psychological impact of the events on Tucson residents, and coordinated a team of mental health experts to assist them in dealing with the associated trauma. Due to his bioterrorism experience, he was also put in charge of implementing southern Arizona's bioterror and emergency preparedness plans.

Although Arizona will surely miss this phenomenal man, and I know he will miss Arizona, in Richard Carmona, our nation will gain an invaluable leader. With his military and law enforcement background, coupled with his demonstrated commitment to public health and community preparedness, Dr. Carmona is extraordinarily, perhaps uniquely qualified to address the needs of our nation as Surgeon General.

I urge all of my colleagues to favorably support this outstanding nominee.

The PRESIDING OFFICER. Is there further debate on the nomination? If not, without objection, the nomination is confirmed.

The nomination was confirmed.

Mr. KENNEDY. I ask unanimous consent that the motion to reconsider the vote by which the nomination was confirmed be laid upon the table, and the President be immediately notified of the action.

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

LEGISLATIVE SESSION

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

The Senator from Oklahoma.

PRESCRIPTION DRUGS

Mr. NICKLES. Madam President, how much time remains on both sides on this issue?

The PRESIDING OFFICER. Forty-six minutes.

Mr. NICKLES. Does that include 46 minutes prior to the lunch break? Is it 23 minutes a side?

The PRESIDING OFFICER. It is evenly divided.

A PRESCRIPTION DRUG BENEFIT

Mr. NICKLES. I will be brief and yield myself 5 minutes.

Madam President, I hope this week the Senate will be able to pass a positive prescription drug proposal. It may be mission impossible. I wish that was not the case.

If we would have done it the ordinary way, the regular way, the way we have handled almost all Medicare bills in the last 20-some years, every single one except for one, it would have gone through the Finance Committee and been reported out with bipartisan support. Frankly, that bill would have been the basis, the foundation for reporting a bill that would eventually become law.

Unfortunately, we were not allowed to do that in this case. This particular bill happens to be probably the most important and the most expensive expansion in Medicare history, more expensive than any other changes and amendments we have made to Medicare since its creation in 1965. Yet we haven't had a hearing in committee on this proposal or the other proposals. We haven't had a markup. We had some bipartisan meetings, but we didn't have a chance to have a bipartisan markup. Maybe it is because it was likely that the product to be reported wouldn't have been what the majority leader wanted. It would have been a majority of the members of the Finance Committee.

I am very troubled by what we see in the Senate time and time again. If we have a committee that may not report something that the majority leader wants, we don't let the committee work. That happened earlier this year when we had a very extensive, expensive energy bill. Twenty-one members of the Energy Committee didn't get to offer an amendment. Now we have 19 members of the Finance Committee who have not reviewed this product or didn't have a markup on this product.

We are going to be voting at 2:45 on a bill that was introduced by Senator GRAHAM and Senator KENNEDY and Senator DASCHLE and others. It is 107 pages. The committee has not reviewed this. We didn't have a hearing on it.

I guess we now have somewhat of a scoring by the Congressional Budget Office, and they say it is $594 billion over the next 10 years. We find out it doesn't go 10 years. This is a benefit that is started but stopped. It doesn't start until the year 2005, but it stops in the year 2010. So we are going to pay part of your prescription drugs, but we are going to stop after a few years.

I find that to be very hypothetical at best. In fact, it wouldn't happen. Once you start an entitlement program, you never stop it, especially one that would be as popular as this.

But what are we starting? Some of us were estimating that the Democrat proposal, as originally outlined—I say ''the Democrat proposal''; Senator GRAHAM and some Democrats are supporting other proposals, but the Graham-Kennedy-Daschle proposal was going to be a lot more expensive than $600 billion.

Keep in mind the budget we passed with bipartisan support last year called for $300 billion. Keep in mind the President requested $190 billion. Yet now we find one at 600. I thought it would be more expensive. The reason why it is not is because they decided to ration prescription drugs.

If our colleagues would look on page 62, it says:

The eligible entity [health plan] shall . . . include . . . at least 1 but no more than 2 brand name covered outpatient drugs from each therapeutic class as a preferred brand name drug in the formulary.

In other words, you can come up with one, maybe two drugs in each therapeutic class. For arthritis there must be a dozen drugs. For blood pressure there must be at least eight or nine or ten brand name drugs. Only one or two are going to get payment. The rest of it, you are on your own. If you are not the Government-chosen drug, I am sorry patients, you don't get any help from the Federal Government. You don't get any help from this new drug benefit. You are out of luck. You are on your own.

The beneficiary is responsible for the negotiated price of the nonformulary drug:

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

In other words, beneficiary, you pay 100 percent. You choose or take the Government-selected drug, which would be a very small percent. Maybe that would cover about 10 percent of eligible drugs in the entire population. If you don't get that drug, you are out of luck. You are responsible for 100 percent.

