The ACTING PRESIDENT pro tempore. The Senator has that right. The Senator from Wyoming.

PRESCRIPTION DRUGS

Mr. THOMAS. Mr. President, we are moving on today, I am pleased to note, to deal with this business of pharmaceuticals. It is a very important issue, one that we have struggled with for some time. I am not particularly impressed with the system we have used. I am afraid it pretty much spells out the fact that it is going to be very difficult for us to come together with any real meaningful legislation with regard to pharmaceuticals. There are a couple of reasons for that. I think we could have done it a little differently.

One, of course, is we do not have a budget. We have not brought up a budget resolution. So the question of funding always comes up. That is the reason for the votes this morning to try and waive a point of order on the budget. Not only does it affect this issue, of course, but the effect is that it is irresponsible not to have a budget for this coming year and be able to have the protections that a budget provides.

We have been talking a long time about the failure of business to do things properly. This is certainly a failure, it seems to me, of the Congress not to have a budget resolution. We have not had it brought up.

The other problem is we are dealing with the very broad subject of pharmaceuticals, which does not have before it a proposition that has been treated by the committee. Obviously, almost all the issues that come before the full Senate—and certainly there are those that are difficult issues—have gone through the committee, and much of the venting, much of the argument, much of the discussion has been done in the committee, and then the committee has come forth with a majority vote.

This is the second time recently we have had bills come to the floor that are complicated and difficult without having had their exposure in the Senate committee.

The energy bill, which we are still involved with, which was on the floor for several weeks, was pulled from the committee. It was not allowed to come through with a committee recommendation, and the same thing with the Finance Committee. So we find ourselves in a very difficult position.

Nevertheless, that is where we are. We have several propositions before us. One is the Graham-Kennedy-Daschle bill, which was in the committee but apparently would not have received a majority vote in the committee, so it therefore was not brought to a vote. This creates a very large increase of Government bureaucracy and basically ultimately sets price controls in pharmaceuticals, has fairly restrictive formulas for the majority of managed-care companies.

The Graham bill has plans to cover at least one name brand drug but not more than two in each therapeutic class. Pharmaceuticals is a difficult issue: How to provide them in terms of distribution; are they a part of this case in the Graham bill; and will they really become part of Medicare?

The competing bill, they have done more in the private sector, and it is separate somewhat. It is a real tough job to encourage people to do it as economically as can be done. How will generics become hopefully more used and useful than they have in the past and therefore reduce some of the costs? How is the distribution done so consumers have some choices in terms of not only brands that are available to them but, frankly, some of us are concerned in States where we have low population whether or not there will be opportunities for consumers to have some choices, whether they will be able to use the local drugstore, or whether they will all have to be mail-in kinds of things.

So it is a tough decision. There are differences in the two proposals. One will be a part of Medicare and will be handled by the Government. The other will be a private sector delivery system that will be set up.

In the case of the Government system, of course, whoever does the distribution will not have to make any particular choices with regard to costs or helping to reduce them. But on the other hand, in the private sector the more they can make it economical, the more profitable it will be.

So I am hopeful as we go through this, we can seek to set forth the best proposition that is possible, at the same time taking into account spending, and the spending in the two bills are quite different. The Democrat bill, the Graham bill, over a period of 7 years, is basically twice as expensive as the other bill. It costs in the area of $600 billion. The other one is very expensive as well, about $330 billion over the course of 10 years. So either one is going to be very expensive, but one quite less expensive than the other. Certainly we need to take a look at the expenses.

The tripartisan plan seems truly to find some common ground between traditional Democrat and Republican views, and that is useful. It reforms Medicare. It provides a prescription drug benefit to ensure that seniors do have coverage more similar to employee-sponsored plans that, of course, we have been accustomed to in the past.

I hoped this proposal could have been debated more—I have already mentioned that—in committees. It spends $330 billion over 10 years to provide prescription drugs for seniors. Even at that, whoever thought we would be talking about something in the area of $330 billion? Nevertheless, that is the case. It is a compromise between various proposals.

In addition to simply the drug benefits, it spends $40 billion to make some overdue changes in Medicare Parts A and B, which need to be done. We have not made changes in Medicare for some time. The prices and payments have caused it to be difficult for people to get services. It tends to bring the Medicare into the 21st century. It does spend $370 billion over 10 years to make those changes, but I think it is a reasonable proposal. It has a monthly premium, which I think is reasonable if they are going to have these kinds of services. It has an annual deductible which, again, is not unusual in terms of insurance payments of these kinds. I think first dollar payments are very important in terms of any insurance program. It has a benefit cap. The Government pays 50 percent for seniors with drug costs up to $3,400. It has catastrophic coverage beginning at $3,700. Seniors will then be responsible for only 10 percent of the cost above that.

