seniors.

The first consideration is affordability. We can have the best prescription drugs in the world, but if seniors can't afford them, they are of little use. So affordability is key. But price is not the only consideration.

A second concern is safety and effectiveness.

We have worked hard over the years to make sure that our drug supply is safe. It is one of the FDA's most important responsibilities. I am proud of the way generic drugs have lowered the cost and improved access for so many Americans. But I also recognize that, if the drug isn't safe, or if it's not the medicine a patient needs, the cost savings are meaningless.

Another concern is innovation. Here in the United States, we have access to the most innovative, cutting-edge medicines. We don't want artificial limits on drug distribution that would delay innovations.

Finally, I believe that a prescription drug benefit must be a seamless part of Medicare. Just like care from a doctor or a hospital visit, prescription drugs are one of the key ways we provide health care today, and it should be treated like that under Medicare.

With all those considerations in mind, I am proud to support the Graham-Miller-Kennedy bill. It is the only plan that strikes the right balance. It is the only plan that delivers on the promise of a real prescription drug benefit for everyone on Medicare. It provides a comprehensive, affordable, and reliable prescription drug benefit. It provides coverage for every prescription without any deductible or coverage gap. It offers predictable, affordable co-payments, and it protects seniors from catastrophic expenses.

Second, it's affordable. It has a fixed monthly premium of just $25. It covers all drug expenses after a senior has spent $4,000 in out-of-pocket expenses. And because there is no deductible, it will help seniors with their very first prescription.

I am also proud that this bill goes to great lengths to help those with low incomes. For example, there is no premium or cost-sharing for beneficiaries with incomes below 135 percent of poverty. For those between 135–150 percent of poverty, there are reduced premiums. That will make a difference for the 168,000 Washington seniors who are below 150 percent of poverty.

Finally, this drug benefit is reliable. It will give seniors the security that comes from knowing that they can get the medicine they need. Seniors will know they are getting the same coverage—for the same price—no matter how sick they are, and no matter where they live.

The Graham-Miller-Kennedy bill is comprehensive, affordable and reliable. The other bills would leave a lot of Washington State seniors behind. Low-income seniors would in fact do far worse under the House and Senate Republican bills.

The Senate Republican bill has a $250 deductible. Our bill has no deductible. Under the Senate Republican bill, there is a big ''benefit hole'' for seniors who spend—out of their own pocket—between $3,451 to $5,300 on prescription drugs.

In Washington State, 212,000 people will fall into that benefit hole—paying premiums and high drug costs—without receiving any benefits. Under the House Republican plan, that benefit hole affects even more people—340,000 in Washington state alone.

There are many other problems with the House and Senate Republican bills—from the very limited stop-loss to the asset tests. And both these plans rely on private insurance companies to provide the benefit. If private insurance companies are not willing to participate, there is no coverage.

Those of us in Washington state have seen the private insurance market shrink in recent years, so that does not give us a lot of confidence in trusting the private sector to solve the problem.

Before I close, I want to mention that we have other parts of Medicare we need to fix. Over the past few months, I have worked with a number of my colleagues to address the regional inequities in Medicare. Even though all seniors pay the same rate into the Medicare system, their access to health care depends on where they live. If they live in Washington state, they have fare less access to healthcare. That is because Washington state ranks 42nd in the Nation in Medicare reimbursements per beneficiary. I have been working with leaders in my state on the issue, and I'm continuing to raise the ideas and the MediFair proposal with my colleagues here in the Senate.

I am proud that the Graham-Miller-Kennedy bill does not base benefits on the same flawed formula that has created regional inequities in Medicare reimbursements. I hope we can move forward on both issues—addressing the fairness sin Medicare payments and providing prescription drugs.

Today, we have the opportunity to help the more than 700,000 people in Washington state whoa re enrolled in Medicare. We know that prescription drugs are more effective—and more important for good health care—than ever before. But seniors don't have access to them because of rising costs and shrinking coverage.

The Graham-Miller-Kennedy bill will provide a prescription drug benefit that's part of Medicare and that is comprehensive, affordable and reliable. I urge my colleagues to help us pass this critical legislation.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

Mr. REED. Mr. President, I rise this afternoon to join my colleagues and the growing chorus requesting that the Senate move expeditiously to pass a universal, voluntary, and affordable prescription benefit plan under Medicare.

I am a proud cosponsor of the Graham-Miller-Kennedy proposal, which I think is the right approach to provide a voluntary, universal, and affordable prescription drug benefit for our seniors.

In 1964, Congress took the bold step to enact a health insurance program that guaranteed coverage for all seniors and disabled persons in the country. That boldness has been justified over the last decade because it has improved materially the health of seniors, and, indeed, this development has improved their economic standing as well. But it is time for their Congress to bring that Medicare Program into the 21st century.

Back in 1964, the key elements of health care for seniors and for all Americans was access to hospitals and access to doctors. Medicare provided for both.

Today, there is a third critical element. That element is pharmaceutical benefits. Thus, we must bring the Medicare Program that has served us so well over these last several decades into this new century by providing a prescription drug benefit for our seniors.

Today, Medicare beneficiaries account for 14 percent of the population, but they account for 43 percent of the Nation's spending on prescription drugs.

You can see that the population most affected by the use of pharmaceuticals and the rising costs of pharmaceuticals is seniors. Another reason why we have to move quickly and expeditiously to provide assistance under the Medicare Program.

Today, the Medicare Program covers approximately 39 million Americans, about 170,000 of my fellow Rhode Islanders. It is a program that is integral to the health and economic security of our seniors and to all of our families. For this system to go forward, it has to be strengthened by pharmaceutical benefits.

I would like to talk briefly about some of the trends we have seen with respect to prescription drug benefits, to highlight the strengths of the Graham-Miller-Kennedy proposal, and to contrast this proposal with competing proposals: the House version and the tripartite package that is before us in the Senate.

Before I do that, I want to commend majority leader DASCHLE for bringing this matter to the floor. This is an issue which every senior and every family in this country is acutely aware of and who have called for our attention to it for many, many years.

This is not something new. There was at least rhetorical consensus in the last election when both sides claimed they were for the inclusion of a prescription drug benefit under Medicare. We have reached the point where words have led to action on this floor. I thank the majority leader for forging that action as we debate this issue today.

I think it is also appropriate that this legislation has been brought together with another bill, the Schumer-McCain legislation that was modified in the HELP Committee by Senators COLLINS and EDWARDS, which provides benefits, we hope, to the entire population of this country when they purchase pharmaceuticals, because it will hasten the introduction of generic drugs into the marketplace while preserving the integrity of our intellectual property system.

These two bills together—a prescription drug benefit for seniors from the Medicare system, and strengthening and speeding access to generic drugs in the country—I think are appropriate responses to the legitimate, persistent, and long-standing demands of the American public.

Last year—if we look at the spending on pharmaceuticals—out-of-pocket spending on prescription drugs was estimated to be $848 a year among Medicare beneficiaries. Nine percent of them, however, spent more than $2,500 a year. This is an extraordinary amount of money for people who are living on fixed incomes. You do not have to talk to too many seniors before you hear their legitimate complaints, that they often have to choose between buying their prescriptions or paying their rent.

Today, we had an event in Providence, RI, where we had seniors and physicians talk about that issue. A physician who joined us was very eloquent on this subject, pointing out that often his patients will tell him the choice they face is either filling their prescriptions or paying the telephone bill that month. That is a choice many seniors have to make. Frankly, many of them will choose to have the telephone—for an emergency, for a lifeline, for communication with their families—and they will forgo the prescriptions.