I could go on and on. We are limited on time. I have several speakers on our side who wish to address this. This is one of many serious mistakes that are in this bill. It is one of the mistakes we made by following the process of not marking it up in committee. I am sure if it had been discussed in the Finance Committee, we would have modified it. Unfortunately, we didn't have that chance.

If I thought this were going to pass, we would be talking about it a lot more because it has several fatal flaws that would be very injurious to America's health. It would mean rationing of prescription drugs; certainly something that we don't want to do.

I urge my colleagues to vote no on the Graham-Daschle-Kennedy amendment at 2:45.

I yield the floor.

GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS ACT OF 2001—Resumed

The PRESIDING OFFICER. The clerk will report the bill.

The assistant legislative clerk read as follows:

A bill (S. 812) to amend the Federal Food, Drug and Cosmetic Act to provide greater access to affordable pharmaceuticals.

Pending:

Reid (for Dorgan) Amendment No. 4299, to permit commercial importation of prescription drugs from Canada.

Graham Amendment No. 4309, to amend title XVIII of the Social Security Act to provide coverage of outpatient prescription drugs under the medicare program.

Hatch (for Grassley) Amendment No. 4310, to amend title XVIII of the Social Security

Act to provide for a medicare voluntary prescription drug delivery program under the Medicare program, and to modernize the Medicare program.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Madam President, I point out to my friend from Oklahoma that there are no provisions in his bill that are going to require the insurance companies to provide more than two drugs in any therapeutic group in a formulary. There is none. What is beyond that is what the cost will be.

In our bill, if the doctor recommends that a patient have a particular brand name drug that is not on the formulary, the patient can have it. We write in our bill how much that patient will pay, which is $40. But there is no such provision in the bill the Senator is talking about.

The Senator cannot show in his bill what the premiums are, what the cost is for premiums, deductibles, or the copay. It is going to be what the insurance company wants to do. It is a blank check for the insurance companies. There is no provision in there that indicates what the costs will be. That is the big difference.

Under the Graham proposal, which was spelled out in great detail last evening by Senator GRAHAM and others, beneficiaries will be able to get that off-formulary drug, and the price will be $40.

On page 29:

Treatment of medically necessary nonformulary drugs will be whatever is medically necessary.

Madam President, I withhold the remainder of my time.

Mr. NICKLES. Madam President, I believe under the unanimous consent request, we had Senator GREGG managing the time. Senator GRASSLEY will manage the remainder of the time.

Mr. KENNEDY. I yield 15 minutes to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Madam President, I was listening to the comments made by my friend from Oklahoma. It is too bad he wasn't here in 1965 because he could have joined the chorus of voices on that side of the aisle that argued against Medicare. He would have fit right in. If you read the debate, it is almost like listening to it again. So it is too bad my friend wasn't here in 1965. He could have led the charge against Medicare.

Mr. NICKLES. Will the Senator yield?

Mr. HARKIN. I only have 10 minutes.

Mr. NICKLES. I was wondering why you were guessing what I might have done in 1965.

Mr. HARKIN. I am just taking it from your approach here because you want to basically—what the Senator is saying is he wants to turn this over to the insurance companies. A lot of people wanted to do that in 1965, to turn Medicare over to the insurance companies.

Mr. NICKLES. If the Senator will yield further——

Mr. HARKIN. I will yield when I get done.

Mr. NICKLES. I would appreciate it, if my colleague is questioning my motives——

Mr. HARKIN. The point is, the Senator from Oklahoma and other people on that side are saying turn it over to the insurance companies. He talks about rationing, but what the Republicans want to do is give private insurers a free ride, charge seniors whatever they want, and then they will be able to tell them what drugs they take. That is what the insurance companies do now anyway.

Look at the debate on Medicare. Turn it over to the insurance companies. You can just go back to 1935 and look at the debate on Social Security. We have heard the same echoes all the time down through the years that we cannot do this. Well, it is time we do it. It is time we make good on the promise to 44 million Americans who rely on Medicare.

The choice is very clear: You either do it under Medicare, which is proven and has a proven track record; it cuts out all of the middlemen in the middle ground and gets the drugs right to seniors, or you can go in the other direction and say we will do it through the insurance companies, which is exactly what the bill on the Republican side proposes to do.

I know a little bit about this personally. My father was quite old when I was born. When I was in high school, my father was already in his late sixties, and he had worked just enough quarters to qualify for Social Security. He worked most of his life in coal mines, but during the war and right after the war he worked enough just to qualify for Social Security. But he would get sick every winter. We didn't have drug coverage. He would go to the hospital, and thank God for the Sisters of Mercy, who would take care of him and send him back home again. I happened to be in the military in 1965 when Medicare passed. I came home on leave and saw my father, and he had his Medicare card. Head held high, he could go in and be taken care of without relying on charity. But the one thing that was missing was prescription drugs.