So it is a tough program. It is one of the programs, however, that does deal with seeking to solve the problem without excessive expenditure. Low-income assistance below the 150 percent Federal poverty level is good for the entire structure. There is no so-called doughnut, middle ground, for low-income seniors, and that is good. This is the program that provides assistance, of course, to all seniors, and for their drug costs. It gives them access to discounted drug prices, and seniors generally now are the only group who pay full retail prices for drugs.

So I am hopeful as we go into this afternoon's program, even though under the circumstances of bringing these bills this way without having a budget we will have to have 60 votes to get one passed, I hope we will give some thought to the only one that is indeed bipartisan, in fact, tripartisan, in nature, so we have the best opportunity of finding success in the Government to provide pharmaceutical and drug coverage to seniors, something that almost everyone agrees needs to be done.

The question is how it is best done, and how we deal with the costs, the distribution; what ought to be the difference in access between low-income and those who are not; what we do to make some improvements in Medicare. This seems to be the proposition before the Senate that can provide for these benefits.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, our time is very short this morning, so I will be brief. Let me discuss the key criteria Senators should consider.

First, is the drug coverage permanent and dependable? Under the tripartisan amendment, drug coverage would be a permanent part of the Medicare entitlement, for the 21st Century.

Under the Graham amendment, however, that coverage disappears into a black hole. The benefit expires the very same year the baby boomers begin to retire. In my view, it's terribly irresponsible to pull a ''bait and switch''

on people who depend on Medicare. How will my colleagues explain to seniors in 2010 that they are out of luck because of a gimmick they used to hide the true cost of their proposal? I ask the Senate to support permanent, dependable drug coverage.

The Graham amendment seriously restricts Medicare enrollees who want access to brand-name drugs. Its restrictive policy will result in long lines for ground-breaking drugs. Why? Because Senator GRAHAM requires Medicare enrollees to wade through a bureaucratic appeals process in order to get needed drugs that are off the formulary. And it's not a short list—their formulary denies access to at least 90 percent of brand-name drugs!

We've heard a lot about gaps in coverage. Mr. President, here's the biggest gap of all: the gap between the large number of brand name drugs beneficiaries may need, and the paltry number Medicare would cover under the Graham amendment. Of the 2,400 brand name drugs approved by FDA, less than 10 percent would be covered. What a gap in coverage.

Our amendment, on the other hand, sets policies to ensure that Medicare enrollees get the drugs they need. We do not limit them to an arbitrary number of drugs in each class, as Senator GRAHAM does. We support making generic drugs an option, with lower cost-sharing, but we don't think depriving seniors of access to brand-name drugs is the way to go about it. So that is a key difference.

Our opponents have talked a great deal about the fact that less than 20 percent of beneficiaries would face a gap in coverage under the tripartisan amendment. But compare that number with the number of beneficiaries who would experience a gap in coverage under their amendment. Under the Graham amendment, fully 100 percent of enrollees would lack full access to brand-name drugs in Medicare. When you lay the two gaps against one another, isn't it clear that their gap, which will affect all enrollees, is the worse one?

Our bill also delivers a cost-effective, quality benefit. 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 among private plans that stand to make money if they drive hard bargains with drug manufacturers. That's what our amendment offers.

Now, our opponents have gone on and on about private plans not being willing to deliver a drug benefit. Well, they too rely on a private sector delivery system, although it is non-competitive and thus is so expensive.

We have worked hard to ensure our delivery system works. Our opponents say that insurers will refuse to participate, even though the government lays $340 billion on the table and bears 75 percent of the economic risk, and even though CBO projects it to work everywhere in the country. But what happens in the off-chance that private plans won't want to participate?

Well, here's what will happen. The government has a duty—mandated in our bill—to do what it takes to ensure a drug benefit for every last Medicare beneficiary. If insurers won't participate at the level of competition we expect, the Secretary must adjust the competition bar downward until they will participate.

At a last resort, we would end up with a Graham-type delivery model in which pharmacy benefit managers are simply government contractors, bearing only minimal performance risk. Put another way, our Plan B is Senator GRAHAM's approach. So why are our opponents so afraid of that?

Under no circumstances will our bill allow any senior, anywhere, to go without access to a drug plan. It's an iron-clad guarantee, and it's right there in our bill.

Now, the Senator from Massachusetts has repeatedly objected to the asset test for the low-income benefit in our bill, as if it's something new. What a red herring! There has been asset testing for low-income Medicare populations since 1987, under the Qualified Medicare Beneficiary program and the Specified Medicare Beneficiary programs. And Senator KENNEDY and his Democratic colleagues voted for it overwhelmingly. There's nothing but politics behind those objections.

Another thing the tripartisan amendment offers is an enhanced option in Medicare. The enhanced option will add protection against the devastating costs of serious illness, and make preventive benefits free to help seniors avoid serious illness in the first place. And it is completely voluntary—seniors get to choose, and they don't need to take it in order to get drug coverage.

