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.

The proposals that include a so-called doughnut, or coverage gap, give pause for concern, simply because during some parts of the year, seniors would not receive any assistance. I don't want to belabor the point, as I know many others have talked about this problem over the past few days.

To my mind, the Graham-Miller bill is right about on target, and I hope that those who support the Grassley approach can, in the spirit of compromise, agree to devote some further resources to helping our seniors.

The final key difference involves what is referred to as ''Medicare reform.'' That means making additional changes to the Medicare system, beyond those necessary to provide a prescription drug benefit.

With due respect to the proponents of reform, I believe that we should keep our eye on the ball. We have limited resources. Many of the reforms are untested and, in some cases, risky. We will have other opportunities to consider broader changes to the Medicare program.

In light of this, I suggest that we defer the debate about additional reforms until a later date, and concentrate on prescription drug coverage.

Those are the key differences. Delivery model, spending, and other reforms.

Are they significant? They certainly are.

Can they be resolved? If we roll up our sleeves and put the interests of seniors ahead of politics or theory, we will get it done.

I yield the floor and encourage my colleagues in the next several days to work to find a compromise that gets the large vote and protects our seniors.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield 3 minutes to the Senator from Maine.

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

Ms. SNOWE. Mr. President, the moment is at hand when the Senate will determine the fate of prescription drug coverage for our Nation's seniors. I hope we will not allow a 60-vote threshold to stand between us and the possibility of passing a meaningful benefit for our Nation's seniors. That would be doing a tremendous disservice to those seniors who desperately need prescription drug coverage. I hope we will avoid the procedural gymnastics and do what is right.

The tripartisan plan is the only plan that has across-the-aisle political support. We worked on this endeavor for more than a year. I hope Members of the Senate will give it serious consideration.

The facts speak for themselves on the tripartisan plan. Our plan is permanent. It does not sunset as the Graham proposal that sunsets after 2010. The language is right in the legislation. We have never, ever added a temporary benefit to the Medicare Program in its 37-year history, and we should not start now. It is providing a false hope to seniors who need this type of coverage. They should not have to beat the clock when it comes to their own health care. I guess you had better not get sick after 2010 because that benefit will expire.

The tripartisan plan is universal, applying to seniors no matter where they live in America, with the lowest premium offered of any bill either in the House or the Senate, thanks to a 75-percent Federal subsidy, which is higher than what Federal employees get under their health care coverage. Our opponents' plan not only creates a higher premium, but they also increase the prices of prescription drugs. That is not our projection; it is the projection of the Congressional Budget Office that estimates it could be anywhere as high as 15 percent, but at least 8 percent, in driving up the cost of prescription drugs.

It is also estimated under the tripartisan plan that 99 percent of seniors will participate, and 80 percent of those who do will never reach our benefit limit of $3,450.

I remind Members that we have a catastrophic benefit of $3,700 to protect people's out-of-pocket costs that are very high. Seniors in our plan will pay less on copayments, less on copayments under our plan for 39 out of the top 50 prescribed drugs for seniors. And we cover all drugs—brand name, generics—unlike the plan offered by the Senator from Florida, Mr. GRAHAM who leaves out most of the brand name prescriptions. In fact, only 10 percent of the brand name drugs will be covered under that legislation. Under the tripartisan plan, seniors will have access to all drugs.

I ask unanimous consent for an additional minute.

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

Ms. SNOWE. That is an important feature because by excluding most of the brand names from coverage, that means you are denying seniors access to the most innovative and cutting-edge therapies available. That is not the kind of coverage we want to provide because that is a huge gap in coverage.

Finally, I hope we will not allow this issue to die today here on the floor. I appeal to my colleagues to do everything they can to prevent killing this legislation. We need to get something done. These votes today are going to be very important in determining who wants the politics or who wants the issue.

We want progress. The best way to get progress on this most vital issue to our Nation's seniors is by supporting the tripartisan plan that has bipartisan support in the Senate.

I hope Members of this body will support this plan that will do more to help our Nation's seniors in providing them a much-deserved prescription drug benefit.

I yield the floor.

Mr. LEAHY. Mr. President, in recent days the Senate has begun to consider a number of proposals designed to help Americans afford their needed prescription drugs, not the least of which is to create a Medicare prescription drug benefit. This is an important debate, and one that has been a long time in coming to the floor of the Senate. Now we have the opportunity to not just talk about creating a Medicare drug benefit but to prove to our Nation's seniors and disabled that we stand by our word. The amendment offered by Senators GRAHAM, MILLER, and others is the best proposal before us, and it is one that I urge my colleagues to support.

I am pleased to be an original cosponsor of this piece of legislation because it is the only one that would create a new, voluntary prescription drug benefit within the Medicare Program that all beneficiaries would be eligible for. Under the Graham-Miller proposal, Medicare beneficiaries will receive assistance starting from the moment they buy their first prescription drug. There is no deductible and there is no gap in coverage, ensuring that no senior will be left stranded without the drugs they need. Beneficiaries would be responsible for copayments of $10 for generic drugs and $40 for medically necessary preferred brand name drugs until they have reached $4,000 of out-of-pocket spending, at which point Medicare pays all expenses. This bill provides low-income seniors and those with disabilities with extra assistance by covering the premiums and copays for those living below 135 percent of poverty, and giving premium assistance to those between 135 and 150 percent of poverty. In my State of Vermont, 28,000 of our 87,000 Medicare beneficiaries have incomes less than 150 percent of poverty and thus will qualify for this extra assistance available under the Graham-Miller proposal.

This amendment will help our seniors get the drugs they need, no matter where they live, what their income, or how sick they are. I urge my colleagues to support this important measure that will put affordable prescription drugs within the grasp of some of our most vulnerable Americans.

Mr. AKAKA. Mr. President, I rise today as a cosponsor of the Graham-Miller-Kennedy amendment that would establish a guaranteed Medicare prescription drug benefit for all seniors.

Approximately 19 million seniors in the United States have little or no prescription drug coverage. Prescription drugs are the largest out-of-pocket health care cost for seniors. Many who cannot afford drug coverage often do not take the drugs their doctors prescribe, and one in eight senior citizens is sometimes forced to choose between buying food and buying medicine. While numerous seniors live on modest fixed incomes, prescription drug costs have increased by more than 10 percent a year since 1995. Medicare needs a voluntary prescription drug benefit so

seniors have the same protection against the high cost of prescription drugs as they have for hospital care.