My father is long gone, but for others since that time, the one thing that is missing is prescription drugs. I have never been able to understand why it is that if you get sick and you go to the hospital, Medicare pays for all your drugs, but if you want to stay healthy, stay at home, Medicare won't pay for your drugs. That has never made sense to me. It seems to me you would want to get the drugs to the elderly to keep them as healthy as possible, to keep them at home, so they don't go to the hospital.

My friend from Oklahoma mentioned rationing. We hear rationing, rationing. I say to my friend, go to Iowa right now and talk to the low-income elderly in Iowa. Here is their rationing. They cannot pay for their prescription drugs.

Mr. NICKLES. Will the Senator yield?

Mr. HARKIN. They cut them in half, or they decide whether or not to pay their heating bills in the winter or take their drugs; and when they have to cut back on their drugs, they get sicker and sicker, and they go to the hospital, and of course then Medicare pays for all their drugs.

Mr. NICKLES. Will the Senator yield?

Mr. HARKIN. I said I will yield when I get through with my statement.

So the Graham-Miller proposal is the one that does it through Medicare. It is the one on which seniors can rely, and it is rock solid.

This is the proposal the Republicans have right here on this chart.

For example, they say, under their plan, a senior with $1,000 in drug care costs still pays $913. That is 91 percent that they still have to pay. And 18 percent of seniors have drug costs of about $250. Under this, they would pay everything. Eighteen percent have drug costs of $1,000. Under the Republican proposal, they would pay 91 percent, $913. Seventeen percent of seniors have $2,000 in drug costs a year. Under the Republican proposal, they would pay $1,413, or 71 percent. Twenty-three percent of seniors—about one out of four—have $4,000 a year in drug costs. Under the Republican bill, they would pay $2,688 out of pocket, or 67 percent. If they have $5,000 in drug costs, they are going to pay 74 percent out of pocket. What kind of insurance is that, where you are paying 91 percent, 71 percent, 67 percent, or 74 percent out of your own pocket? Would you buy insurance like that?

Mr. NICKLES. Will the Senator yield?

Mr. HARKIN. Would you buy any kind of insurance—say a homeowners policy, and if your house burned down, you would pay 91 percent? Or if your car gets wrecked and it has to be fixed up, you would pay 71 percent of the fees. What kind of insurance proposal is that?

It is nonsense, not insurance. It is just another rip-off for the drug companies. Again, this does not provide adequate coverage and it doesn't contain costs.

Two weeks ago, I had a roundtable discussion in Iowa with insurers, business leaders, and consumers about drug costs. They were united in saying that not only are rising drug costs hurting seniors, they are a growing problem for employers trying to maintain affordable health insurance for workers. It is a problem for younger workers, feeling the pinch of higher health insurance premiums and cost sharing as a result. These Iowans were adamant, saying that any bill we pass has to have some new tools to hold down the rising drug prices.

Only the Graham-Miller bill makes progress toward cost containment. It

includes a bipartisan plan that will close the loopholes that have allowed drug companies to block lower cost generics from coming on the market. It addresses the issue of the 30-month rollover that they get all the time. The bill on that side doesn't do that. It is crucial because generic drugs cost a fraction of what the name brand equivalent costs, and they are just as safe and effective. But only the Graham-Miller bill addresses that issue of bringing generics on the market and providing for that competition with brand names.

The Graham-Miller bill has the Stabenow amendment, which will allow States to provide the discounts they get through Medicaid to others in the State, including seniors.

There is also the important Dorgan amendment, which says drugs could be reimported from Canada by pharmacists. If you want to know how important this is, talk to my friend Marie, a 67-year-old retired nurse from Council Bluff. She dedicated 43 years of her life to helping others. She told me she is lucky compared to her friends because she is only on three medications. She recently got an advertisement from a drug company in Canada that would sell her drugs to her for less. She did some research and got a prescription from her doctor. She is saving over $80 a month right now.

She has a friend who takes tamoxifen, an anticancer drug for breast cancer. She tried buying her tamoxifen from the Canadian company. In the United States, it cost her $319 for a 3-month supply. It cost her $37 from Canada.

The problem with that is that individuals are doing that, and they are leaving out their local pharmacists. It is vitally important for the elderly to have communication and a relationship with their local pharmacist to make sure they are taking the right drugs and the right dose.

While I think it is fine for seniors to get their drugs from Canada reimported, we have to make sure local pharmacists can do the same thing. Let them reimport the drugs from Canada at that same price. The Republican bill does not do that, but the Graham-Miller bill does.