What does the Graham amendment have to offer beyond drugs? Nothing. Why would anyone want to deny Medicare beneficiaries the choice of free preventive benefits and better protection against serious illness? I will let the other side answer that.

The choice is clear. The Graham amendment offers drug coverage that swiftly disappears into a black hole, and it has the biggest gap of coverage of all. The tripartisan amendment is the right prescription for 21st century medicare. Because that is the biggest gap of coverage of all. The tripartisan plan is the right prescription for 21st century Medicare.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Maryland.

Ms. MIKULSKI. Mr. President, in the last 2 weeks the Senate has taken up two of the most important issues facing the American people. First, we took on the issue of corporate governance. We passed a tough, new regulatory framework to deal with the cronyism and corruption in America's private sector. Now we are moving on to deal with prescription drugs for seniors.

I have talked to many seniors in my State. They are really worried. They are worried about corporate scandals and they are worried about the impact these scandals are having on the market. They are watching the Dow Jones go down along with their life savings. While they see their life savings evaporating, they also see the cost of their prescription drugs going up. These two issues are linked. The crisis in corporate governance and the crisis in our markets, and also the whole issue of making affordable prescription drugs available to seniors, are linked together.

Seniors now are talking about their own lives and times and families. The two things they do not want to worry about at this point in their lives are outliving their savings and the rising cost of prescription drugs. With the evaporation of their savings and the escalation of the cost of prescription drugs, they are really scared.

We have faced many fears in the United States of America this year. We salute our military and others who are working on homeland defense. But we really need to provide another defense, a defense against the fear of outliving your savings and not being able to afford the prescription drugs you need. In my State, my constituents are fairly conservative investors. They put money in CDs. I don't mean the kind that are rock and roll recordings, I mean certificates of deposit. Or they put money into conservative mutual funds. We had many of those family funds run right in Maryland.

What did they see? They saw as Greenspan lowered interest rates, it meant a lower return on their conservative investments. Again, what is happening in the stock market, they see the downside of the Dow Jones and no one is trusting the numbers and no one is trusting the CEOs.

Because of what was happening to the cost of prescription drugs, many families got help from their adult children. But their own adult children are worried about the loss of jobs and the loss of economic security as well. What we see in the private sector is that it is being squeezed in terms of the benefits it had hoped to provide.

In my own State, what we see is that American manufacturing, such as the American automobile industry, is competing against Japanese companies that do not have to pay for prescription drug benefits because they have a national health care system. Steel in my State is in bankruptcy because of predatory foreign competition. It is struggling to keep its promises to workers and retirees, providing pensions and health care.

I even see it as someone who appropriates funds for the veterans health care system. More and more veterans who do not have service-connected disabilities are turning to VA because of

the prescription drug benefit. The collapse of the system in which they were able to afford that benefit is having them turn to other systems.

We need a prescription drug benefit, and we need it now.

Considering the possibility of passing a prescription drug benefit, it has to be a meaningful benefit, not just slogans and sound bites. Seniors need a benefit they can count on, and it needs to follow these criteria. First, any benefit we pass has to be voluntary. It must be run by Medicare, not by insurance companies that simply gatekeep, that privatize profits and socialize risks.

The second thing is the benefit must be the same for all seniors, no matter where they live. No benefit should vary from State to State.

Then, who should decide what medications a senior gets? The decision should be made by the doctor, not an insurance gatekeeper. Of course, it needs to be affordable to seniors and also to the taxpayer.

I believe the Democratic plan, the Graham-Miller plan, which I support, meets these criteria. It answers the questions that seniors ask me as I am out and about talking to them.

Who runs it? Our plan is run by Medicare.

Is it available anywhere I live? Our plan says yes.

Who decides what medicines I get? Your doctor.

Is it affordable? You bet. There is no deductible; premiums are $25; copays are defined, specific, and reasonable; catastrophic drug costs are covered if you have to spend more than $4,000 on prescription drugs.

This is what our plan is. It is voluntary. It is available anywhere. It is going to be run by Medicare, not by insurance companies. The other plans fail those criteria and therefore I believe fail seniors. The Republican and tripartisan plans do not provide a benefit under Medicare. They turn it over to the insurance companies. Remember them? They are the same people who brought us Medicare+Choice, and they pulled out, leaving seniors without coverage throughout my State. People had signed up believing it was going to be a benefit, but after they squeezed their profits, they dumped the seniors. We cannot have the same experience in this bill.

Another problem is the benefit will not be the same for all seniors. It will vary according to different plans and different States. If in fact it is going to be a Federal program, it should be uniform and available in every State.

Who decides the prescription drugs? Once again, insurance companies will be the gatekeepers, not doctors, and their decisions will be based on profits, not patient care.