The Graham-Miller-Kennedy amendment is the most comprehensive Medicare prescription drug benefit proposed in the Senate thus far. It provides coverage to all seniors regardless of their health or income. In Hawaii, 159,000 senior citizens and disabled Medicare beneficiaries would be eligible for coverage under the Outpatient Prescription Drug Act, 41,000 low-income seniors in Hawaii would qualify for additional assistance under the plan.

Affordable premiums and copayments are key components of the Graham-Miller-Kennedy plan. For example, if a senior spends $4,000 on prescription drugs, she would reach the catastrophic limit and all additional drug expenses would be covered under this proposal. Seniors will not lose their current employer retirement coverage and will not have to rely on the public benefits provided by the plan. There also would not be a asset test required for participation in the Graham-Miller-Kennedy program.

The competing amendment proposed by the Senator from Iowa is well intended, but the Grassley amendment would not provide adequate coverage for seniors. The Grassley amendment would result in 26,000 seniors in Hawaii losing their existing retirement coverage, 47,000 seniors and disabled Medicare beneficiaries in Hawaii would fall into the benefit hole and would have to continue paying premiums and paying higher drug costs while not receiving any benefits. The Grassley amendment would also include a means test to qualify for additional assistance that would prevent seniors with assets greater than $4,000 from qualifying for additional assistance.

Today, the Senate has a historic opportunity to provide seniors with the missing piece of health care coverage that is urgently needed. We must ensure that all seniors are provided with an affordable and comprehensive prescription drug benefit for all seniors. I urge my colleagues to support the plan which does this, the Medicare Outpatient Prescription Drug Act.

Mr. VOINVICH. Mr. President, I rise to speak in favor of the tripartisan prescription drug proposal before the Senate. I applaud the efforts of Senators GRASSLEY, BREAUX, HATCH, SNOWE, and JEFFORDS, in developing this legislation.

Their work is the culmination of a year's effort to bridge the gap between the Medicare of 1965 and the Medicare for today and the future. As my colleagues know, when Medicare was enacted in 1965, Congress made a commitment to our Nation's seniors and disabled to provide for their health security. Unfortunately, that security is on shaky ground because Medicare has not kept up with the evolving nature of health care. The delivery of health care has vaulted ahead so dramatically 37 years after the inception of Medicare, that this system which was once sufficient is now anticipated and ineffective.

For example, conditions that used to require surgery or inpatient care can now be treated on an outpatient basis with prescription drugs. It is time for Medicare to reflect the realities of today's health care delivery system. The vast majority of my colleagues will agree when I say providing prescription drug coverage through Medicare is the next logical step towards modernizing the program. The best way to deliver such a benefit, however, is a point on which a number of my colleagues on the other side of the aisle disagree. My colleagues from the Finance Committee have found a solution that is a good compromise and is result that can be agreed to by both Democrats and Republicans. In fact, I would venture to say that the tripartisan proposal has the support of a majority of Senators.

Unfortunately, a simple majority will not suffice. As my colleagues know, we are working under the fiscal year 2002 budget resolution, which set aside $300 billion for a prescription drug benefit. Because we never voted on a fiscal year 2003 budget resolution, the first time the Senate has not done so since 1974, we have no choice but to stay within the parameters of 2002 funding levels. The fact of the matter is we have stacked the deck against passing any sort of meaningful benefit that costs over $300 billion, regardless of whether the majority of Senators support the proposal.

Regardless, the bar has been raised to pass prescription drug coverage, which clearly indicates that any bill that passes through this body will have to be bipartisan in nature—or tripartisan in this case. The tripartisan bill is the only measure we have before the Senate that bridges both parties and is a benefit that can pass.

We cannot delay any further. Each year we delay means another year our Nation's seniors will be forced to do without. already we have heard too often of seniors that have had to choose between food and prescription drugs. I, for one, am ready to go to my constituents in Ohio and say we were able to move past partisanship and provide real security for their health. The tripartisan proposal does that. We must act now, and we must act responsibly.

It is vital that we pass a prescription drug benefit this year, and it is vital that we pass one that is fiscally responsible. Ideally, the Federal Government would able to pay for every pill ever needed for every senior. Unfortunately, we live in the real world and are subject to limited resources. I would like to take a few moments to shed some light on our Government's current fiscal condition. Last year, the Congressional budget Office predicted a unified budget surplus of $313billion or fiscal year 2002. As my colleagues know, this rosy budgetary picture is no longer the case. Recent budget projections show that the Federal Government is in much worse fiscal condition than we thought. These new projections show that the Federal Government will spend the entire Social Security surplus in both the current fiscal year and in fiscal year 2003 and we will be borrowing $52 billion this year and $194 billion in 2003.

With this in mind, it is imperative that we act not only to provide Medicare benefits for today's beneficiaries, but also for the baby boomers who will arrive in 2011. If we do not act responsibly in providing a benefit, we will end up writing IOUs not only for Social Security, but for this benefit as well. The tripartisan proposal strikes a balance between providing seniors and the disabled access to needed prescription drugs today and doing so in a fiscally sensible way that will allow benefits to extend to future generations.

I cannot say the same for the Graham-Miller bill. Top the best of my knowledge,I cannot definitively state what the Graham-Miller bill will cost. My colleagues on the other side claim that their bill will cost $450 billion over 6 years. Then, after 6 years, as their bill is currently written, the benefit would sunset.

However, let us make the assumption that the Graham-Miller bill passed and their benefit did not sunset. What would that mean for the American people? I have a sneaking suspicion that $450 billion will somehow become $800 billion or as much as $1 trillion over 10 years. This is on top of the estimated $3.6 trillion it will cost the Federal Government to provide basic Medicare services for seniors and the disabled. As I see it, under the Graham-Miller bill, the American people get stuck between choosing cyanide and hemlock.

Senator GRASSLEY and the others in the tripartisan group have put before the Senate a proposal that would cost $370 billion as scored by CBO. The natural question that I think the American people would like to know is what does $370 billion buy? In my opinion, $370 billion provides a real prescription drug benefit that is affordable to both the beneficiaries and the Federal Government.

Under the tripartisan proposal, premiums would be $24 a month, an amount that is lower than the Graham-Miller bill. After a $250 deductible, the Government would cover half of all prescription drug costs up to $3,450.