Today we have a chance to pass a bill that will contain costs, that will provide affordable and reliable prescription drug coverage without gaping holes. We have the chance to make sure we bring generics on the market sooner to provide competition and to let our pharmacists reimport drugs from Canada at a cheaper price for our consumers.

All of that is in the Graham-Miller-Kennedy amendment, not in the Grassley-Breaux-Jeffords, et al, amendment. If you want good coverage, if you want to close the loopholes, vote for the Graham-Miller bill and not the fake substitute on the other side.

The PRESIDING OFFICER (Mrs. CLINTON). The Senator's time has expired.

Who yields time? The Senator from Iowa.

Mr. GRASSLEY. Madam President, I yield 1 minute to the Senator from Oklahoma, and then I would like to immediately yield 9 minutes to the Senator from Louisiana.

The PRESIDING OFFICER. Is there objection?

Mr. KENNEDY. Madam President, I do not intend to object. If the Senator from Oklahoma should be provocative, which for a moment or two he might be, I hope I can yield a moment to the Senator from Iowa just to be quiet, calm and reserved, and then go to the 9 minutes for Senator BREAUX.

The PRESIDING OFFICER. The provocation standard is recognized. The Senator from Oklahoma.

Mr. KENNEDY. Do we have that understanding?

Mr. GRASSLEY. I agree.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. NICKLES. Madam President, people are entitled to their own opinion, but they are not entitled to their own facts. The tripartisan bill—and I will let Senator GRASSLEY and Senator BREAUX and others defend it—says for people with incomes less than 150 percent of poverty, the Federal Government, or this new plan, will pick up 95 percent of the drug—95 percent.

Under the Democrat proposal, if you do not have the Government-chosen plan or prescription drug, you get zero. Zero. Not 9 percent, not 50 percent.

The chart the Senator from Iowa has is incorrect. Under the basic plan, if you have an income above 150 percent of poverty—in other words, above $20,000 for a couple—the Federal Government picks up half the prescription drug cost up to $3,450—half, 50 percent—and you choose your drug, not the Government choosing the drug. There is a big basic difference in this plan. You get to choose the drugs, not the Federal Government.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Madam President, I ask for 1 minute to respond.

Mr. KENNEDY. I yield 1 minute.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Madam President, I heard the Senator from Oklahoma. Talk about a Harry Houdini magic trick and trying to pull a funny curtain over issues. If you are below 150 percent of poverty, then it picks up 95 percent, but what he is not telling you is there is an assets test.

Take someone in Iowa who has an automobile worth $4,500. We need cars in Iowa. We do not have mass transportation. If you have a $4,500 car, you are not eligible for less than 150 percent of poverty. That is the assets test. If you have a burial plot worth $1,500, then you are out of the 150-percent poverty test; $2,000 worth of furniture, you are out. They are not telling you that. Have him stand up and tell you about the assets test and tell my elderly in Iowa, many who are below 150 percent of poverty, that they cannot have a $4,500 car, that they cannot have a $1,500 burial plot, that they cannot even have $2,000 worth of furniture in their house. If they do, they do not qualify. Go ahead and tell them that.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. WELLSTONE. Madam President, with my colleague's indulgence, I ask unanimous consent that I follow the Senator from Louisiana for 5 minutes.

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

Mr. BREAUX. I thank the Chair. Madam President, I thank my colleague for yielding me time.

On this amendment, on the argument in which the two colleagues were engaged, there is already an assets test for Medicare. The assets test is part of the concept of delivering health care in this country. If someone has low income but has assets—a house in Florida, a large bank account, investments in stock—those assets are always considered to determine whether a person is eligible for Medicaid. We have all supported that. It is not new.

The purpose of my taking the limited time that I have is not to criticize the other approach because our approach cannot be good just because the others are deficient. The tripartisan plan should be able to stand on what it stands for, not because the Graham plan is deficient in any particular area. So I am not going to spend my time talking about any perceived deficiencies in their plan but rather explain what we have presented to the Senate.

Legislating is the art of the possible. It is not trying to get something done that cannot happen. There are a number of proposals trying out how we are going to do what everybody thinks we should do, and that is an attempt to provide some reform to Medicare and at the same time do what we should have done in 1965, and that is to cover prescription drugs under Medicare.

Prescription drugs today are equally as important as a hospital bed was in 1965. Mostly that is on what Medicare tried to focus. It should cover prescription drugs, we all agree. There are various proposals as to how we should do that, ranging from $150 billion over 10 years, the Hagel proposal from the Republican side; the House has a plan for about $350 billion which includes provider givebacks; the Graham proposal is $594 billion dollars; our proposal is Medicare reform and a prescription drug plan that is about $370 billion, which I think fits between the various proposals.