The doctor spoke of one case—one among many—where he was treating an elderly person, a woman, for high blood pressure, and she could not afford the full range of drugs he prescribed. So he tried to make do with whatever was in his supply cabinet: the samples he got from pharmaceutical companies. This caused, of course, a situation where they were frequently changing prescriptions; and even then she could not fill all the prescriptions because of her economic circumstances.

The high blood pressure was treated on an ad hoc basis. Sometimes she could take her medicine because she could afford it; sometimes she could not. And what happened? The lady suffered a devastating stroke. Ironically, today that doctor can prescribe and ensure she gets the full complement of pharmaceuticals because she is disabled and her health care is paid for through the Medicaid Program as a disabled citizen. That is not right, and it does not make any sense. If that woman had been covered by the provisions of the Graham-Miller-Kennedy bill, she could have purchased those medicines that would have, hopefully, prevented her stroke.

That is just one example, but we see it time and time again. Seniors are under tremendous financial and economic strain, as prescription drug costs go up and up and up.

I spoke to another senior this morning: 70 years old, still working, and working primarily to pay for her prescriptions. She said she went back to a druggist the other day and was told her drug cost over $100. She cannot afford it.

These are the realities that seniors face throughout the country. The bill Senators GRAHAM, MILLER and their colleagues have proposed—and one I proudly support—will address those concerns. They will provide a prescription drug benefit that is voluntary, a benefit that will require a $25 monthly premium, and no deductible. It will require the senior to pay $10 for generic prescriptions, $40 for a preferred brand name prescription, and $60 for a nonpreferred brand name prescription—simple, direct, well defined, the essence of what I believe we should do to help seniors.

The bill sets forth a clearly defined framework for what a Medicare recipient would expect to receive in benefits. The assistance is there from the very first prescription. There is no deductible. There are no gaps or limits in coverage. There is a catastrophic cap on out-of-pocket expenditures above $4,000. And there are additional subsidies for individuals with incomes below 150 percent of poverty—simple, direct, well defined, the essence of what we should do.

It is a program that will not be administered at the discretion of private health insurance. It will be a Medicare program, available to every American, no matter where they live, something I think should be inherent in any drug proposal we make here on the floor of the Senate.

In contrast, the House bill and other Senate proposals do not provide reliable drug coverage as part of Medicare's defined benefit package. These alternative bills have no defined benefit, no guaranteed premiums, no standard copayments or cost-sharing. And because the plans rely on private insurance companies and HMOs, the actual benefit a person receives could vary, depending on where that person lives.

As we have experienced with the Medigap and the Medicare HMO market, private insurers are not capable, often, of providing stable, predictable coverage that older Americans and the disabled need and deserve. I hear regularly from constituents who are confused and upset by the constant

changes in premiums, copayments, and benefits under these plans. And I suspect the same confusion will result if these pharmaceutical plans are administered exclusively by private insurers.

So I believe we should move forward, very deliberately and very quickly, to adopt the version proposed by my colleague from Florida, Senator GRAHAM.

Again, in contrast to the Graham bill, the House-passed bill would require a monthly premium of $34, but the first $250 in drug costs must be assumed entirely by the beneficiary. You would be paying a premium, and yet you would be getting nothing for the first $250 in costs.

For the next level, from $251 to $1,000, you would only pay 20 percent. But then, if you went over $1,000, you, the beneficiary, would have to pay 50 percent of the cost. And what, to me, is the most astounding aspect of this House proposal is, once a patient spends up above $2,000, they would have to pay the entire cost of their prescriptions until $4,800. Just at the point where these pharmaceutical costs were accumulating, a beneficiary would have to pay all of the costs and still the premium.

This bill and its counterpart, the tripartisan bill in the Senate, I think, are not sufficient to meet the task before us. I urge my colleagues—all of my colleagues—to support strenuously the Graham-Miller-Kennedy bill and provide seniors and the disabled with a real pharmaceutical benefit.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I will ask that we have a brief quorum call and that the time not be charged to either side. I suggest the absence of a quorum.

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

The legislative clerk proceeded to call the roll.

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

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

Mr. LOTT. Madam President, if I could inquire about the parliamentary situation or the time situation, how much time is left on this side of the aisle on this debate?

The PRESIDING OFFICER. No time remains on that side.

Mr. LOTT. How much time on the other side?

The PRESIDING OFFICER. Forty-two minutes.

Mr. LOTT. Madam President, I yield myself time that I might need under leader time. But for the information of the Senators who are here, I don't believe it will exceed more than about 10 minutes or so.

The PRESIDING OFFICER. The Senator has that right.

Mr. LOTT. Madam President, I know there has already been a good debate on this very important issue today. I do sincerely hope that we can produce a result that will provide prescription drug coverage for our low-income elderly, sick people who need this help. Certainly, from personal experience, I know of low-income elderly who need the help. My concern, though, is we do it in such a way that the costs are not so extreme that they wind up causing serious problems with our Medicare funds. In short, we don't want to blow a hole in the Medicare fund and cause all kinds of problems as a result of our good intentions. That is my first concern with the Graham-Kennedy proposal.

I know it has been difficult to get a cost analysis. I am still not quite sure exactly what the cost has been estimated on this proposal, although I understand it is in the range of $600 billion over a 10-year period. I understand the plan perhaps may be defined as only covering 8 years, which doesn't begin until 2004, so it is pretty hard to match apples and apples. But over a 10-year period, I think it would probably wind up being at least $600 billion.

The cost factor is something we have to be aware of in all these different plans.

The other thing that bothers me is the universal coverage aspects. Regardless of income, you are going to get subsidized prescription drugs if you are, I guess, in a certain age category. That is my understanding. That is one of the fundamental differences. I have always said we should target sick low-income elderly or certainly, low-income elderly. But even using those three words produces a different number of people. We would have to think about that very carefully.

But the idea that we would be providing subsidized prescription drugs to people who have income in retirement of $50,000, $60,000, I guess any amount, is a major concern I have.

I am also disturbed about new revelations that I have discovered in the Graham-Kennedy amendment over the weekend. We had an earlier version that has been changed. Everybody is entitled to do that up until the time the different proposals were offered. But there are some critical changes that have been made, I presume, to reduce, at least to some degree, the cost estimates on this proposal. There are some details embedded in this plan that will have critical repercussions on the lives and health of 40 million seniors if the amendment were ever to become law.

There are two critical differences that I want to point out today between the Graham-Kennedy amendment and Senator GRAHAM's original bill, S. 2625. When you look at what those two apparently small changes actually mean in the operation of the prescription drug benefit, I believe you will want to oppose the Graham amendment in its current form.

In the first change, which is on page 30 of the amendment, it has to do with copayments for brand name drugs that are not on the health plan's approved list. First, it would help if we review the original language in the Graham bill and what it had to say about the copayments. The original Graham bill said if you used a generic drug, you would face a copayment of $10 per prescription; that is, if you use a generic drug.

If you use a brand name drug that was part of the so-called formulary—I will call it the approved list—you would face a copayment of $40 per prescription. And if you used, under diagnosis by a doctor, a brand name drug that was not part of your plan's formulary or approved list, you would face a copayment of $60 per prescription. So we had copayments for prescriptions of $10, $40, and $60.