Now, my colleagues on the other side of the aisle will claim that the so-called doughnut hole after $3,450 will be the financial ruin of every senior. The truth is that the vast majority of seniors, 80 percent, would never even hit that hole. Moreover, the hole exists only until the beneficiary accrues another $250 in costs, at which time the government would pay for 90 percent of all remaining drug costs.

While this benefit will greatly help seniors throughout the Nation, there are still some seniors for whom the $24 per month premium and additional

cost-sharing is still too high. For those individuals, the tripartisan bill provides protections that will allow access to prescription drugs. For those seniors under 135 percent of poverty, the tripartisan plan would provide a full subsidy for monthly premiums. In addition, the Government would cover 95 percent of their prescription drug costs to the initial benefit limit and 100 percent above the stop-loss limit. And for those seniors between 135 and 150 percent of the poverty level, the tripartisan proposal would provide assistance with their monthly premiums on a sliding scale. In addition, these individuals would pay no more than 50 percent of their drug costs once the $250 deductible has been reached.

When we talk about dollars being spent, we should also point out to seniors that they will receive more bang for their buck under the tripartisan proposal. Seniors will not just receive direct assistance from the government to cover their prescription drug bills. Rather, under the tripartisan plan, competing pharmaceutical delivery plans will be forced to provide the best value on prescription drug prices in order to attract beneficiaries to their respective plans. To the advantage of both Medicare beneficiaries and the Federal Government, this competition will decrease the price of prescription drugs and permit all parties to stretch their dollars further. For example, the same dollar that today would buy one day's dose of Lipitor, might purchase 2 days' worth of the drug when competing plans vie for consumers as they would under the tripartisan plan.

This body has been playing this political posturing game for too long. I am tired of explaining partisanship as the excuse for why this body has not passed a prescription drug benefit and has forced the least of our brothers and sisters to choose between food and prescription drugs. I am pleased that the Senate will have the opportunity to show the American people, especially our Nation's seniors and disabled, whether we are serious about enacting legislation to provide a prescription drug benefit this year.

The tripartisan bill has support from both sides of the aisle. The House has passed their measure. The President is ready and willing to sign a bill into law this year. The burden is squarely on the Senate's shoulders. All eyes are on us. I am confident that we will have more than 50 votes in favor of the tripartisan plan. I hope that those that are considering voting against this proposal have a very good reason for not supporting it, because the people in their State will be asking them the question: Why didn't you support a plan that gets the job done in a fiscally responsible way.

So while seniors wait for a prescription drug benefit, I will continue to work to educate seniors about generic drugs. I have been working on this issue for some time, providing funds at the Food and Drug Administration for consumer education and working with other non-profits to educate our seniors about the availability and efficacy of generics.

In the meantime, I urge my colleagues to waive the budget point of order on the tripartisan amendment so that Medicare can move forward into the 21st century and so that seniors and the disabled are able to have access to affordable prescription drugs.

Ms. COLLINS. Mr. President, as an original cosponsor of the tripartisan 21st Century Medicare Act, I rise in support of this amendment to make affordable prescription drug coverage available to all of our Nation's seniors.

Prescription drugs are as important to a Medicare beneficiaries' health today as a hospital bed was in 1965, when the program was created, and I have long been a supporter of providing a prescription drug benefit as part of our efforts to strengthen Medicare. With recent advances in research, prescription drugs can literally be a lifeline for patients whose drug regimen protects them from becoming sicker and reduces the need to treat serious illness through hospitalization and surgery. Soaring prescription drug costs, however, have placed a tremendous financial burden on the millions of Medicare beneficiaries who must pay for these drugs out of their pockets.

More and more, I am hearing disturbing accounts of older Americans who are running up huge, high-interest credit card bills to buy medicine they otherwise couldn't afford. Even more alarming are the accounts of patients who are either skipping doses to stretch out their pill supplies or being forced to choose between paying the bills or buying the prescription drugs that keep them healthy. It is therefore critical that we bring Medicare into line with most private sector insurance plans and expand the program to include prescription drugs.

The tripartisan plan that is before us today will provide an affordable and sustainable prescription drug benefit that will be available to all seniors. Moreover, unlike the alternative bill, our plan will make the drug benefit a permanent part of Medicare and is fully funded at $370 billion over 10 years.

Under the tripartisan bill, all seniors will have the choice of at least two prescription drug plans, regardless of where they live. This will enable them to select the kind of prescription drug coverage that they need. Moreover, the coverage under these plans will be comprehensive. Seniors will have access to every drug, from the simplest generic to the most advanced, innovative therapy.

Our plan is also affordable and has the lowest monthly premium—$24—of any of the comprehensive prescription drug proposals that are on the table. Not only does our plan offer a lower premium, but it also offers lower copays for most drugs than the amendment proposed by the Senator from Florida. As the senior Senator from Maine pointed out on the floor the other day, seniors will pay more for most of the top 50 drugs under the Democrats' bill than they will under the tripartisan plan. For example, the copayment for Glucophage, which is used in the treatment of Type 2 diabetes, would be $40 under the Graham-Kennedy bill, and only $31 under the tripartisan plan.

In fact, our plan is such a good deal that the Congressional Budget Office tells us that just about everyone will take it. According to the CBO, 93 percent of seniors will enroll in our program, while 6 percent will elect to retain their current prescription drug coverage. This means that 99 percent of all seniors will have prescription drug coverage once our plan is implemented.

No one should have to choose between paying their bills and buying their pills. That is why our bill provides additional subsidies to low-income seniors. For example, the 10 million seniors nationwide, including 65,000 Mainers, with incomes below 135 percent of poverty will have 98 percent of their prescription drug costs covered by Medicare with no monthly premiums and no gap in coverage.

In addition, these low-income seniors will not be subject to any deductible, and they will pay an average copayment of just $1 and $2 for each prescription. This is comparable to the copays required under Maine's Medicaid Program, which requires beneficiaries to pay $2 for each generic drug and $3 for each brand name drug.

The 10,000 Maine seniors with incomes between 135 percent and 150 percent of poverty will also receive generous subsidies under our plan. All seniors with incomes below 150 percent of poverty will be exempt from the benefit limit. As a consequence, 80 percent of Medicare beneficiaries will never experience any gap in coverage under our plan. Seniors with incomes below 150 percent of poverty will also receive a subsidy that lowers their monthly premiums to anywhere between zero and $24 a month, based on a sliding scale according to income.