Every one of us should remember from where the money is coming. The money on any plan is coming from the Social Security trust fund. Our plan, the Graham plan, the Hagel plan—all of it is taking the money for the people today out of the trust fund for Social Security for our children and our

grandchildren. That is from where it is coming.

I can say I want $1 trillion, but from where is it coming? We have to be realistic in these economic times to recognize there is not a whole lot of money floating around that we can do with what we think is appropriate without doing grave damage to the Social Security trust fund for our children and our grandchildren.

What we have tried to do in the tripartisan approach is to figure out what is a good drug delivery system and what is an affordable price. I mentioned the price we have is about $370 billion, which includes about $30 billion for reforming Medicare, which desperately needs reforming.

The model we have used is to ask: What has worked? One approach that has worked is the health care plan I have as a Senator—it is a pretty good plan; we wrote it—as do about 9 million other Federal employees. It is contained in the Federal Employees Health Benefits Plan that we get every year. We get to choose our drug plan or our health plan. We have private contractors come in and say: This is what we can offer to provide you health care at this price.

What we have tried to do in the tripartisan plan is say let's combine the best of what Government can do with the best of what the private sector can do. Some of my colleagues on this side of the aisle would say the private sector should do everything—keep the Government out of it. Some on my side of the aisle will say we need to have a Government-run program because nothing else is going to work.

The truth is, the best of what both can do needs to be combined, and that is exactly what the tripartisan plan has attempted to do. We combine the best of what Government can do, i.e., helping to raise the money to pay for it; No. 2, supervising it to make sure nobody in the private sector tries to scam it; to have Government controls and Government approvals over all segments of participation, and then what the private sector can do is bring about innovation and bring about competition to help keep costs down. So that is the proposal we have before the Senate.

Some have said that is not going to work because the big insurance companies are somehow going to try to rip off the beneficiaries in this country. Well, there are insurance companies right now that provide Medicare to beneficiaries, which is supervised by the Federal Government. Blue Cross and Aetna regularly provide all of the benefits, the hospitals and doctor coverage, under a contract with the Federal Government.

What we are saying is have the same type of delivery system for prescription drugs but have the plans have some of the risks. We are talking about Blue Cross and Blue Shield, Aetna and Merck-Medco, national operations that are big boys in this business. Under the Graham plan, they say we are going to have a management contract with them, but if they overshoot their costs and their costs are more than they say they are going to be, the taxpayer is going to pay the difference. The difference in our plan says these guys are big players and if they say they can provide prescription drugs for $100 per beneficiary, and it ends up costing $102, they are going to have to assume the risk. They are going to have to eat their mistake, not the taxpayers of this country.

Why is that important? It is important because if they know they are on the hook for some of the risk, they are going to have an incentive to negotiate the best possible price with the pharmaceutical companies in order to make sure the price they say they can do it for is, in fact, that price or even less. They will then have an incentive.

What kind of an incentive does a provider have if they know when they bid costs more than that, the taxpayer is going to pick up the cost? That is exactly what the other approach does and why I think the approach, by saying these companies should have some of the risk, not all of it, but they ought to have enough risk to make sure they negotiate and compete, and that is one of the differences in our plan.

All of this is done under the supervision of the Health and Human Services Secretary to make sure the plans they present do not try to scam the beneficiaries, do not try to cherry-pick only the healthiest. The Government can do that, and in our plan the Government does that.

One of the other concerns I have had is that people have said it is not going to work in rural areas; Medicare+Choice does not work in rural areas. And that is true. One of the reasons is that Medicare+Choice has to do a lot more than just provide prescription drugs. They have to have a hospital in a rural area, doctors, emergency rooms, ambulance services, all the things that are necessary to create a health care system in a rural area. As the Presiding Officer knows, that is a very difficult challenge.

If only prescription drugs are being delivered, that infrastructure is not needed. The only thing that is needed is a doctor to write a prescription and a drugstore to fill it, or a mailbox if one chooses to do it by mail order. The entire infrastructure is not needed as it is under Medicare+Choice.

What we say in the bill very clearly is that every administrator shall, consistent with the requirements, approve at least two contracts to offer a Medicare prescription drug plan in an area. What that means is that every person, even in the most rural part of America, has to have at least two people or two companies offering prescription drugs to the people in that area. If only one bids, the Government can make the assumption of the risk even greater until one gets at least two plans to compete. If one ends up with only one, the Government will be the one that provides the other alternative.

So rural areas are protected. Can't we tighten that up? I am certainly willing to try and do it. I think we state very clearly that every part of the country has to have at least two plans offered to them on a competitive basis. That is what the law would be. The Government has to make sure that there are two plans, and if someone does not get two plans, then the Government will come in and offer the prescription drugs to the people in the area.