These plans will not be affordable for seniors. They are going to have a high deductible, copayments that fluctuate, and also an enormous, huge gap in coverage. The tripartisan plan—on which I know there was serious effort—leaves people without a drug coverage between the costs of $3,400 to $5,000 a year. For $1,500, you are on your own.

These plans raise more questions than they answer. How would a senior know what he or she is getting? How would they know what is covered? Who will make sure that insurance companies stick by the plans they offer? And how do seniors pay for their medicine in the gap months? America's seniors need their questions answered. They deserve more than that. They deserve—and they need—a real benefit under Medicare.

I know the Presiding Officer could tell me stories he hears in his own State of Rhode Island. I hear them wherever I go in my home State. I hear them from seniors, and I hear them from their families. When you listen to the families, you hear heart-wrenching stories. With the collapse of manufacturing in my State, it is even worse. The fact is that the farmers in my State are facing drought and will have to turn to Federal assistance. The fact is that watermen, who are out there on the Chesapeake Bay during this heat trying to forage for crabs, are foraging for their health care. We have to help meet those needs.

I held a hearing earlier this year on the healthcare benefits of steelworker retirees where I heard from retired steelworkers and their widows. If steel goes under, these people will lose their prescription drug coverage.

I was particularly touched by a story from a steel-widow—Gertrude Misterka. She has diabetes, high blood pressure, high cholesterol, asthma, and periodic chest pains.

She asked her pharmacist how much her medications would cost her without her retiree coverage. He told her—about $5,800. Gertrude may lose her health care from Beth Steel. Under the Republican and the Tripartisan plan, assuming she could get coverage from a Maryland insurer, she'd pay a $250 deductible and up to $33 in monthly premiums. That is $646 a year, before buying a single pill, and, she could still have no coverage for total drug costs between $3,450 and $5,300.

How does that help her? She needs a benefit that she can count on. Beth Steel and other American manufacturing companies need the Federal Government to offer a Medicare benefit so their workers are taken care of.

By passing a Medicare prescription drug benefit Congress will deliver real security to America's senior. Retirement security means more than pension security. Seniors need healthcare security to be at ease in their retirements.

Congress created Medicare as a promise to our seniors. It guaranteed meaningful healthcare coverage. Medicare kept seniors healthy and relieved their fears of being bankrupt by huge hospital bills. But Medicare didn't keep up with medical advances. To be a meaningful safety net, Medicare must include a prescription drug benefit. To be a meaningful benefit, Congress can't leave it up to insurance companies. Promises made to our seniors must be promises kept.

I really hope we will pass a senior prescription drug benefit that is meaningful, affordable, available nationwide, and that we do it now. Truly honor your father and mother. It is a great Commandment to live by, and it is a great Commandment to govern by.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Michigan.

Ms. STABENOW. Mr. President, I rise to join with my colleague from Maryland who spoke so eloquently about the need for real Medicare prescription drug coverage. I thank her for her leadership for our seniors over the years, both in Maryland and around the country. I join her today, and I would like to start by sharing some additional stories, some voices from Michigan.

I have been inviting people to join me in a prescription drug peoples' lobby. The idea of the people's lobby is to counter the huge special interest lobby in the form of the prescription drug lobby that we see every single day. We know there are six drug company lobbyists or more for every Member of the Senate. Yet what we are doing here is so important to people—businesses, farmers, seniors, families—and their voices need to be heard in this debate. I am very confident, if their voices are heard, the right thing will be done.

So I would like to share a story from Christopher Hermann from Dearborn Heights, MI. He writes now as a member of our People's Lobby:

I am a Nurse Practioner providing primary care to Veterans. I am receiving many new patients seeking prescription assistance after they have been dropped by traditional plans and can no longer afford medications. Many of them have more than $1,000/month in prescription costs.

The Vets are lucky! We can provide the needed service. Their spouses and neighbors are not so lucky.

I also have such a neighbor. ''Al'' is 72, self-employed all his life with hypertension. When he runs out of his meds due to lack of money, his blood pressure goes so high, he has to go to the emergency room and be admitted to prevent a stroke. I provide assistance through pharmaceutical programs, but this is not guaranteed each month. We either pay the $125.00 per month for his medications, or Medicare pays $5,000.00 plus each time he is admitted. It's pretty simple math to me.

I would agree with Mr. Hermann that it is pretty simple math, that what we are talking about is saving dollars in the long run by helping people stay out of the hospital and remain healthy. It is important that it be a real program that is defined, that folks can count on every month.

Let me also share a story from Debbie Ford from Clio, MI, who called

my office. Her 72-year-old mother cannot afford a supplemental, so the family pays for her prescriptions. This is a very common story, as I know the Presiding Officer knows. She is the widow of an ironworker whose pension continued for only 10 years. She gets what assistance she can—food assistance, energy credits—but no medication assistance. Her Social Security disability is $800 a month. She has resorted to pill splitting and borrowing medication from others who have prescription coverage.