My biggest concern about the amendment offered by my colleague from Florida is the cost. My understanding is that this plan will cost anywhere between $600 billion and $1 trillion over the next ten years. This is simply too heavy a financial burden for both current and future generations to shoulder, particularly given our mounting Federal deficit.

Moreover, despite its tremendous cost, the alternative plan promises only temporary help, not a permanent solution. Their plan sunsets after 6 years, and makes no provision for a drug benefit after 2010. In other words, their plan ends just as the tidal wave of baby boomers is preparing to retire.

The tripartisan plan also includes other improvements to the Medicare Program that are not included in the Graham-Kennedy proposal. The current

Medicare benefit package, which was established in 1965, now differs dramatically from the benefits offered under most private health plans. Our bill would provide a new, enhanced fee-for-service option for Medicare beneficiaries that more closely mirrors private health plans. For example, it would cover more preventive services than traditional Medicare at little or no cost. It would also provide protection against catastrophic medical costs for those seniors with serious health problems. The traditional Medicare Program provides no such catastrophic protection.

No one would be forced to enter this new plan. It is simply another option. If seniors want to stay in the traditional Medicare Program, that is fine, and they will still be eligible for the new prescription drug coverage.

Access to affordable prescription drugs is perhaps the most important issue facing our Nation's seniors today. It is therefore my hope that the Senate will stop playing politics so that we can pass a meaningful Medicare prescription drug bill this year. The 21st Century Medicare Act is the only legislation before the Senate that has not just bipartisan, but tripartisan support. Moreover, it has the support of 12 of the 21 members of the Senate Finance Committee, which has jurisdiction over Medicare. That is not to say that I think the tripartisan plan is perfect. I do not, for example, like the copayments imposed on home health care in the new fee-for-service option, and I would, of course, prefer a plan that had no gaps in coverage.

The tripartisan plan does, however, provide a major improvement in coverage, and I believe that it is the only proposal that gives our seniors any real hope of getting an affordable Medicare prescription drug benefit this year.

Since the cost of providing a meaningful drug benefit will only increase as time passes, it is all the more important that we act now. I therefore urge all of my colleagues to join me in supporting this tripartisan amendment.

Mr. REED. Mr. President, I would like to take a few minutes before we vote later today on the Graham amendment and the Grassley amendment to describe some of the grave concerns I have with the tripartisan amendment sponsored by Senators GRASSLEY, JEFFORDS and BREAUX.

The tripartisan Senate bill offers the following ''benefits'' to seniors: an expected monthly premium of $24; a beneficiary must cover the first $250 in drug costs; then half of his or her drug costs are covered between $251 and $3,450; at that point the beneficiary is then responsible for all drug expenses between $3,451–$5,300;

Moreover, the plan claims to offer assistance for low-income beneficiaries. What is not mentioned is that a strict asset test would prevent 40 percent of low-income seniors from even qualifying for this subsidy. A car, a wedding ring, or a burial plot over a certain value would render a beneficiary completely ineligible.

The purpose of insurance is to provide protection against certain costs. The kind of insurance some of my colleagues in the Senate have proposed would leave those seniors and persons with disabilities holding the bag when their drug expenditures are highest. Under the tripartisan plan, beneficiaries could still be required to pay thousands of dollars in drug expenditures.

This proposal would create a serious lapse in what is supposed to be a safety net for our most vulnerable citizens, only paying a quarter of an average Rhode Islander's prescription drug costs.

When a person breaks an arm, Medicare pays for the whole cast, not half. A prescription drug benefit should pay for all of your benefits.

There are other nonprescription-drug-related provisions contained in the tripartisan bill that are also of great concern, particularly Title II, the ''Option for Enhanced Medicare Benefits'' section. To me, the provisions outlined in this section of the bill are a direct affront on the Medicare Program as we know it. It seeks to create a new Medicare option that combines both Part A and Part B with a combined premium.

Under this option, a beneficiary would pay more upfront, out-of-pocket costs, such as a $10 co-payment for the first five home health visits and $60 per day for the first 100 days in a skilled nursing facility. In return, the beneficiary would pay nothing for preventive health services such as mammography and cancer screening and would receive protection against catastrophic health care costs.

This new Medicare benefit option would reverse the universal nature of our current program by creating a new line of services for those who can pay more. During the Balanced Budget Act debate of 1997, I fought against the addition of copayments for home health and other essential services because they threaten the access of low-income beneficiaries to those services.

This new enhanced benefit option would create a two-tiered system of the haves and the have-nots. Since there is no premium assistance for low-income beneficiaries who may wish to enroll in the enhanced benefit option, only more wealthy beneficiaries would be able to afford it. And since it requires beneficiaries to pay a greater share of their upfront costs, it would divert healthier, younger beneficiaries from the traditional program. This adverse selection would ultimately result in higher costs for those who remain in the traditional Part A and Part B program.

The sponsors and supporters of the tripartisan Senate bill have argued that even though our Nation's most vulnerable citizens deserve a Medicare prescription drug benefit they can depend on, the proposal offered by Senators GRAHAM, MILLER, and KENNEDY is simply too expensive. I would like to take a moment to highlight for my colleagues a recent report by the Center on Budget and Policy Priorities that I believe adds an important perspective to that point of debate.

The report compared the cost of last year's tax cuts with the costs of two prescription drug proposals for the Medicare population. The estimated 10-year cost of the first plan being roughly $350 billion and the second $700 billion for the same period. The report found that when the tax cut is fully in effect, the cost of the tax cut for just the top 1 percent of the population would exceed the entire difference in cost between the two prescription drug proposals.

I voted against the President's tax cut because I felt that it failed to leave room for critical immediate needs such as a prescription drug benefit, nor did it allow us to adequately address the long-term solvency of Social Security and Medicare.

Once Congress enacts a Medicare prescription benefit, it will be difficult to modify or significantly alter it. If we are going to enact a benefit, we must pass a solid, reliable benefit that will continue to meet the needs of Medicare beneficiaries in years to come. And if resources are the issue, many Members have already stated clearly that there is a way to address that issue, either through the reserve fund set aside in last year's budget or by other means.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. Mr. President, I yield myself 4 minutes, after I ask unanimous consent that Senator DAYTON be added as a cosponsor of this amendment.

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

Mr. GRAHAM. Mr. President, I rise to respond to criticisms raised about the availability and cost of drugs under the Democratic proposal. The minority leader has distributed a memo in which he cites selected provisions of our bill to come to a false conclusion about the access seniors would have to prescription drugs. I want to set the record straight.