Under the Federal Employees Health Benefits Plan, pick the most rural part of New York or the most rural part of Montana and there is a Federal employee who probably works in one of those counties that has Federal health insurance. They get it in the most rural part of this country, under a system that utilizes private contractors to provide it. They get their prescription drugs under the Federal Employees Health Benefits Plan.

The other part is that people have said there is too much flexibility in our plan. Every plan that everybody gets, including mine, has flexibility of choice. We can pick the plan that is actuarially equivalent and pick the one that makes the most sense for us.

How much time do I have remaining?

The PRESIDING OFFICER. The Senator has used 9 minutes.

Mr. BREAUX. I would conclude by saying I think we have offered something that is possible, that is doable and that we can actually adopt. I think that is a good suggestion this body ought to take under consideration.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Madam President, Eli Lilly has a discount card. It is called Lilly Answers. The card is supposed to give low-income seniors a 30-day supply of any Lilly drug for a $12 fee. Sounds like a great deal, but when one reads the fine print, it turns out that a lot of drugs are excluded.

Noland Decks from Winona sent me this letter about his sister:

> I am writing to relate to you the prescription medicine situation for my sister, Hazel Decks, who has Parkinson's disease. Her income is such that she has qualified for the Lilly Answers program which is supposed to give her a one month supply of Permax for $12. When I approached the pharmacy to get her prescription refilled, I was informed that Eli Lilly has chosen to exclude this medication from the program, in spite of the fact that the bottle says it is manufactured by Lilly. I contacted Lilly and could find no one who would explain why. I now believe that they will not allow it because it is too expensive. The 30 day supply costs Hazel $375.

For Parkinson's medication. I had two parents with Parkinson's disease.

Her Social Security check is $479 a month.

I give this example because in 5 minutes I cannot even begin to cover the ground, but there are about three or four thoughts that come to mind as we come close to a vote. First, I do not think, based upon what we have seen in the last month or two, anybody any longer would believe that the Arthur

Andersens of this world should be writing any kind of reform legislation when it comes to securities reform, when it comes to protecting investors and consumers. I do not believe that hardly anybody in the Senate would argue that when it comes to a clean air bill or a clean water bill that environmental polluters should write that legislation.

So it is, I do not believe that the pharmaceutical companies ought to be writing a prescription drug benefit plan. I think it is a mistake.

What are the differences? I will not go through all the numbers. Everybody has heard the numbers. To me, the differences are as follows: In the Graham-Kennedy-Miller plan, at least there is a defined benefit. Does it sound familiar, a ''defined benefit''? Not defined contribution. Senior citizens' prescription drug coverage is part of Medicare. It is a defined benefit. They know what they are going to be eligible for and they are going to have the coverage.

The competing proposal basically has the Federal Government farming out a subsidy to private health insurance plans, Medicare managed-care plans, and basically saying we hope to give enough of a subsidy that they then will provide the benefit. It is a suggested benefit. It is not a defined benefit. There is no security for senior citizens with this alternative.

For my own part, I will go one step further. When there is too high a deductible or there is a doughnut hole where a lot of seniors are worried about what they are going to do about these expenses as they run up $2,000, $3,000, $4,000 a month, that is the other big issue. We do not want to have a huge gap where people get no coverage, and that is exactly what is in the competing proposal.

Finally, I say to all of my colleagues, which is a different point, but I get a chance to say this, I want to see us do better on discounts and cost containment. I want to see us for sure support the Schumer-McCain amendment on generic drugs. I want to make sure this reimportation from Canada actually is put into effect—it looks like the administration does not want to—because of the huge discount for senior citizens and other seniors as well. I would personally like to see the Federal Government become a bargaining agent for 40 million Medicare recipients, and in the Graham-Kennedy-Miller bill there is allowance for the different managers around the country, benefit managers to do that work getting discounts. I want to see the States building on the Stabenow amendment and see States able to recoup some of the savings they get from exacting a discount for people with no coverage now and adding that on to medical assistance.

Colleagues, what is going on is there are quite a few Senators in good faith—I don't assume bad faith—who do not believe there is a major government role here. They do not believe this ought to be part of Medicare. They are not quite sure they believe in Medicare, though it has been an enormously successful program. We should extend prescription drug benefits to Medicare and make it a clear, defined benefit that is affordable for senior citizens. That is the right thing to do.

I yield the floor.

Mr. FRIST. Madam President, how much time do I have?

The PRESIDING OFFICER. The Senator from Tennessee has 5 minutes and 40 seconds.

Mr. FRIST. And the other side?

The PRESIDING OFFICER. Three minutes 55 seconds.