The current language, which has been changed in the Graham-Kennedy amendment, changes the last part. It changes the copayment for the brand name drug, which is not part of your health plan's approved list. The amendment now says that your prescription drug plan will not cover any brand name drug that is not on your health plan's approved list. In that case, you have to pay the full price of the drug. Here is the key language on page 30 of the amendment. We have it blown up here so Members can see it, even though they don't have it available to them to read out of the bill:

Beneficiary responsible for negotiated price of nonformulary drugs: In the case of a covered outpatient drug that is dispensed to an eligible beneficiary and that is not included in the formulary established by the eligible entity for the plan, the beneficiary shall be responsible for negotiated price for the drug.

Now, you got it right. The new plan does not cover brand name drugs, unless they are on your drug plan's approved list. You, the Medicare recipient, would have to pay for the drug out of your own pocket. Well, you might say that should not be too big a problem. But let's get into it a little deeper and you will see what is a further change in the bill and how the two of them tie together and cause problems.

The other shoe drops on pages 61 and 62 of the Graham-Kennedy amendment. Let's look at the legislative language in this case:

The eligible entity (health plan) shall include at least one, but not more than 2, brand name covered outpatient drugs for each therapeutic class as a preferred brand name drug in the formulary [or the approved list].

That means that under the current plan in the Democrat proposal, your health plan cannot include more than two name brand drugs for arthritis. Your plan cannot include more than two brand name broad antibiotic drugs, or not more than two brand name narcotic pain killers, or antiseizure drugs, or diabetic drugs, or hypertension drugs. In any case, it is no more than two.

So look at what happens when you combine what you see on page 30 with what you see on page 62. If you need a name brand drug and if that brand name drug is not on the list of two on your approved list, then you are out of luck. Your new wonder drug plan here from the Democrats doesn't cover that drug. You would have to pay the full cost out of your pocket. So here is what that would lead to. Suppose you use an antihistamine every day and your health plan chooses to cover Allegra or Zyrtec, but not Claritin because it is limited to only two brand name antihistamine drugs. If you prefer Claritin because it clears up your symptoms better—just today, I was talking to an elderly person who was having problems, and I asked that person what they were taking because it obviously wasn't working. They told me it was one of the two that I mentioned here. I suggested maybe he try a Claritin D, since it seems to work better for me; certain drugs may work differently on different people, and doctors prescribe different brand name drugs. If the one you need the most is Claritin, which is not on the list, but these other two are—and you also have the Claritin reditabs—then you would have to pay $68 more per prescription to get the drug that has been prescribed to you, which is your choice, or the one you need.

Now, that, of course, is a concern if you are in that category. It gets even worse if you look at other examples. For instance, antiarthritics. Suppose you need Celebrex but your health plan, limited to only two drugs, chooses Vioxx or Enbrel. As many seniors with arthritis know, arthritis drugs are very particular. What works for one senior citizen doesn't necessarily work for another. The Graham amendment limits your health plan to two of these four drugs. So if you need Celebrex, you could be out of luck, and you would then have to pay about $90 per prescription out of your pocket in order to get this particular arthritis drug.

And then it can go into other areas, too; for instance, antidepressants. Under the Graham amendment, only two antidepressants would be covered. If you needed one not on the list, you would have to pay the cost out of your own pocket. It could be—in the case of Prozac—$110 to get the particular drug that you might need.

Madam President, that is the plan we have before us. One thing that bothers me about it, too, is who decides exactly what two would be on this approved list? Is it going to be a board? What would be the criteria in deciding what two drugs would be on the list? This is a solution that I think causes a real problem. Some people say just take a generic. Substitute in a different brand name drug, they will argue. But sometimes you just cannot do it. Many times, drugs have specific effects on different people. So I think this is a major flaw that has been created by limiting or dropping out the $60 copayment per prescription, and then coming up with the two-drug limit.

I was going over this information this afternoon and I wanted Senators to know about this change. I know that everybody is trying to work toward the right end result and with good intentions. But I do think that what is happening is you have limited choices and you guarantee that many seniors who need these specific drugs—Prozac is as good an example as you are going to find, where you would have to come up with a significant cost—$110—for the drugs.

Before you vote tomorrow afternoon, I urge my colleagues to look at the changes that have been made. I presume they were made because of the cost impact. But you need to also look at what the medical impact is—the result of the decision that has been made. I urge my colleagues to vote against it on this basis, as well as on many others.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Madam President, I yield 30 minutes to the Senator from Florida, and I think I still have 12 minutes or so remaining?

The PRESIDING OFFICER. The Senator is correct.

The Senator from Florida is recognized.

Mr. GRAHAM. Madam President, I hope the minority leader might be able to stay on the floor so he would not run the risk of being unable to sleep tonight, as he tosses and turns, concerned about the fact that we have provided, as almost every private health care plan does provide, for a specific formulary as to what will get the benefit of the preferred $40 deductibles.

At an appropriate time in my remarks, I am going to go into this in more detail, and I will also direct the Senator's attention to other language in the pages from which he was quoting, which indicates that we are sensitive to exactly the concerns he has expressed; we have, in fact, provided a means by which other drugs that are found to be clinically necessary would be added to the list of those which could be secured at the $40 copayment level.

I think the Senator from Mississippi will find many of the remarks I am about to make to be informative, insightful, possibly requiring a reassessment of position and hopefully tomorrow at 2:30 p.m. to see him march proudly to the front of the Chamber and cast a vote in favor of the Graham-Miller-Kennedy bill. We would be honored to have that vote and would even keep the list of potential cosponsors open for his possible signature.

One of our colleagues has specifically asked that I request unanimous consent that he be added as a cosponsor: Senator AKAKA. I make such a request on his behalf.

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

Mr. GRAHAM. I thank the Chair.

Last Thursday, the 18th of July, Senators KENNEDY, MILLER, CORZINE, and I offered this amendment to provide affordable, comprehensive, and reliable prescription drug coverage for the 39 million older Americans and disabled citizens who are currently covered by Medicare.

I have an interest in all Americans who will benefit by the adoption of this proposal. I have a particular interest in the 2,750,000 of these Americans who call their home Florida.

I do not wish to repeat the remarks I made last Thursday, so let me just recap some of the principles that we think are important and should be the touchstone in evaluating any plan that is proposed for prescription drugs.

We believe these principles include: a modernization of the Medicare Program; providing beneficiaries with real benefit; giving to the beneficiaries real choices; using a delivery system that seniors can rely upon and is affordable for the beneficiaries; and a program which is fiscally prudent.

I also outlined last Thursday our specific proposal and indicated how it complied with those principles of a prescription drug program for Medicare.

What does our proposal provide? We guarantee a universal benefit to all seniors, no matter where they live; that if they determine it is in their interest to voluntarily elect to participate in the prescription drug plan, they would pay $25 per month for that participation. Having done so, assistance would begin with the very first prescription. There is no deductible. They would pay a predictable copayment. For the year 2005, the first year that this program would be operational, the seniors would never pay more than $10 for a generic drug and $40 for a medically necessary brand-name drug.

Medicare beneficiaries can also rest easy knowing that they would never pay more than $4,000 in a year for their prescriptions. Seniors with incomes below $13,290 for an individual and for couples below $17,910 annual, if that is your income, then you would receive additional assistance, including the waiver of copayments for those who are below 135 percent of poverty.

We would also be able to guarantee that this benefit would be available to all seniors because we use a system to deliver the drug benefit that is as tried and true as the 37-year-old Medicare Program itself. It is the same system that you and I and all Members of the U.S. Congress use to receive their prescription drugs through the Federal Employees Health Benefits Program.