Under the Democratic proposal, all medically necessary drugs would be available to our seniors at a rate of no more than $40 per prescription for the year 2005—all medically necessary drugs, not just the drugs that are on the preferred list.

The sections of the amendment Senator LOTT chose to omit make clear that every senior would have access to any drug that is medically necessary for that senior. Seniors are further protected because the Medicare Program would assure that the definition of a class of drugs is clinically appropriate. To the contrary, the Republican bill allows the drug HMOs to define the classes of drugs and, further, on page 32 of their amendment, clarifies that not all drugs within a class would have to be covered.

Senator LOTT may want to take a closer look at the Republican language given his concerns in this area.

Under the Democratic proposal, seniors will know in advance exactly how much they will pay for any drug. In 2005, they will never pay more than $10 for a generic and $40 for a medically necessary brand name drug.

Under the Republican plan, there is no way of knowing how much a senior would pay for a specific drug because there is no defined benefit in the Republican plan. Who makes the decisions? The drug HMOs make the decision. They choose how much the beneficiaries will pay, what the deductibles will be, and how much they will pay for each prescription in coinsurance. It could be 50 percent, which is what their charts say. It could be 80 percent. It will be determined not by the seniors, not by Medicare, but by the drug HMO.

I urge my colleagues to consider carefully the differences between the Democratic and Republican bills. Our bill uses the Medicare Program, a tried and true delivery system, to provide prescription drugs to our seniors. The Republican bill privatizes Medicare and requires seniors to get their drugs from a drug HMO—if they can find one in their State.

Our bill assures that seniors in rural America are guaranteed the same benefits provided to senior Americans elsewhere in this country. The Republican bill abandons rural Americans. Our bill gives seniors an affordable drug benefit and guaranteed prices. The Republican bill lets private insurers decide what drugs are covered and how much seniors will pay for each prescription.

Our bill uses every taxpayer dollar, every dollar paid by the beneficiary in monthly premiums to lower the cost of prescription drugs for seniors. The Republican bill uses taxpayer dollars and premium dollars to lure uneager private insurers into a market for which today there is no private insurance being offered.

Our bill is a bill for seniors. The Republican bill is a bill for drug companies and private insurers. The differences between the bills will make a very real difference in the ability of our seniors to afford the prescription drugs they need, and enjoy the improved health that those drugs will bring.

I urge my colleagues to support the Graham-Miller-Kennedy Medicare prescription drug benefit. In the event that none of the proposals that will be voted on this afternoon garner the necessary votes to move forward, I urge my colleagues to roll up their sleeves and begin work immediately on a proposal that can be adopted this year.

The outcomes of the votes today should not be viewed as a trumpet of defeat, but as an even more urgent call to find a proposal this year, in 2002, that will bring our seniors the drugs they need, the drugs that we have promised, the drugs a compassionate America will provide to this, our greatest generation.

The PRESIDING OFFICER. Who yields time?

The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield 3 minutes to the Senator from Louisiana.

Mr. BREAUX. Mr. President, I thank the distinguished Senator and say how much I have enjoyed working with him on the tripartisan group.

The Senate will be faced, in a few moments, with an interesting proposition. We will have Graham legislation that will not get the requisite number of votes to proceed. And we will be faced with the tripartisan proposal to see if we have an opportunity to proceed with that legislation. That will be the second and final vote, I take it, today on this issue. At least, I think it will be.

I don't think the Senate and this Congress can go back this year and tell our constituents that we didn't do prescription drugs because it is the other party's fault. I don't think the Republicans can say they didn't bring back prescription drugs because it is the Democratic Party's fault, and I don't think we will get very far saying we didn't have a prescription drug plan because the Republicans would not support ours. I think the seniors are wising up and know that this blame game is no longer going to help them one bit. You cannot take an excuse to the drugstore and buy prescription drugs. What the seniors need is both sides to come together and create a program that would work. Our tripartisan bill is somewhere between the two versions that I have described—the Hagel bill at $150 billion, and the Graham bill at about $594 billion. All of that comes out of the Social Security trust fund money. We have tried to be responsible in how much we can spend to make sure we have a sufficient number of votes to actually pass something and also create a delivery system that can work.

What we have suggested is that for people in the Medicare Program, just like those of us in the Federal Employees Health Benefits Plan—the program that we have drug coverage under and all of our insurance—that private companies compete for the right to sell us that coverage. They compete for the right to sell us prescription drugs. The company that can do it the cheapest is the one, in most cases, from which we purchase the plan. That is what we are suggesting.

We are also suggesting that these companies are big people, big players. There are PBMs like Merck-Medco or Aetna or Blue Cross. These companies are used to assuming risk. That is their business. Why should we say we are going to get companies to deliver the product, but if they underestimate how much it is going to cost, the taxpayers are going to cover their loss? Our bill says if these companies bid $100 to provide prescription drugs for seniors, and it costs them $102, then that is their responsibility. That is the risk they have to assume. Why should the taxpayers say: Look, we don't care how much it actually costs, the taxpayer will pick up the difference no matter what.

Regarding rural areas, our legislation says there will be at least two competing plans in every area of the United States. The Government will ensure that there are at least two competing plans. It is not like an HMO. Here you had to have a hospital and doctors and emergency rooms. The only thing you need to deliver drugs in a rural area is a drugstore to have the prescription filled and a doctor to write the prescription. We guarantee that every part of the country will have at least two competing plans.

What do we do if neither side has 60 votes? Do we give up? I suggest we try to find common ground. I think we can do that and we will continue to work in that regard.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, how much time remains on each side?

The PRESIDING OFFICER. The minority has 5 minutes 45 seconds. The majority has 4 minutes 45 seconds.

Mr. GRASSLEY. Mr. President, I yield 3 minutes to the Senator from Utah.

Mr. HATCH. Mr. President, just a few years ago, when President Clinton was President, he was asking for a drug benefit program of $168 billion. Last year, the Democrats wanted a $311 billion program. This year it is $600 billion. Frankly, I think it is a lot more than that because they have written in a sunset provision that actually helps to reduce the cost of that program, but also makes the program temporary.

I have to say that some of the things I find objectionable about the Graham approach is that the bill sets up a Government formulary that allows only two drugs for each illness. Because of that, it means that literally dozens of drugs that may be prescribed by doctors will have to be purchased by the patients themselves.