Mr. FRIST. I yield myself 3 minutes.

Madam President, soon we will vote on one of the most important matters facing the Nation—whether to provide within Medicare a prescription drug benefit. In order to strengthen Medicare, we must include affordable prescription drug coverage as part of the package. Too many seniors today find prescription drugs unaffordable. The high cost of prescription drugs serves as a barrier between seniors and the health care security they deserve—which this body has promised them.

There is only one proposal that accomplishes the goal of modernizing Medicare and including a prescription drug benefit within Medicare: that is the tripartisan bill. Senator SNOWE, a Republican, BREAUX, a Democrat, JEFFORDS, an Independent, HATCH, a Republican, GRASSLEY, a Republican, COLLINS, a Republican, and LANDRIEU, a Democrat, collectively have sponsored this bill which reduces the cost of prescription drugs and provides a stable and sustainable prescription drug benefit. The word ''sustainable'' is critical.

The tripartisan bill provides low-income seniors and those with initially high drug costs special additional coverage in order to give them security. It expands and improves Medicare benefits under the traditional Medicare fee-for-service program that seniors and individuals with disabilities are comfortable with and understand today. It begins the critical element of instilling competition as we seek to add a new benefit—which means prudent decisionmaking will be made. The tripartisan bill is designed to be permanent, sustainable, affordable and responsible. Even though the cost—$370 billion—goes beyond what was intended in the initial budget, I believe it is a reasonable first step.

In closing, the tripartisan bill is not perfect, but it is clearly more responsible than the alternative bill. Many think $370 billion, the cost of this bill, is high. And it is high, especially since it is not coupled with as much reform as I think will be required to ultimately strengthen Medicare. Additionally, the bill lacks some of the necessary reforms that are needed to make Medicare truly sustainable—considering that the number of seniors will double in the next 30 years. Finally, the bill is not immediate, but neither is the alternative bill.

The time to help seniors is now. We must act now, act responsibly, and implement a plan that can be sustained. I will support the tripartisan bill because it provides the best and only real opportunity for progress this year on this important issue.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

The Senator from North Carolina.

Mr. EDWARDS. Madam President, I yield myself 3½ minutes.

This debate taking place in the Senate is about people's lives. We have senior citizens who desperately need a prescription drug benefit. This is what they want. They want one that is affordable and reliable. It is no more complicated than that.

The Graham-Miller bill meets that criteria. Unfortunately, the bill from the other side does not for at least two major reasons. It turns the prescription drug benefit over to private insurance companies. The insurance companies themselves have said this will not work. It will not work because they are in the business of making a profit. They will only go to the markets where it is profitable. That means there will be millions of senior citizens around this country with no access to a prescription drug benefit.

Second, it has an enormous gap in coverage. For those who have $400 a month in prescription drug costs, there will be 3 or 4 months toward the end of the year where they will get no coverage at all, no help for their prescription drugs, although every month they are writing a premium check. That makes no sense. Those problems are taking care of in the Graham-Miller bill.

In addition, we have to bring the cost of prescriptions under control. That is why, no matter what, we have to pass the underlying bill that gets generics in the marketplace, stops the frivolous use of patents to keep generics out of the marketplace so we can have competition and bring down the cost of prescription drugs for everyone.

Second, to allow, in a safe fashion approved by the FDA, for drugs from Canada at lower cost to be brought into the United States so folks can buy at a lower cost.

Third, to allow States to make prescription drugs available to the uninsured at the same cost of those of us with health insurance and those in the Medicaid Program pay, to make the same cost available to them that is available to everyone else so they are not taken advantage of.

Those things will help make this prescription drug benefit affordable.

Last, in addition to all of that, this has to be considered in the context of a responsible fiscal budget, in order to get this country back on the path to fiscal discipline. In January of 2001, there was a $5.6 trillion projected surplus; $5 trillion of it is gone. Why? The biggest single reason is because of a tax cut proposed by the President that

has now been passed and signed into law.

To get this country back on the path to fiscal discipline, which it so desperately needs to be able to afford a prescription drug benefit, we ought to do at least three things; First, we ought to have pay-as-you-go rules apply in this Congress; Second, we ought to follow spending caps; Third, we ought to do something about the top layer of the tax cut for the 1 percent of Americans, the highest earning, richest people in America, scheduled to go into effect in the year 2004, to ask them to give up that tax cut in order to help their fellow Americans, in order to help us get back on the path to fiscal discipline and operate this Federal Government and this Federal budget in a responsible way.

The American people want us to do all these things. Give them a real prescription drug benefit, one that is affordable, one that is reliable, one they know they can depend on to bring down the cost of prescription drugs and find a way to pay for it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. I yield myself such time as I may consume of the remaining 2 minutes and 40 seconds.