This is the greatest country in the world. This is the United States. We should have folks having to either split pills or borrow medication in order to get what they need to live.

Let me also share something from Myra McCoy of Detroit, MI. She says:

I receive disability due to a number of medical problems; it is not a choice for me. My poor health has been the hardest thing I have ever had to deal with in my life and it started at age 35, my whole life over. I have lost so much and the depression has made it so bad, I'm in so much debt for medication, I have a second mortgage I can't afford because of my medication.

I've been robbing Peter to pay Paul for medication and trying not to lose my mind in the process. It is hard to talk about this even after ten years. I hope something can be done about the high cost of medication.

We do live in a time of damaged care, if I could work again I would just to cut the cost of my medication. I would like to know what has to happen to make sure all people get treated fairly!

I thank Myra for sharing this as a part of the People's Lobby.

Now is the time to get it right, to make it fair, to make prices affordable for everybody, and to have a real plan.

What do we have in front of us? We have two kinds of plans: One passed by the House, a similar one called the tripartisan plan supported by my good friend from Vermont and Senator BREAUX from Louisiana, joining with the Republicans in this plan; and then we have a separate plan which is being supported by the Democrats in the Senate.

What are the differences? What does it mean to the people I have been talking about today, and so many others?

The question is, Which plan guarantees seniors a defined benefit and premium? They know they receive the benefit, and they know what the premium will be every month. This is a pretty important issue to folks—to have a regular benefit, and they know what it is, they know what it will cost.

The Democratic plan will provide that. The other plans—Republican or tripartisan—will not.

Seniors receive the same benefit regardless of where they live. That is a very important issue. Whether you are in the upper peninsula of Michigan or the southwestern tip of Benton Harbor, St. Joe or Detroit or Saginaw or Bay City or Alpena, it should not matter where you live, you should be able to have the predictability of knowing the same plan exists with the same premium for you. The Democratic plan does that. The other plan in front of us does not.

Seniors are guaranteed affordable coverage throughout the whole year. People debating this issue have talked about the so-called doughnut hole. People probably think we are debating breakfast or something, but the reality is, there is a gap in every plan, except the Graham-Miller-Kennedy plan, supported by the majority.

For the other plans, you would be paying all year but there would be part of the year—in some cases a majority of the year—where you would not receive any help, even though you have to continue to pay. I do not think that is a very good idea.

The plan that we have in front of us, the Graham-Miller-Kennedy plan, would guarantee people that if they pay all year, they get coverage all year.

Another important principle: Seniors are guaranteed access to local pharmacies and needed prescriptions. Under our plan, yes; under the other plan in front of us, no.

And then, finally, seniors retain their existing retiree coverage. This is very important. I have a lot of retirees in Michigan, retired autoworkers and others, who have coverage and we want to make sure they can keep their coverage. Our plan would say yes to that; the other plan would say no.

On the last point, let me share that the Congressional Budget Office has estimated that a similar provision to the one that is in the tripartisan plan, a similar provision that was in the House plan would prompt about one-third of the employers to drop retiree coverage. This translates into about 3.6 million seniors who would lose their coverage. That is not a good deal.

What we have in front of us is an optional plan, optional under Medicare, so you can get the full clout of Medicare and get a group discount. People are covered all year. It is affordable. It is reliable. It has a premium of $25 a month. It is clear. Every month you pay you are getting help with your bill. It is a very clear, straightforward effort to make sure that low-income seniors are fully covered, without out-of-pocket expenses.

And we make sure that we keep intact Medicare because one of the real concerns I have, in the long run, is that by forcing seniors to retain coverage through private drug-only insurance plans or HMOs—such as the tripartisan plan does—I am concerned that ultimately we are moving to a privatization of Medicare. It certainly is a step in that direction, which would be certainly something that I would strongly, strongly oppose.

So I say to people today—even though we are voting today—if there are not the votes for either of the two plans in front of us, we are going to be continuing to work in a direction to get the kind of plan that we need.

I urge people across the country to get involved and go to a Web site that has been set up—fairdrugprices.org—to sign a petition, to get involved, to share their story, to make their voice heard in this debate.

There is nothing more important than the debate in front of us—to the economy, to the cost of business, to the out-of-pocket expenses for our seniors and for our families.

It needs to be done right. We have the right plan. I urge my colleagues to support the Graham-Miller-Kennedy plan. If, in fact, that is not adopted, I urge that we keep these principles in whatever plan that we are able to construct.

Thank you, Mr. President. I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Vermont.

Mr. JEFFORDS. Mr. President, I ask unanimous consent to speak for not more than 10 minutes.

The ACTING PRESIDENT pro tempore. There are 8 minutes available.