I might also add that it means a situation of price controls without question. Countries that set price controls on prescription drugs have been unable to duplicate the success of the United States in developing new pharmaceuticals.

Our tripartisan plan provides a permanent benefit, not a temporary one like Graham-Miller does. It gives beneficiaries choice in Medicare coverage, drug coverage, and options to select any prescription they want. It is affordable. Our plan costs $370 billion over 10 years. The Graham plan costs $600 billion over 10 years. Our plan, in addition, includes Medicare reforms. The Graham-Miller plan does not. Our plan is not run by the Government, but by the private sector, and it depends on private competition. It trusts seniors to make their own decisions and choices. The Graham-Miller bill does not. Ours is affordable, it creates competition, and there are no price controls on drugs. We take care of the

poorest of the poor and we do it within reasonable budgetary limits.

Mr. President, I yield back the remainder of my time.

Mr. KENNEDY. Mr. President, I yield 4 minutes to the Senator from Georgia.

The PRESIDING OFFICER. The Senator from Georgia is recognized.

Mr. MILLER. Mr. President, first I want to quickly make a point about a matter that has been raised on the provision in the Graham-Miller-Kennedy bill that says we take a second look at this legislation after a few years. That is not a weakness. It is one of its strengths, and it is nothing new. That is what we did with welfare reform, and that is what we did with the farm bill.

I submit to the Chair, if we had that provision in the original Medicare bill, we probably would have had a prescription drug benefit years ago.

Back in April, right after the Easter recess, I came to the Senate floor and talked about the urgency of passing a prescription drug bill. I spoke then of my 88-year-old Uncle Hoyle who lives next door to me in the mountains of North Georgia. He has been like a father to me in many ways. Once a very strong mountain man, Uncle Hoyle now suffers from diabetes, prostate cancer, recently had angioplasty, and also suffers from a kidney infection. Although he still makes a great garden—and I had tomatoes and corn out of it this last week—that once strong body is growing frail. I cannot get Uncle Hoyle, or millions like him, off my mind.

Many—too many—refuse to see these elderly waiting, waiting for someone, anyone, to knock on that screen door and say, as John Prine sings: ''Hello in there.''

The elderly are waiting for something else, too. They are waiting for us to do something about their health needs. So far, they have waited in vain, each day growing older, growing weaker. Now it comes down to us on this July afternoon 2002.

If we do not do something, you know who we are going to be like? If we do not do something, we are going to be like those who pass by that man in the ditch on the side of the road in that Biblical story of the Good Samaritan: Passed him by, tried not to look at him, refused to help him. We will be no better than they were and should be remembered in the same negative way.

We must come to the aid of our seniors by adding a meaningful prescription drug benefit to Medicare. The Graham-Miller-Kennedy bill would do just that. I believe and, more importantly, the AARP believes that our bill offers the best value for seniors. We deliver our prescription drug benefit through the tried and tested Medicare system. We provide extra help for our neediest seniors. We guarantee coverage 24 hours a day in every corner of this country, including that tiny rural town that the Presiding Officer knows, where I and my Uncle Hoyle live.

Remember what FDR once said: Try something; if it doesn't work, try something else. But for God's sake, try something. That is what I am trying to say. I want Uncle Hoyle and all those millions like him in this land of plenty who played by the rules, raised their families, and worked hard to have some hope and dignity in their twilight years.

Is that really too much to ask? Mr. President, I do not think so.

I yield the floor.

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

Mr. REID. Mr. President, I ask unanimous consent that the Senator from Iowa be granted 3 additional minutes and the Senator from Massachusetts, the manager of the bill, be given 3 additional minutes prior to the vote.

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

Mr. GRASSLEY. Mr. President, I yield myself such time as I might consume.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, soon we will cast what could be our final votes on a new Medicare prescription drug benefit. I am deeply disappointed with the process that brought us to this point, a process that ignored the good bipartisan will on the Finance Committee in favor of politics and partisanship that has seemed to dominate the debate on the floor of the Senate.

However, I continue to believe that our bill, the Tripartisan 21st Century Medicare Act, represents the broadest and best approach to providing prescription drug coverage.

Our work on this bill over the course of a full year involved fine Senators from every party. I have never been prouder to work in a bipartisan manner than with my colleagues Senator HATCH, Senator BREAUX, Senator SNOWE, and Senator JEFFORDS on probably the most important change in Medicare in the 37-year history of that legislation.

Together the five of us, bipartisan or tripartisan, whatever one wishes to call it, consulted stakeholders of all political persuasions and the Congressional Budget Office as we developed our policies over the last year. At every step of the way, we faced tradeoffs and made compromises, all in the spirit of cooperation, with the common goal of getting something done that could actually work without breaking the Medicare bank.

Our bill reflects the best of what good bipartisan cooperation can do. It offers seniors affordable coverage on a permanent basis. It does not sunset, and it does not take brand name drugs away from our seniors. It improves and enhances other unfair aspects of the Medicare Program, and it does it all on a voluntary basis. It does so at a total cost that reasonable people from both parties should be able to support—$370 billion over 10 years.

I urge my colleagues to remember that anything that comes to the floor on a purely partisan basis, such as the Graham-Kennedy bill before us right now, is destined to failure, and I remind everyone again that nothing ever passes this body on a partisan basis alone. Around here, it takes bipartisanship to make things happen, and apparently the Democrat leadership is not interested in making things happen for our senior citizens.

Our bill is built on a bipartisan foundation. Had it been given a chance to be debated in the Senate Finance Committee, it could no doubt have been improved further still, but we were denied that chance all because the other side did not want real debate. They wanted a real issue instead.

I urge my colleagues, especially those on the other side of the aisle, to listen closely when Senators claim to care about bipartisanship. Our bill is the only bipartisan prescription bill in all of Washington, DC, this year. It deserves consideration of the full Finance Committee, but since we have been denied that right by the Democratic leadership, it deserves your vote today.

The bill, other than the tripartisan bill before us, is without a doubt a program for big Government. Rather than allow prescription drug plans to design cost savings and innovative benefits that best suit seniors' needs, the Graham-Kennedy bill requires Federal bureaucrats to set up 10 regional drug formularies, basically deciding which prescription drugs seniors can and cannot access.

Under Graham-Kennedy, plans would not compete with one another. It would not be allowed to deviate from a regional drug formula, thus restricting seniors' choices. Plans would be further restricted from offering more than two brand name drugs in a therapeutic class.