First, I am happy to hear the Senator from North Carolina mention the prescription drug program has to be within the context of a fiscally sound budget process. I agree with that. But I think that is very much an argument for a piece of legislation that is permanent as the tripartisan plan is, as opposed to a sunsetted provision coming from the other side of the aisle that is $370 billion as opposed to $595 billion, the latter being the figure from the other side of the aisle. Just basically getting more for your money in the sense that CBO has scored the tripartisan program as the only program that brings down drug prices because of competition and the efficiency with which they are delivered as opposed to the program on the other side of the aisle that is very much a partisan plan as opposed to our bipartisan plan that drives up the price of drugs according to the CBO, which is our nonpartisan scoring arm.

Also, for the benefit of the Senator from Massachusetts who is still here and my colleague from the State of Iowa who is not here, I go back to the assets test. I think they think they have something. But the point of the matter is, they do not. We have heard these repeated objections to the assets test for low-income benefits in our bill as if it is something new. That is a red herring. There has been an assets test for low-income Medicare populations since 1987, and I happen to know that these programs passed by overwhelming margins—under the qualified Medicare beneficiary program as one example, as a specified Medicare beneficiary program as a second—and these programs have passed overwhelmingly with the support of my Democrat friends on the other side of the aisle.

I think that is injecting an argument into the program that is not legitimate. Current law excludes from the test the home and property it is on, a car that is necessary. I can also say it happened to be in the 1999 Clinton Medicare bill—that included an assets test as well.

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

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived, the Senate will now stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:31 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. CLELAND).

GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS ACT OF 2001—Continued

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, what is the parliamentary situation? What is pending?

AMENDMENTS NOS. 4309 AND 4310

The PRESIDING OFFICER. Under the previous order, there will now be 30 minutes for debate, to be equally divided between the Senator from Massachusetts, Mr. KENNEDY, and the Senator from New Hampshire, Mr. GREGG.

The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, on behalf of Senator KENNEDY, whom I do not see in the Chamber yet, I yield myself 4 minutes.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I am going to vote for the Graham-Miller amendment because it is, to my mind, the best proposal before us. It will provide affordable prescription drug coverage throughout the country. I think that is the best policy.

But it now appears there may not be enough votes for that amendment. The same, I might add, is also true of the Grassley amendment, which embodies the so-called tripartisan approach.

If that turns out to be the case, we will be at a stalemate. At that point, we will have to decide whether there is some way to resolve our remaining differences so we can write a prescription drug bill that can pass.

With that in mind, I would like to briefly discuss the three key remaining differences.

The first, and probably most significant, is referred to as the delivery model. That may sound like some kind of technical jargon, but it is actually a very important matter and will determine whether we are passing some theoretical, pie-in-the-sky prescription drug benefit that works on paper but fails out in the real world or whether we are passing one that will really get prescription drugs to seniors at affordable prices.

There are two approaches.

Under the Graham-Miller approach, prescription drugs will simply be added to the existing Medicare Program, with some new incentives for efficient administration.

Under the Grassley approach, in contrast, prescription drugs will be provided through a new, market-based system that relies on private insurance companies.

People may ask: Why not try something new? What is wrong with a new market-based system?

Simply this: The new system is untested and may leave seniors without adequate coverage, especially in rural States such as my State of Montana.

Let me explain. Montana seniors, like those living in other rural areas, lack the rich retiree coverage options their urban counterparts enjoy. There just are not as many large companies offering benefits to retired workers in my State of Montana as there are in other parts of the country.

We also do not have any Medicare+Choice plans offering free or low-cost drugs to beneficiaries as in places such as Florida or some other parts of the country. In addition, our Medigap rates are higher than the national average and Medicaid coverage is lower.

On top of all that, we have been burned in the past by the promises of competition and efficiency. Rural areas often get the short end of the stick when we deregulate and leave people at the complete mercy of market forces that favor highly-populated areas. Consider airline deregulation, managed care, and energy deregulation, to name a few.

I don't want to overstate the case. I'm not saying that a new approach is absolutely unworkable. But I am not willing to buy a pig in a poke. I want a reasonable assurance that a private insurance model will work.

I know that many other Senators share my concern. How can we address this concern? Is there another way, another idea? There may be.

In essence, we would shift to a new, market-oriented system but do it gradually, with plenty of safeguards to make sure that it really works, especially in rural areas and other underserved areas.

The resulting system might not be quite as efficient as some would like but in exchange, it is more stable than it otherwise would be under the private model.

The second key difference, between the two main proposals, is how much to spend on a prescription drug benefit. Clearly, we are talking about a big investment of government dollars, and even at the amounts we are considering here, we won't buy a benefit that will meet seniors' expectations.