Mr. GRASSLEY. He may have all of that 8 minutes and whatever else the Senate wants to do for another 2 minutes.

The ACTING PRESIDENT pro tempore. The Senator may proceed.

Mr. JEFFORDS. Mr. President, I will proceed for 8 minutes. I first commend all of our colleagues who have devoted so much effort and leadership on the issue we have the privilege of debating today.

It is largely through their collective efforts that we have the chance to provide our seniors with the most significant expansion of the Medicare program in over 35 years an opportunity to provide them with the most important weapon in our healthcare arsenal prescription medicines.

This is an opportunity that we cannot let political differences block from going into law this year.

Many of our colleagues have come to the Senate floor during this debate and voiced either opposition or support for the two amendments that we will vote on today.

Our colleagues from both sides of the aisle have made pointed criticisms and voiced their strong objections over specific provisions in both of these measures.

There are honest differences and disagreements over the details of how we should develop this Medicare prescription drug expansion.

However, it is important that we recognize something that few have mentioned, and that is, there is extraordinary agreement that we should create this benefit.

We are not debating the question of whether but instead, the question of how to best provide medicines for our seniors. Senators from across the political spectrum, liberal to conservative, Republican, Democrat and Independent have declared their support for providing prescription drugs.

We should not let this opportunity pass today because we may not see it again for a very long time.

Today, we will have the opportunity to vote on two approaches for creating this new entitlement.

One approach has been offered by my friends, Senator GRAHAM and Senator MILLER, and others; and it is an approach with merit and one that I gave serious consideration to supporting.

The other measure is one that many have come to call the Tripartisan Medicare bill. It is called the Tripartisan bill because it was developed by Senators who are Republican, a Democrat and myself, the lone independent in the U.S. Senate.

But that is a bit of a misnomer, because it is not about being tripartisan—or even nonpartisan.

This proposal should not be about politics. It is about providing older Americans with the medicines they need through the best Medicare program we can afford. We can only do that by finding a measure that at least 60 of our colleagues can support. We have to get 60 votes to get it out of here.

I am very proud to join my colleagues here today in support of the tripartisan bill, the 21st Century Medicare Act. Senators GRASSLEY, SNOWE, BREAUX, HATCH, and I have dedicated ourselves to this effort.

We have had many policy discussions over the course of the last year and each have made their particular contributions to the underlying bill. I am honored to be a part of this outstanding group of legislators.

I believe our bill is the best opportunity we have to enact a modernized and strengthened Medicare program that will for first time provide a meaningful and affordable prescription drug benefit for all of our seniors.

This measure guarantees the promised care of the original Medicare program created in the mid-1960s and it delivers the benefits of today's modern health care system.

These are the key provisions of the 21st Century Medicare Act.

First, our legislation preserves the traditional Medicare program for our seniors today and tomorrow.

Our bill does not weaken traditional Medicare, make it more expensive or less available.

If the traditional Medicare program is what seniors want then it will be there for them plain and simple—guaranteed.

Second, we create an all new voluntary enhanced fee-for-service part to the Medicare program that provides new benefits such as disease prevention screenings and coverage for catastrophic health care costs while continuing all of the services available under traditional Medicare.

Our enhanced Medicare program protects our sickest seniors from the high costs of repeated hospitalizations that Medicare doesn't pay for at this time. Our enhanced Medicare would establish a single, $300 deductible that will save seniors hundreds of dollars in high hospitalization costs.

In addition to better benefits for our sickest seniors, the enhanced Medicare plan provides better disease prevention benefits so our healthy seniors can remain healthy. These benefits, which are not now provided under traditional Medicare, include: tests to detect breast, prostrate, and other cancers early when they are most treatable; adult vaccines that prevent a host of diseases; tests to predict the loss of bone mass before people break their hips and other bones; and, medical nutritional therapy to make sure seniors are getting the nutrition they need to keep them healthy.

Finally, the 21st Century Medicare Act ensures that seniors will have access to prescription drug coverage no matter where they live. I know my colleagues will spend the rest of today praising or criticizing the details of each other's proposal for providing the prescription drug benefit, but I want to be straight to the point: our plan is comprehensive, affordable and sustainable into the future. Is it perfect? No, it probably isn't perfect, but it is a good solid plan that will provide seniors with a significant drug benefit at an affordable cost.

Yesterday, Senator SNOWE, my good friend and co-sponsor of the 21st Century Medicare Act, pointed out that this language is not a line drawn in the sand. I agree with her. It is a legislative proposal that was developed, like the one our colleagues, Senators GRAHAM and MILLER have proposed, in a good faith effort. I think all of the principal cosponsors of these bills and many of our other colleagues are willing, and can agree to further refine this measure during a conference with the House, but let's get them out of here.