We rely on pharmacy benefit managers, or PBMs, to deliver and manage our drug benefit. PBMs are private commercial companies that negotiate with the pharmaceutical companies to get discounted prices. These companies are currently providing drug benefits through public and private employer plans in every zip code in America, and they would work as well for our seniors

as they do for Federal employees, private sector employees, and Members of Congress.

What I wish to do this afternoon is focus first on what I think are some of the key concerns raised by the Republican plan and then respond to some of the questions which have been raised, such as the questions raised by the Senator from Maine, who is in the Chamber now, and the Senator from Mississippi.

These key problems raised about the Republican plan include its reliance on a yet-to-be-created delivery system, the gaps in coverage, and their test of beneficiaries' assets, which will make it difficult, if not impossible, for many of our low-income seniors to get the drugs they need because even though they will qualify for special assistance based on their income, they will be rejected because they have too many assets.

Let me discuss each of these principal flaws in some detail.

Our Republican colleagues have criticized our proposal for being an integral part of the Medicare Program. Instead, they would use the prescription drug benefit to begin privatizing the Medicare Program; they would give the important task of delivering prescription drugs to private drug HMOs.

I have grave doubts about the private insurance model for prescription drugs for the very basic reason that it has never been done this way. There is no place we can turn to say: How has a private insurance subsidized plan for only prescription drugs worked? If there is such a plan, if there is someplace that we can turn to inform our judgment on this, I would ask for the name of the company, its address, and its telephone number so we might call and ask some of the questions that concern us about how such a plan would work.

I am afraid we will find there is no name, there is no address, and there is no telephone number. Private insurance plans have had every opportunity to offer drug-only insurance plans, and yet not one has stepped forward to do so.

Private insurers simply have no interest in providing drug-only benefits. Why are they not interested in drug-only benefits? Let me use an analogy to the private insurance market as it relates to casualty insurance.

Most of us who own a home have insurance on that home to cover risks, such as fire or windstorm damage. You can call State Farm and ask whether it would offer a kitchen-only casualty insurance policy, or would it offer a policy that would only cover that back room which is next door to an old and frail tree that might blow over in a storm and fall on the rear of the house. The answer to that is obviously no. State Farm and any other casualty insurance company would consider insuring your whole house, but they are not going to insure a specific room and particularly a room that is probably more vulnerable than other parts of the house.

This is exactly what is being asked of insurance companies as it relates to offering a prescription drug-only plan. Prescription drugs happen to be the fastest growing segment of total health care costs in America. When Medicare was established in 1965, the average older American spent $65 on prescription drugs. I am not talking about $65 a week or $65 a month. I am saying $65 a year was the average amount that seniors spent on prescription drugs.

That number has increased by a factor of 35 in the history of Medicare, the fastest growing segment of health care in America. That is why insurance companies have been unwilling to offer a prescription drug-only private insurance policy.

This is what we are going to require as the model for delivery under the Republican proposal.

About a year ago, I invited a group of chief executive officers of pharmaceutical companies to come into my office to talk about the various plans and specifically the method of distributing prescription drugs. I asked these executives a fairly simple question: How do your employees get their prescription drugs? Do they get them through a drug-only private insurance plan? Do you rely on drug HMOs for your employees, for you and your family to get these drug benefits?

The answer from each of the CEOs was the same. No.

Why not, I asked.

The answer was: No such plan exists.

So I asked this question: Why do we want to impose this untried system on our Nation's seniors? Why should they be the guinea pigs in some vast theoretical laboratory experiment of a plan that has never been tried?

I am particularly concerned about how the Republican HMO drug plan will work in rural areas of which, in my State, in the State of the Presiding Officer, in virtually every State, is a significant amount of our population. We have to look no further than the Medicare+Choice system—these are the full Medicare HMOs—to see how rural areas would likely fair.

According to the Congressional Research Service, 94 percent of Medicare beneficiaries in rural areas have no access to Medicare HMOs. Why is this the case? In significant part, it is because rural beneficiaries on the whole tend to be older and sicker than other senior Americans. Therefore, it is more difficult for a private insurance plan to spread its risk. Most of the beneficiaries served in rural areas are considered high-risk beneficiaries. A likely result of the prescription drug model that relies on drug HMOs is that seniors in rural areas will pay higher premiums than beneficiaries in urban areas, if they are able to get any coverage at all.

In addition to questioning whether a drug benefit would actually be available if we rely on drug HMOs as proposed by our Republican colleagues, I have great doubts about the affordability of any benefit that is offered. Why is that? Because the drug HMOs get all the choices when it comes to the benefit they would offer.

We cannot tell our seniors what the Republican prescription drug benefit is. No place in their bill does it tell us what premium the seniors will be charged. It does not say what the deductibles and coinsurance levels will be. They are only ''suggestions.''

My Republican colleagues talk about providing choices. What they do not tell us is they give all the choices to the private insurance companies. Under the Republican plan, our seniors will pay different premiums depending on where they live. Under the Republican plan, the drug HMOs determine what the premiums will be, not the Medicare Program.

If it is not troubling enough that the insurance industry would be making these choices about what the premium is, what the deductible is, what the cost sharing will be, consider this: The Republican plan would spend precious resources to lure private insurers into the market. Instead of using these resources, Federal dollars, Federal taxpayer dollars, to ensure an affordable drug benefit for all seniors, they would use them to induce private drug HMOs to participate in the system.

My concerns about the Republican plan are not based on speculation but on lessons learned in Nevada, which began offering seniors a drug benefit. The Nevada plan, while it has significant differences, is the closest example we have to the Republican plan that will be voted on tomorrow. We know from Nevada's experience that what seniors want is an affordable drug benefit, not a requirement that they analyze multiple and confusing plans with different premiums, deductibles, and cost sharing.

Let me give this piece of history: When the State of Nevada originally offered seniors a multiple choice plan of drug benefits, how many seniors in Nevada signed up for the plan? The answer is 124. That was the total number of seniors in a relatively large State in our Nation who wanted to sign up for this multiple benefit plan. When the program was restructured and seniors were given one defined benefit plan, when they knew what they were going to get, how many people enrolled? Over 6,000.

We also know from Nevada's experience that private insurers will not participate in the Republican model unless there are high profits to be made, dollars that could have been used to make the benefit more comprehensive or more affordable. In order to get a private insurer to participate, the State of Nevada had to pay the plan $106.54 per member per month, even though the member's actual drug cost averaged only $37.64 per month. That is a difference of nearly $69 per member per month, $69 that could have been

used to offer a better benefit, cover more seniors, give an earlier catastrophic benefit.

Even after adjusting for administrative and other costs, the State calculated that the private plan had a profit of $1 million over a 6-month period to serve a mere 3,000 beneficiaries.

My Republican colleagues would repeat this mistake but on a massive scale. Rather than assuring that the money is spent on a drug benefit and is used to maximize drug coverage for seniors, the Republican bill would allow the money to be siphoned off to induce insurance companies to participate when they have indicated by their past behavior they do not want to participate.

I also have grave doubts that seniors would get the drugs they need if they were to adopt the Republican proposal. Under their approach, the fewer drugs used by seniors, the higher the profits for private insurers.

We hear a lot about the idea of transferring risk, insurance risk, to the private insurance companies, and because they will be responsible for this risk, therefore they will be more aggressive in containing costs. I find it a little disingenuous that this plan, which is supported by almost all the major pharmaceutical companies, has as one of its recommendations to be adopted that it is going to be more effective in containing costs.

We have all heard the argument of the fox in the chicken coup. I think we have an example of that with the pharmaceutical company saying they support the plan with the principal benefit being its capacity to reduce pharmaceutical costs.