This approach puts control squarely in the hands of bureaucrats in Government, and we know from experience that exclusive Government control over medicine has not worked well. The Government has lagged many years behind the private sector in covering immunizations, physicals, mammograms, and other preventive care in Medicare.

By contrast, the Tripartisan 21st Century Medicare Act approach puts control in the hands of our senior citizens. The bill guarantees multiple plans will compete in each region of the country, giving seniors a choice to pick the plan that best suits their needs and the right to get out of plans that do not meet their needs.

The tripartisan bill also does not restrict plans from offering more drug choices and better overall drug coverage. Under the tripartisan bill, private plans compete for seniors, not Government bureaucrats. What if the specific drug a senior relies on is not on the regional Government formulary? The Graham-Kennedy bill forces seniors to go through multiple layers of bureaucratic red tape to convince the Government to give them the drugs that their doctors think they need.

The tripartisan bill lets seniors and their doctors decide what drugs they should receive.

Take your choice. We have it within the next 5 minutes. I hope you will vote for the tripartisan plan.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Will the Chair let me know when there are 15 seconds remaining?

The PRESIDING OFFICER. The Chair will so advise the Senator.

Mr. KENNEDY. Mr. President, this vote is one of the most important any of us will ever cast. It is a vote about our national character and national priorities.

It is a vote about the quality of our society. But most of all it is a vote about senior citizens and disabled Americans and their right to live in dignity.

Medicare is a solemn promise between Government and the individual. It says, ''Play by the rules, contribute to the system during your working years, and you will be guaranteed health security in your retirement years.'' Because of Medicare, the elderly have long had insurance for their hospital bills and doctors bills. But the promise of health security at the core of Medicare is broken every day because Medicare does not cover the soaring price of prescription drugs.

Today, we have the opportunity and the duty to mend the broken promise of Medicare. It is time to pass a Medicare prescription drug benefit. It is time for Congress to listen to the American people instead of the powerful special interests.

When I first came to the Senate, I was privileged to participate in the debates that led to Medicare's passage. Then, as now, there were two plans before us. One plan was the solid, dependable, comprehensive Medicare program that became law. The other was little more than a political fig leaf for the elections. One plan was supported by all the organizations representing senior citizens and working families. The other plan was supported only by the powerful special interests. That is the same situation we face today.

Senators GRAHAM, MILLER, and I have offered a solid, affordable Medicare prescription drug benefit that offers senior citizens and disabled Medicare beneficiaries the protection they need at a price they can afford. There is no deductible, there are no gaps, there are no loopholes. The benefit and the premium are both guaranteed in the law itself. Low income senior citizens get special assistance.

But the other side has taken a different approach. Their plan is not affordable, not adequate, and not Medicare.

Under their plan, benefits are so inadequate that senior citizens will still be forced to choose between food on the table and the medicines they need to survive. There is a high deductible and a large coverage gap. Whether the senior citizen has large drug needs or more modest ones, the program only pays a small fraction of the cost of needed medicine—leaving the elderly to shoulder the rest or go without.

Special help for the low income elderly is conditioned on a cruel and intrusive assets test.

Instead of guaranteeing benefits for senior citizens, their program provides subsidies for insurance companies—and allows them to set the premium and determine the benefits that the elderly can receive.

And to reduce the cost of their plan, they have set it up in such a way that it actually encourages employers to drop the good retirement coverage that more than ten million senior citizens now enjoy.

According to the Congressional Budget Office, under the Republican plan one-third of these retirees—three and one-half million—would actually lose the good coverage they have today and be forced into the inferior Republican plan.

From the AARP to the Leadership Council of Aging Organizations to the National Committee to Preserve Social Security and Medicare, virtually every organization representing senior citizens and the disabled supports our amendment. Not a single legitimate organization of senior citizens or the disabled supports their proposal.

We are proud that our Democratic leader brought this matter to the floor of the Senate. This is the time for us to act.

The PRESIDING OFFICER. The Senator from Massachusetts has 15 seconds remaining.

Mr. KENNEDY. Senior citizens and their children and their grandchildren understand that affordable, comprehensive prescription drug coverage under Medicare should be a priority. Let's listen to their voices instead of those of the powerful special interests. Let's pass a Medicare prescription drug benefit worthy of the name.

Every single member of this body has a good prescription drug benefit. Let's do the same for the American citizens. That is what our program does.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. I think the time has expired.

The PRESIDING OFFICER. The Senator from Iowa has 45 seconds.

Mr. GRASSLEY. Mr. President, I yield back the remainder of our time.

Mr. President, I make a point of order that the Graham amendment, No. 4309, violates section 302(f) of the Budget Act.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, pursuant to section 904 of the Congressional Budget Act of 1974, I move to waive the applicable sections of that act for purposes of the pending amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from North Carolina (Mr. HELMS) is necessarily absent.

The PRESIDING OFFICER (Mr. CARPER). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 52, nays 47, as follows:

[Rollcall Vote No. 186 Leg.]

YEAS—52

Akaka	Dorgan	Lieberman
Baucus	Durbin	Lincoln
Bayh	Edwards	Mikulski
Biden	Feingold	Miller
Bingaman	Feinstein	Murray
Boxer	Fitzgerald	Nelson (FL)
Breaux	Graham	Nelson (NE)
Byrd	Harkin	Reed
Cantwell	Hollings	Reid
Carnahan	Inouye	Rockefeller
Carper	Jeffords	Sarbanes
Cleland	Johnson	Schumer
Clinton	Kennedy	Stabenow
Conrad	Kerry	Torricelli
Corzine	Kohl	Wellstone
Daschle	Landrieu	Wyden
Dayton	Leahy	
Dodd	Levin	

NAYS—47

Allard	Enzi	Nickles
Allen	Frist	Roberts
Bennett	Gramm	Santorum
Bond	Grassley	Sessions
Brownback	Gregg	Shelby
Bunning	Hagel	Smith (NH)
Burns	Hatch	Smith (OR)
Campbell	Hutchinson	Snowe
Chafee	Hutchison	Specter
Cochran	Inhofe	Stevens
Collins	Kyl	Thomas
Craig	Lott	Thompson
Crapo	Lugar	Thurmond
DeWine	McCain	Voinovich
Domenici	McConnell	Warner
Ensign	Murkowski	

NOT VOTING—1

Helms

The PRESIDING OFFICER. On this vote, the yeas are 52, the nays are 47. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected. Under the previous order, the amendment is withdrawn.