Over the next hours there will be detailed descriptions of competing ideas and competing proposals debated here on the Senate floor, and I look forward to that debate. I have examined the proposals that are being proposed and this is what I found that is unique about our 21st Century Medicare Act. It strengthens Medicare by building on programs where patients and their doctors can choose the best course of treatment and it ensures that a better Medicare will be there for today's seniors.

It improves Medicare by providing a comprehensive prescription drug benefit and new voluntary disease-prevention benefits that will help seniors live longer, healthy lives. And, it guarantees that the benefits of today will be there for seniors tomorrow.

I am very proud to join my colleagues Senators GRASSLEY, SNOWE, BREAUX and HATCH in support of the 21st Century Medicare Act. This legislation is the result of over a year of concentrated effort and it includes in it provisions that should garner the support of a wide majority of our colleagues.

I look forward to working with all of my colleagues to resolve our differences and enact this quality health care program and prescription drug benefit for our seniors. I urge my colleagues to begin that effort with their support of the 21st Century Medicare Act.

The ACTING PRESIDENT pro tempore. The Senator from Georgia.

Mr. CLELAND. Mr. President, I ask unanimous consent that I be allowed to speak for 7½ minutes and then my colleague from Missouri, Senator CARNAHAN, be allowed to speak for 7½ minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. CLELAND. Mr. President, I come to the floor this morning to share the story of Betty Almeida, a gentle southern lady of 75 years and a life-long resident of Atlanta, who just last week came face to face with the hard reality that she can no longer afford the medications she needs. Betty called my office shortly after visiting her local pharmacy, where she had discovered that the cost of the two medications her doctor prescribed for her was simply too much for her to afford. She had been following the prescription-drug debate in Congress for some time, but last week, with a new sense of urgency, she called me to plead for swift action.

Betty had been retired for a year when she learned she had a heart condition. Unable to afford the medications she needed to keep her condition under control, she came out of retirement and went back to work just to earn money to pay for her prescription drugs. For a while, that arrangement, though a hardship, enabled Betty to earn just enough to pay for her medicine. But recently, after Betty underwent a surgical procedure to remove a blockage from her heart, her doctor prescribed two new medications: one to treat an irregular heartbeat and one to lower her cholesterol to a safe level. Thank God these wonderful, life-saving drugs exist. But when Betty approached the pharmacy counter last week hoping to buy them, she was asked for $197 for the cholesterol-lowering drug and almost $150 for the other. Fortunately, it was Senior Citizens Day, so Betty was able to make use of a $5 discount. Still, the combined cost of the two medications—nearly $350—was far beyond what Betty could afford. And so, as she stood at the counter, Betty faced a choice: which condition would she treat? Her doctor told her she needed to treat both, but Betty couldn't afford to do that, so she had to choose. Which did she need more: a regular heartbeat, or safe cholesterol levels that would prevent future blockages?

The time to pass a prescription drug benefit for seniors like Betty is now. Actually, the time was yesterday, but it would be an act of gross negligence on the part of the Congress—and a violation of a promise—if we fail this year to bring Betty and so many others the help they desperately need. The Graham-Miller-Cleland bill has received high marks from the AARP and

will, if passed, bring meaningful relief to Betty. Forced to choose, Betty elected to forego the cholesterol-lowering medication because of its $200 cost. Under the prescription drug program established by the Graham-Miller-Cleland bill, Betty would pay just $40 for the $200 drug—one-fifth the cost. There would be no deductible to meet first, and there would be no gap in coverage. Over the course of a year, Betty would pay $4,200 just for the two heart drugs I mentioned without coverage. Under the Graham-Miller-Cleland bill, her annual out-pocket-expenses on medications, even after factoring in the $25 monthly premium, would be just $1,260—a 70 percent reduction in yearly costs. Under the House bill, however, Betty's annual out-of-pocket expenses for just those two drugs would be $3,500—her savings, just 17 percent.

For Betty, and for the millions like her, I urge my colleagues in this body and in the House to pass the Graham-Miller-Cleland Medicare prescription drug benefit without delay. Anything less is unacceptable.

Thank you, Mr. President. I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Nevada is recognized.

Mr. REID. Mr. President, Senator CLELAND asked for 7½ minutes and time for the Senator from Missouri, and that is fine. To be fair, we should also give the minority 7½ minutes. I ask unanimous consent that they be given 7½ minutes and that the vote occur at or around 11 o'clock, whenever that time runs out.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The ACTING PRESIDENT pro tempore. The Senator from Missouri is recognized.

Mrs. CARNAHAN. Mr. President, next week marks the 37th anniversary of the day the Medicare program was signed into law. President Johnson traveled to Independence, MO to sign the bill in the presence of Harry S. Truman, who began the fight for the Medicare program in 1945. I am sure that our effort today to add a prescription drug benefit to Medicare is the type of common sense measure that President Truman would understand. Without this benefit, the Medicare program does not provide seniors with the security and protection its Founders intended.