Private insurance companies, in my judgment, have exactly the opposite goal. They are likely to want to restrict the drugs that the senior wants and needs because that is the way they can maximize their own profits. We need to listen to what our seniors have to say about privatizing Medicare before we go down this path.

In 2001, a senior lady from Cincinnati, speaking before one of our major senior groups, said the problem with privatizing Medicare is these insurance companies will make the rules and you will live by the rules. You will not have any representative if you go to an insurance company and tell them you do not like the way they are doing something. Do you think they are really going to care?

It is not just the delivery model, however, which worries me. It is also the benefit design in the Republican plan. In fact, the phrase ''truth in advertising'' should apply. If we are going to pass the Republican bill, we better be prepared to tell the truth. We better be prepared to tell seniors that they will face an enormous gap in the benefit, a gap which some people have referred to as the doughnut hole.

This is Freda and Coleman Moss of Tampa, Florida. Freda is 80 years old. Coleman is 84. Freda has had serious health problems. She spends, on average, $7,800 on prescription drugs every year. Under the Republican plan, from about mid-June until the end of September, roughly a third of the year, she will be getting no help at all. The reason is that the Republican plan has this gaping gap in coverage. During that period when she is getting no benefits at all, however, her monthly premiums are not suspended; she continues to write that check out every month for monthly premiums. But while she is in the gap, the doughnut hole, she will get no benefit. How could this be?

The Republicans insist the doughnut hole is so small, they would like to call it a bagel hole. Let's call it what it is: It is a gimmick. It is a gimmick which helps to lower the cost of their bill at the expense of seniors getting the drugs they need.

It is important to understand what is really going on in the gap. They say this little bagel hole of a gap is only between $3,450 and $3,700, or $250. Is that really the size of the gap?

Madam President, we will now talk a little arithmetic. If anyone would like to settle back and relax, this is a good time. Let's look at how the Republican plan works.

Beneficiaries have to reach a point where the total spending—the spending of you, as the beneficiary, the Federal Government, and any other source—reaches a level of $3,450. Once you reach that point, you receive no assistance for your prescription drugs until you spend, out of your own pocket, $3,700.

How does the math work? To get to the $3,450 level, the out-of-pocket expenditures by the beneficiary will be, first, a $250 deductible. You have to pay that before you get any assistance. Then, between $250 and $3,450, you pay half and the Federal Government pays half. You pay $1,600 and the Federal Government also pays $1,600. By the time the combined expenditures reach $3,450, you pay $1,850 out of your pocket—the deductible plus the $1,600.

In order to get out of this doughnut hole, you have to have total expenditures out of your pocket of $3,700 or an additional $1,850 beyond the $1,600 you already paid. So you will have to pay a total of $3,700 before you escape what is not a bagel hole, what is not even a doughnut hole, what is really a Grand Canyon of a gap. That is devastating.

Let us consider the case of Freda. After spending $250 for the deductible, she would pay 50 percent for each prescription drug prescription until the total drug cost was $3,450. Freda would spend $1,600 in addition to the deductible, for a total of $1,850 from her own pocket. Freda already spent a lot of money. But guess what is coming. While she is in the gap, she pays 100 percent for every prescription to get her from a total of $1,850 that she has already spent to the $3,700 she needs to get to cross the Grand Canyon and remove herself from the gap. That means she will have to spend $1,850.

During this period of time, she is paying for all of her prescription drug costs, paying her monthly premiums. The gap is confusing. But one thing is certain: It is no small amount. Most years, Freda would pay 50 percent of her prescription until about June 15. This is out of the $7,800 which is her average annual prescription drug cost. Then for 3 months—assuming she could, in fact, afford to pay 100 percent for the drugs she needs and would not have to cut down on prescription drugs in order to afford food, rent, and the other necessities of life—she would be paying that next $1,850 out of her pocket. It is a big assumption that she will be able to do that.

Freda and Coleman Moss have a monthly income of $1,038. Freda would have to spend 65 percent of the total income she and her husband share during these 3 months she is in the gap in order to pay for prescription drugs alone. It is not hard to imagine Freda would not be able to get the drugs she needed during the time she was in the gap.

This gap is bad medicine for Freda Moss. It is bad medicine for America's seniors. The gap is a gimmick that lowers the cost of the Republican plan at Freda Moss's expense. I am not going to inflict this gap on Freda Moss, on Coleman Moss, or any of the other 816,000 Floridians who would fall every year into this benefit gap.

To my colleagues on the other side of the aisle, I say, let's be truthful about what we are doing to our seniors. If you think it is too expensive to offer the plan you are offering, be honest. Raise the monthly premiums. Increase the $250 deductible. Increase the percentage of coinsurance that the senior has to pay. But do not hide it in the middle of the benefit program to tell Freda Moss: From June 15 until the end of September, you have to pay 100 percent of your prescription drug costs. The fact is, she cannot afford to pay 100 percent of her prescription drug costs.

The third key fault in the Republican plan is the assets test.

I ask Senator KENNEDY for an additional 10 minutes.

Mr. KENNEDY. We will do 20 minutes evenly divided.

Mr. GRAHAM. Senator KENNEDY has talked extensively about the assets test, so I mention it briefly.

It is a mirage to tell low-income seniors they are going to get access to the benefits of reduced or, in some cases, no copayments because of their limited income when we then impose, for the first time in the history of Medicare, an assets test that says if you own something as basic as a $1,500 burial fund, so she might be buried next to your loving spouse, that makes you ineligible to get any of the low-income benefits.

It has been estimated that one-third of the 11 million seniors who would otherwise qualify for some special assistance because of their low income

would be denied that assistance because they would not comply with the assets test.

I will briefly touch on some of the criticisms the Republicans have made about our plan: First, the plan is too costly; that we cannot in our rich society afford to provide to our older citizens what is now a fundamental part of a comprehensive health care program. I do not believe that is the America we live in today.

The Republicans have thrown around some numbers as to what our bill will cost. Let me say that we have a CBO number, a Congressional Budget Office number, which they do not have in their plan. It is that, assuming that the underlying generic drug bill is passed, which will encourage generic drug use, our plan for the first 8 years will cost $407 billion and for the full 10 years will cost $576 billion. Is this a cheap proposal? The answer is: No. A cheap proposal means meager benefits, less than universal coverage, less than comprehensive coverage. That will not do for America's seniors.

But rather than looking at the cost of our drug proposal in isolation, let's put it in context. What are we currently paying? What percentage of the cost are we paying for all the other health care benefits that seniors receive through Medicare? The answer is approximately 77 percent. That is what we are paying for doctor care, hospitalization, all the things that Medicare covers. If we were to cover 77 percent of prescription drugs, this plan would not be costing $594 billion over the next 10 years. It would cost more than $1 trillion over the next 10 years.

We also maybe should look at ourselves. We are all participants in the Federal Employees Health Benefits Plan. If we were to give seniors the same benefits that we get as Members of the Senate, with an average income that is 10 times what the average income of senior Americans is today, this plan would cost $750 billion. We are talking about, over 10 years, $596 billion.

The reality is that the benefits of prescription drugs do not come cheap. The cost of prescription drugs is the fastest growing component of every health care plan, the private sector, the public sector, and it will be a significant part of any decent Medicare prescription drug benefit. That is what the debate that we had last week was all about.

Are we going to pass generic drug, patent reform, reimportation, State group purchasing—all of which are designed to give to all Americans, including senior Americans, greater access and affordability to a very expensive part of our national budget today, prescription drugs? The reality is the plan that our Republican colleagues have offered will cover less than 25 percent of seniors' drug costs. That is based on the latest estimate that their plan will cost, in the range for prescription drugs, of $330 billion to $340 billion. And the total drug expenditures by seniors over the next 10 years will be $1.3 trillion.