If you have expensive and debilitating surgery, Medicare will pick up virtually the whole cost. But Medicare will not pay a single penny for prescription drugs that would cure your condition and make the surgery unnecessary. That does not make sense.

So today the Senate has an historic opportunity. People such as Annie Gardner from Columbia, MO will be watching us closely. She is an impressive 63-year-old, retired, mother of five adult children. But she suffers from diabetes and high blood pressure. She lost her health insurance and then could not afford her prescriptions. First she rationed her prescriptions by taking half the prescribed amount, even though she knew, as a former nurse, that this was a dangerous practice. Later she had to quit purchasing the drugs entirely because of other expenses, like fixing her car and paying increased taxes on her house.

In 21st century America, no one should have to make this type of choice. Today we have the chance to make Medicare the kind of program that we all want it to be. But we have before us two very different plans.

In my view, the benefit plan proposed by my colleagues BOB GRAHAM and ZELL MILLER is the superior choice. Their bill would create a benefit program that seniors could afford and could count on regardless of where they live.

Assistance begins with the very first prescription and is the same all year long. Senior will pay a monthly premium and then $10 for generic drugs and $40 for brand name drugs. There are no gaps or limits on the coverage. And once you hit the catastrophic cap of $4,000, you do not pay another dime for prescription drugs.

The alternative plan before the Senate is riddled with complexities and gaps. Before getting any benefits, seniors pay a $250 deductible. After that, seniors must pay 50 percent of the cost of their prescriptions. And then, once seniors have paid $3,451 on drugs—which is a great deal of money for virtually all seniors in Missouri—the coverage simply stops. But seniors still have to continue paying their monthly premium. The coverage does not start up again until seniors have laid out $5,300.

Under this plan, seniors will be paying a different amount almost every month. Some months they will get coverage—others they will not. I do not believe this is what seniors want from a prescription drug benefit.

The same flaws occur in the alternative plan for the treatment of low income seniors. But our plan would give low income seniors assistance with copayments and premiums, and 220,000 senior citizens in Missouri would qualify for this assistance. But under the alternative plan, low income seniors will have to pass rigorous assets test.

Mr. President, the reason we are passing a drug benefit is so seniors do not have to sell the family possessions to pay for their prescriptions. I cannot understand why the alternative plan would require low-income seniors to sell off assets to qualify for additional help.

My other concern is that seniors be guaranteed access to a benefit no matter where they live. Under the Graham-Miller plan, all seniors, regardless of whether they live in a rural or urban area, would have guaranteed access to a reliable, affordable benefit administered by the Medicare program.

We all know that the Medicare system is not perfect, but it is reliable, has always been there for our seniors, and always will be there in the future.

The alternative plan we are voting on today, however, creates a risky structure that does not guarantee that all seniors will be able to access the benefit.

Seniors in rural areas would have the greatest risk of being left empty-handed. How do I know this? Because the Republican plan gives government subsidies to drug HMOs to administer the benefit. This is the same system that Medicare+Choice runs on.

Seniors in rural Missouri know that Medicare+Choice programs have shut down all over the state. We do not want the same thing to happen to the prescription drug benefit. Our seniors deserve a dependable benefit, under Medicare, available to all.

Today is the day when we can put this program in place. We have a choice between an affordable, secure, and reliable benefit that will work for seniors—and a confusing plan that will not provide security and stability.

Mr. President, the Irish poet, Seamus Heaney, wrote that:

> Once in a lifetime, the longed for tidal wave of justice can rise up . . . and hope and history rhyme.

Today we have a chance to perfect the Medicare Program, and I pray we have the courage to seize the moment.

I yield the floor.

PROTECTING WOMEN'S RIGHTS AND HEALTH IN AFGHANISTAN

Mr. REID. Mr. President, under the Taliban regime in Afghanistan, women were forbidden to work or attend school. They weren't allowed to leave their homes unless they were accompanied by a male relative. For example, women who laughed out loud or wore shoes that made clicking noises could be beaten. There were many other examples of how women were so poorly treated.

After the fall of the Taliban, we heard encouraging news from Afghanistan. Women could go back to work and to school. They were no longer forced to wear burqas; that was a matter of choice.

A recent report from the United Nations found that now nearly 3 million Afghan children are attending school, and 30 percent of these kids are girls.

In fact, women took part in last month's Loya Jirga, a national conference to choose an interim government, and four women were appointed to positions in the interim Afghan Government.

Earlier today, I had the pleasure of meeting these courageous women. I met them in the Senate. Habibha Surrabi is Minister of Women and Refugee Affairs in Afghanistan. She was a professor of pharmacy at Kabul University, but was forced to flee when the Taliban took over in 1996. In Pakistan, she worked for refugee organizations where she focused on the rights of women, education, human rights, health care, and sanitation.