Our plan would provide almost twice the amount of coverage as the Republican proposal. It would provide $594 billion of the $1.3 trillion that seniors are going to spend on prescription drugs in the next 10 years.

In my opinion, as costly as this is, it is not an extravagant benefit. It is far less than the 77 percent that we are covering for other medical services, and it will provide critical assistance to our seniors.

It has been argued that seniors would pay more in copayments. The reality is seniors prefer to have their drugs acquired through a known amount per prescription, rather than through the unknown of a percentage of an unknown actual amount.

If seniors go to the doctor and get a prescription, they are unlikely to know what that prescription is going to cost. But they do know if it is a generic drug it is going to cost them $10, and if it is a brand drug it will cost them $40. They like that degree of reliability and security.

It has been said that this is a Government-run price control system. This is not a new argument. It is not an argument about prescription drugs through Medicare. This goes to the heart of whether America should have a Medicare Program at all. This debate was ongoing before Medicare was adopted. It was an argument which kept Medicare from being adopted for many years. And it has been an argument that has continued since Medicare was established in 1965. We should not forget that Republicans voted against the creation of the Medicare Program in 1965, and they have made their thoughts about Medicare very clear since then.

Just listen to some quotes by prominent Republican leaders. In 1995, then-majority leader of the Senate, Senator Bob Dole, said:

> I was there fighting the fight, voting against Medicare in 1965 because we knew it wouldn't work.

Former Republican Speaker Newt Gingrich, speaking on Medicare in 1995, said:

> Now we didn't get rid of it in round 1 because we don't think that it's politically smart and we don't think that's the right way to go through a transition. But we believe it is going to wither on the vine because we think people are voluntarily going to leave it.

Republican House majority leader DICK ARMY said Medicare was ''a program I would have no part of in a free world.''

He deeply resents the fact that ''when I am 65 I must enroll in Medicare.''

Somebody should tell him that Part B of Medicare, as well as this drug benefit, are voluntary. If he chooses not to enroll, that is his election.

I have news for my Republican colleagues. The Medicare program, as it is administered, has worked. Let me tell you a few of the successes.

Since its creation, Medicare has provided health care coverage for more than 93 million elderly and disabled. Medicare has made a dramatic difference in the number of seniors with health insurance. In 1964, the year before Medicare, half the seniors were uninsured.

Today, 97 percent of seniors have health insurance. Medicare has lifted countless seniors out of poverty, has expanded access to high-quality care for minority seniors, has improved the quality of life for seniors by providing access to procedures such as cataract surgery, hip replacement, cardiac bypass surgery, and organ transplant.

We have the Medicare Program in part to thank for increasing the average life expectancy available to Americans. A 65-year-old woman who is entering Medicare today will live 20 percent longer than her counterpart who became 65 in 1960.

It is Medicaid, making the miracles of modern medicine accessible and affordable, not private insurance, that made these advances possible. It wasn't private insurance plans that stepped to the plate in 1965 to provide health insurance coverage for seniors. In fact, they didn't want to cover seniors. That was why Medicare was established.

I wish I had time to go into more detail on some of the reactions of seniors toward these plans and why virtually every major senior group has supported our plan. I wish I had greater opportunity to respond specifically to the concerns of the Senator from Mississippi, and hope I will have such an opportunity before we vote. But let me just conclude.

This debate is not about programs. This is not about charts. This plan is about human beings, our parents and our grandparents. It is about working Americans who are paying the cost for their elderly family members' prescription.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. GRAHAM. Mr. President, I appreciate your indulgence and my colleagues' indulgence. I hope tomorrow we will grasp the rare opportunity we have to give greater security and comfort to our senior citizens by their knowledge that they will now have affordable and accessible opportunities to experience the miracles that prescription drugs make available, and that they will be there for them in a reliable manner, in a manner with which they are familiar—tried, tested, and assured.

The PRESIDING OFFICER (Mr. DAYTON). The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I believe I have 12 minutes remaining. I welcome the opportunity to inquire of my friend and colleague. I have a question or two about the legislation and some of the points that were raised earlier this evening.

I believe all of us who have listened to the Senator from Florida commend him for a superb presentation. I particularly welcome the final comments he made with regard to what this debate is really all about: It is about real people. It is about a great generation. It is about seniors who have made a difference in building this Nation, who fought in the wars, who fought in World War II, who brought us out of the Depression, and who really made this country great. The Senator brought us back to that element. I certainly welcome it.

All of us will be voting tomorrow, and hopefully we will keep that in mind.

We heard earlier in the debate and the discussion that the proposal of the Senators from Florida and Georgia misleads the seniors of this country because it is going to sunset in several years. Therefore, we are misleading our seniors by promising them one thing today that after a period of years, by 2010, will not be available to them.

I am wondering if the Senator would agree with me that if we had an authorization on Medicare back in 1965—say it was 6 or 7 years, and we came back to debate that—we certainly would have gotten a prescription drug benefit for seniors in this country much earlier than we are now able to, if we hopefully can get this passed. Does the Senator not agree with me that we would have assured some action? Will the Senator not agree with me that in 7 or 8 years we will have the opportunity to find out what needs to be done with this program to make it fairer and more effective for the seniors, and that this would be a welcome opportunity to do so?

We should embrace this concept rather than retreat from it. I would be interested in the Senator's reaction.

Mr. GRAHAM. Mr. President, one of the enigmas about Medicare and why it has fallen so far behind other major health care plans, such as the one that the Senator and the Senator from Maine and I participate in, along with Federal employees—one of the reasons is the system was established in 1965 and has not been forced to defend itself by making those changes which are required to continue to be a modern health care system.

It is not only the absence of prescription drugs but the whole array of preventive measures. You would be shocked and appalled to know that, for instance, illnesses such as prostate and various forms of cancer for females, as well as colon cancer, have only in the last few years been added to the list of preventive services available through Medicare, and that a long, long list of items continue to be uncovered.

If we had had a requirement that forced us to periodically look at this program as we, for instance, are now looking at Welfare to Work, which in 1996 said after 6 years it had to be reexamined and reauthorized—we are going to do so, and I think it will be a better program because it wasn't on autopilot. It had some real thoughtful considerations, analyses and improvements.

Mr. KENNEDY. I couldn't agree with the Senator more.

Let me get to the issue of cost of the program. I have listened with great interest to the debate from the other side about their $24 monthly premium. Yet, I have great difficulty in reviewing their proposal and finding where that $24 is even mentioned. Of course, it is not mentioned, because it is an estimate, as they indicated. But the premium is written right into the law on page 26 of the Senator's bill. Then on page 28, the cost of generics, $10, is listed and then the cost for the preferred, $40, is listed. It is written right into that bill.

Has the Senator, in his examination of the alternative, seen any statement or indication of that kind of precision reflected in the Republican bill?

Mr. GRAHAM. The answer is no. It is because they start from a fundamentally different position. Our bill is what would be described as a ''defined benefit.'' You know what you are going to get, and you can rely on it.

The Republican bill is a defined contribution. The Federal Government will subsidize private insurance companies, if some can be found that would be willing to provide a prescription drug-only benefit. Therefore, it is going to be up to the insurance companies to say what the monthly premium and the deductible will be.

This is a chart which talks about what the costs would be for some of the major brand-name drugs. We can tell you with precision what they will be under our plan. A whole period of question marks are under the Republican plan because the insurance company can say we may cover 50 percent of the cost, or we may only cover 40 percent of the cost, or we may only cover 25 percent of the cost. It is up to the insurance plan.

Mr. KENNEDY. So they have no idea today. It will be left up to the insurance companies. They will make that decision.

This is an estimate—and a favorable estimate—that they are making on this side; whereas under the Graham proposal, it is explicit.

I would like to move on to another area that was talked about by the Senator from Mississippi and others regarding the formulary issue.

Let me see if I understand what is in the Graham proposal. In the Graham proposal, it says that all generics included in the therapeutic class must be on the formulary, and at least one brand-name drug but no more than two in the therapeutic class must be in the formulary. It is designed, obviously, to obtain the deepest discounts. That is obvious. But if you need a drug that is not in the therapeutic class, you can still get it at a formulary price, as I read on page 29 of the Graham bill.

I thought the Senator from Mississippi missed this element. It says: The eligible entity shall treat a nonformulary drug as a preferred brand-name drug, if such nonformulary drug is determined to be medically necessary. The cost of that drug would then be $40. If it is medically necessary under the Graham proposal, seniors will be able to get it.

This is what was missing from the debate and discussion with our friend from Mississippi earlier.

Mr. GRAHAM. There are two rates. One is what I would call the retail rate, and the second is the wholesale rate. Insofar as the overall expenditures for individuals, if it is determined that individual requires a specific drug, which is not on the formulary, and it is medically necessary for that individual, then that particular drug will be treated as a preferred drug. Therefore, the maximum amount of copayment would be $40.

But, on the wholesale level, if you would turn to page 62 of our legislation, it says that at least one but no more than two brand-name drugs shall be included for each therapeutic class unless—this is line 2 through 4—the Secretary of the Department of Health and Human Services determines that such limitation is clinically inappropriate for a given therapeutic class.

If the Secretary of HHS determines that, let us say in the area of antidepressants, there needs to be more than two in order to be clinically appropriate, he or she has the authority to order that there will be whatever number of drugs within that therapeutic class are required.

Let me point out, as the Senator already knows, that because of the defined contribution nature of the Republican plan, there is no assurance that even two drugs in any therapeutic class will be offered under their plan. As I understand it, the insurance companies, rather than the Department of Health and Human Services, will determine what the therapeutic classes will be.

So one insurance company may say, we will use a very broad definition of therapeutic class, another may use a narrower definition, and, therefore, affect the number of drugs that are realistically available.

Mr. KENNEDY. Does the Senator agree with me that there is no requirement for a generic formulary in their proposal whatsoever?

Mr. GRAHAM. Again, it is a leap of faith as to what you are going to have, whereas ours is a defined benefit.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. KENNEDY. We had additional time.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. KENNEDY. Both times? I had 22 minutes.

The PRESIDING OFFICER. The Senator is correct.

Mr. KENNEDY. May I have 2 more minutes, just on this point. I ask unanimous consent for that, and the same additional time for the other side.

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

Mr. KENNEDY. Just so we understand this, on page 37 of the tripartisan bill, in the formulary determinations, they say:

An individual who is enrolled in a Medicare Prescription Drug plan offered by an eligible entity may appeal to obtain coverage for a covered drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

But there is no price limit on this, as I understand it. There is no price mentioned in here, in contrast to the Senator's provisions that have been included in his legislation.

His legislation provides what is medically necessary and then goes on to indicate what the costs will be, to ensure that they are reasonable. In the other bill, seniors may have the ability to get what is medically necessary, but there is no indication about what the cost would be, as I understand it.

Mr. GRAHAM. That is true, I say to the Senator. What you have just said contributes to a recent poll, done by the Kaiser Family Foundation in May of this year, which asked Americans: Which kind of plan did they want?

For Republicans in America, 58 percent said they wanted a defined benefit plan; only 33 percent wanted the Republican plan as is offered today. Among Democrats, 71 percent wanted a defined benefit and 23 percent preferred the Republican plan. Among Independents, 72 percent—even more than Democrats—wanted to have a defined benefit plan delivered by Medicare as a means by which they would get their prescription drug benefit.

Mr. KENNEDY. I thank the Senator. That is why I agree with the Senator.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. KENNEDY. That is why we have such strong support from seniors and why it is justified.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. KENNEDY. I thank my friend and colleague from Maine.

Mr. President, I ask that she be entitled to whatever additional time she needs.

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

The Senator from Maine.

Ms. SNOWE. Mr. President, I just want to make several comments in response to some of the issues we have discussed today regarding the two competing plans.

What is most important about this debate is that we have the ability to discuss the programmatic differences in policies that each of our approaches have taken with respect to delivering this prescription drug benefit plan.

First and foremost, I should say that the plan we are offering is a tripartisan plan. It was crafted by Senators BREAUX, JEFFORDS, HATCH, GRASSLEY, and myself as members of the Senate Finance Committee, primarily designed to overcome many of the partisan differences that might exist on this issue and, hopefully, to bridge the gap so that we have the opportunity to pass a prescription drug benefit this year.

I heard mention the issue about a doughnut that exists in our bill; that is, the gap between the benefit limit of $3,450 and $3,700.

First of all, 80 percent of those seniors who would be participating in this program—80 percent of the Medicare beneficiaries—would not even reach the benefit limit of $3,450.

In fact, I recall back in 1999, President Clinton proposed a drug benefit that provided for an initial benefit of $2,000. We are at $3,450. He had a much greater gap in coverage between that initial coverage of $2,000 and a catastrophic benefit, which was about a $3,000 gap. We are talking about $3,450, and a catastrophic benefit threshold of $3,700. But what could be a greater gap than having this most critical benefit to seniors sunset in the year 2010? In 2010 it expires. According to the legislation: No obligation shall be incurred, no amounts shall be appropriated, no amounts expended for expenses incurred for providing coverage of covered outpatient drugs after December 31, 2010.

The legislation goes on to say, provided, of course, the actual spending does not incur, so there is leftover you can use for a prescription drug benefit or the program itself results in lower expenditures. Nevertheless, it would require, in order to extend that most important benefit of prescription drug coverage, additional action by the Congress, obviously, to provide for the funding of that program. So it expires.

The second gap in coverage provided in this legislation offered by Senator GRAHAM is the fact there is a major omission of coverage for brand-name prescription drugs. There are more than 2,400 that exist. The Senator's legislation is limiting to, at most, two brand-name drugs in each therapeutic class.

So it is going to be very limiting at best because it will deny a senior the ability to have access to an alternative medication if it is not called for under this legislation. It either has to be generic or one of the two prescribed brand names.

As I mentioned earlier, there are many alternatives in a brand name category. Whether it is for arthritis or cholesterol or blood pressure, there are many options.

I heard it suggested, if it is defined as medically necessary, then it goes through a major process. It has to go through the Secretary of Health and Human Services. There has to be an internal/external appeals process, so there will be a review process underway.

I can imagine there would be quite a lineup if there were a number of views that would be required of the Secretary to make exceptions to this legislation.

So there will be a whole process that would be required in order to allow somebody to take a prescribed medication that has not already been stipulated under law, according to this legislation. That is very explicit in this particular proposal. I think we want to provide coverage similar to what Members of Congress and Federal employees currently enjoy: options, choices, competition, variation.

Frankly, the preference of variation is important because it then allows a plan, for example, to use innovation, providing for a certain type of drug or all generics, providing lower premiums than what we stipulate into law.

In our proposal we do have a standard benefit package described.

But what we also say is, we allow flexibility to design plans that can offer even a lower deductible than $250, even a lower premium than $24 a month. We want to vest that type of flexibility into the design of a plan that could provide the maximum amount of benefits to those seniors who need this type of coverage. There is no such thing as a one-size-fits-all.

The point is, in the proposal we have crafted, there is a standard benefit. In fact, the Congressional Budget Office has indicated that our standards of equivalence are strict enough that the Medicare drug plans will have very little room to vary from premiums of cost sharing. But they have the flexibility to design an even lower benefit in terms of deductibles or premiums. And don't we want to allow seniors to have the benefit of that reduced price? That is a result of competition.

That is why the Congressional Budget Office has indicated that prices for prescription drugs could actually increase under the Graham proposal, upwards of as much as 8 percent, if not higher, because there is no competition. As a result, there is no drive, no incentive to allowing for lower cost, because there are no competing plans. In a sense, the Government is delivering the plan through a pharmacy benefit manager, so restrictive that it does not allow for competing prices, and there is no incentive for keeping the prices of prescription drugs down. That is a major difference between our two plans. We want to offer the most choices, the most comprehensive, because we have preferred and nonpreferred drugs, lower copays in most all of the categories.

We have the lowest premium per month. We have the maximum amount of benefits to low-income seniors. We cover the donor for under 150 percent of the poverty level or below for seniors. We provide catastrophic at $3,700 a month. It is a permanent, fully funded part of the Medicare Program.

I hope Members of the Senate will consider very carefully the policy and programmatic differences that do exist between our two plans. They are very distinct.

I know it has been suggested that our system is untried. That is not true. We benefit from a system that is comparable to what we have designed in the tripartisan proposal, and it offers the maximum choices to our seniors. We think it is important to create as a permanent part of the Medicare Program.

To provide for any limitation of that type is doing a disservice to our seniors. It is giving them a false hope to say that your benefit expires in 7 years, unless, of course, future Congresses decide to make a change. So we are predicating their future, their health care, on whether or not a future Congress might decide to extend that program. I really don't think that is the type of precedent we want to take. We have never created a temporary benefit under the Medicare Program—never. We have never created a temporary benefit, and we should not start now.

I know there has been some question about the assets test included in the tripartisan proposal. First of all, this assets test was not something that was newly created. It is included in the Medicaid Program. Yes, this assets test is used for some Medicare beneficiaries, the dual eligibles, the qualified Medicare beneficiaries, QMBs, and specified low-income Medicare beneficiaries. So an assets test was included in our legislation that is the equivalent of the assets test in the Medicaid Program that was supported by this Senate back in 1987 and 1986 with overwhelming support. So this is not unprecedented. It is not unusual. It includes the same type of waivers that are included in the current Medicaid Program.

I welcome the debate that has developed between the two competing proposals regarding prescription drugs. It is my sincere hope that we will have the ability to work through our differences beyond the threshold of tomorrow, the 60 votes. I hope, again, that this system and this process are not designed for failure, that neither side gets the 60 votes and, therefore, we move on to other issues and we defer this to another year. It has happened far too often.

This benefit is long overdue for our Nation's seniors. We negotiated this compromise in good faith, in the hopes that we could have worked through with our colleague from Florida, who I know has worked very hard, who is very genuine in his interest in developing a prescription drug benefit for Medicare beneficiaries—I would have hoped we could have worked through the process in committee, but that was not to be. So we are at a point now of whether we can reconcile our differences to move beyond the 60 votes and be able to work through the various amendments and reach a conclusion.

The seniors of this country deserve that. I honestly don't understand why we can't at this point in time agree to pass a prescription drug benefit program for Medicare beneficiaries. Our compromise wasn't designed to be an all or nothing or lines drawn in the sand. It was really an attempt in good faith, in the spirit of consensus building and compromise, because you can't do it without the other side of the aisle; there is no way you can possibly do it. That is why we started more than a year ago to develop this tripartisan proposal with the hope that we could have made this a reality for our Nation's seniors.

I urge my colleagues to give very serious consideration to what we have provided in this particular proposal for our seniors. Hopefully, we can come together and pass this legislation that is such an urgent need for the more than 44 million Medicare beneficiaries.

I yield the floor and 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 proceed to a period for morning business, with Senators permitted to speak therein for a period not to exceed 10 minutes each.

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

ADDITIONAL STATEMENTS

THE KETCHIKAN VENEER PLANT

• Mr. MURKOWSKI. Mr. President, today I offer my congratulations and state my full support for the actions taken this week by the Ketchikan Gateway Borough in acquiring the idle veneer plant at Ward Cove. At a time when the regional economy is reeling from a long series of blows that go back to 1993 when the first pulp mill closed, the Ketchikan Borough showed exceptional leadership by stepping to the plate to retain this vital manufacturing facility in the community.

The importance of encouraging an increase in healthy wood products manufacturing facilities in Southeast Alaska cannot be overemphasized. Such plants are vital necessities for Southeast Alaska to have good, year-round, family wage jobs providing the economic backbone to its communities. Proof of this is readily seen in the current jobs picture. As a consequence of the Clinton Administration's actions, Alaska's 2 pulp mills and several sawmills were forced to cease operation, costing the region more than 3,500 direct timber jobs in the last 10 years. Add to that the loss of countless indirect jobs and you have a formula for economic disaster.

With Ketchikan's action, we now enter a new era. Its leadership will help Southeast Alaska embark on a much-needed recovery phase in which real jobs for real people can bring new life back to litigation-weary communities. I congratulate Ketchikan and pledge to help in any way I can.

A critical component of making the veneer plant a viable operation will be economic timber supply. A spate of lawsuits by environmental groups has artificially driven down the supply of timber and has even stopped timber sale planning on the Tongass. As quickly as possible, the Borough needs to conclude an agreement with a company to operate the veneer mill and together we must address the supply issue with the U.S. Forest Service.

To that end, I am calling today for the Alaska Regional Forester, Denny Bschor, to meet in a timely manner with Borough officials to reach an agreement to ensure a stable and sufficient supply of economic timber to enable the veneer plant and the sawmills of Southeast Alaska to succeed. The new Bush Administration owes Ketchikan a commitment to bargain in good faith to help the community succeed in rejuvenating its economy.

The Regional Forester has the statutory authority to offer timber under 10 year contracts, and I urge the Forest Service to conclude agreements using that authority. Furthermore, I call on all Alaskans to join me in supporting a 10 year sale for Ketchikan in recognition of the community's substantial leadership in restoring the regional economy.

The biggest impediment to making timber available is the plethora of lawsuits that have been systematically leveled against the agency. Those lawsuits, if not resolved soon, will result in more mill closures and further unemployment. The recent court injunctions on timber sales that have already passed environmental review highlight the need for longer term agreements.

The Tongass National Forest is fully capable of supporting the level of harvest needed to supply the region's mills without affecting the other legitimate uses of the forest. Less than 400,000 acres, only 2.4 percent of the Tongass, have been harvested since industrial harvest began in the 1950s. Moreover, each year about 800 million board feet of timber is lost to natural tree mortality on the Tongass. That is nearly 4 times the maximum annual harvest under the current management plan and 16 times the amount cut last year.

Under the Tongass plan, an average of less than one-half of 1 percent of the Tongass can be harvested in any given year. If offered in economic packages, that small part of the available resource can be sufficient for the needs of the existing industry. There is simply no reason the Forest Service should not make sufficient economic volume available to run a veneer mill and provide logs to the sawmills of South East Alaska. This action is essential to the