VOTE ON AMENDMENT NO. 4310

The PRESIDING OFFICER. The question now occurs on the Grassley amendment No. 4310.

The majority leader.

Mr. DASCHLE. Mr. President, I make a point of order that the pending amendment violates section 302(f) of the Congressional Budget Act of 1974.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, pursuant to section 904 of the Budget Act, I move to waive the point of order for the pending amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The question is on agreeing to the motion. The clerk will call the roll.

The legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from North Carolina (Mr. HELMS) is necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 48, nays 51, as follows:

[Rollcall Vote No. 187 Leg.]

YEAS—48

Allard	Enzi	Murkowski
Allen	Fitzgerald	Nickles
Bennett	Frist	Roberts
Bond	Gramm	Santorum
Breaux	Grassley	Sessions
Brownback	Gregg	Shelby
Bunning	Hatch	Smith (NH)
Burns	Hutchinson	Smith (OR)
Campbell	Hutchison	Snowe
Cochran	Inhofe	Specter
Collins	Jeffords	Stevens
Craig	Kyl	Thomas
Crapo	Landrieu	Thompson
DeWine	Lott	Thurmond
Domenici	McCain	Voinovich
Ensign	McConnell	Warner

NAYS—51

Akaka	Dodd	Lieberman
Baucus	Dorgan	Lincoln
Bayh	Durbin	Lugar
Biden	Edwards	Mikulski
Bingaman	Feingold	Miller
Boxer	Feinstein	Murray
Byrd	Graham	Nelson (FL)
Cantwell	Hagel	Nelson (NE)
Carnahan	Harkin	Reed
Carper	Hollings	Reid
Chafee	Inouye	Rockefeller
Cleland	Johnson	Sarbanes
Clinton	Kennedy	Schumer
Conrad	Kerry	Stabenow
Corzine	Kohl	Torricelli
Daschle	Leahy	Wellstone
Dayton	Levin	Wyden

NOT VOTING—1

Helms

The PRESIDING OFFICER. On this vote, the yeas are 48, the nays are 51. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected. Under the previous order, the amendment is withdrawn.

Mr. DASCHLE. Mr. President, I move to reconsider the vote.

Mr. GRAMM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. DASCHLE. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. CORZINE). Is there objection?

Mr. REID. Mr. President, I object.

The PRESIDING OFFICER. The objection is heard.

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

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

Mr. REID. Mr. President, I ask unanimous consent that when the Senate considers the Hagel amendment, it be considered under the following time limitations: During today's session there be 90 minutes under the control of Senator HAGEL or his designee and 30 minutes under the control of Senator KENNEDY or his designee; that upon the use or yielding back of the time, the amendment be set aside to recur when the Senate resumes consideration on Wednesday, July 24; and there be additional time of 120 minutes prior to the vote in relation to the amendment controlled as follows: 60 minutes under the control of Senator HAGEL or his designee and Senator KENNEDY or his designee; that upon the use of the time, the Senate vote in relation to the amendment.

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

Mr. REID. Mr. President, before Senator HAGEL begins the debate, we hope to get from the House today the supplemental appropriations bill. After Senator HAGEL and Senator KENNEDY finish debate time today, we will begin the debate on the supplemental appropriation.

Based on the unanimous consent agreement just entered, I have the authority of the majority leader to announce there will be no more rollcall votes tonight.

I have been asked we have a consent request on the supplemental. The time, of course, is not running against the Senator's amendment.

Senator HAGEL has been his usual courteous self. He has been very patient in waiting for us to write this agreement. We have known his was going to be the next amendment for some time, and it is unfortunate it has taken so long to get to where we are.

Mr. President, I ask unanimous consent that at the conclusion of the Hagel amendment debate today, and notwithstanding receipt of the conference report to accompany H.R. 4775, the supplemental appropriations bill, there be 2 hours 40 minutes for debate with respect to the conference report, with the time divided as follows: 60 minutes each for the chairman and ranking member of the committee; 30 minutes under the control of Senator WELLSTONE, and 10 minutes under the control of Senator REID of Nevada or his designee; that on Wednesday, July 24, the Senate proceed to the consideration of the conference report at 10:30 a.m. with the time until 11 a.m. equally divided and controlled by Senators BYRD and STEVENS or their designee; that at 11 a.m., without further action or debate, the Senate vote on adoption of the conference report.

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

The Senator from Nebraska.

AMENDMENT NO. 4315 TO AMENDMENT NO. 4299

(Purpose: To provide medicare beneficiaries with a drug discount card that ensures access to affordable outpatient prescription drugs)

Mr. HAGEL. Mr. President, I call up amendment No. 4315, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Nebraska [Mr. HAGEL], for himself, Mr. ENSIGN, Mr. LUGAR, Mr. GRAMM, Mr. INHOFE, and Mr. GREGG, proposes an amendment numbered 4315 to amendment No. 4299.

Mr. HAGEL. I ask unanimous consent reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. HAGEL. Mr. President, we have spent 4 days debating and voting on two Medicare prescription drug proposals, the Graham-Miller-Kennedy bill and the so-called tripartisan bill. I have worked with Senators ENSIGN, LUGAR, PHIL GRAMM, INHOFE, SANTORUM, and GREGG to introduce relevant, straightforward, realistic legislation to add a prescription drug benefit to our Medicare Program.

Our legislation would create a permanent Medicare prescription drug program that would be available to all Medicare beneficiaries beginning January 1, 2004. We keep it affordable to both beneficiaries and taxpayers. We do it without creating a new Federal Government bureaucracy. The program is not perfect. None of the Medicare prescription drug bills we have considered have been perfect.

This bill accomplishes a very important goal. This bill gives seniors the peace of mind that comes with knowing they have security from extremely high drug costs, catastrophic costs that ruin families.

Why are we engaged in this debate?

Medicare was created, as we all know, in 1965—and it is a 1965 model. Preventive health care, like diet, lifestyle, and exercise, was not emphasized in 1965. Prescription drugs were not as widely prescribed or used. Research had not developed the kind of lifestyles and life expectancies and quality of life we now enjoy—prescription drugs, pharmaceutical research, being the core of that development.

Seniors needed protection, in 1965, from high hospital costs for inpatient services, and we gave them that protection. It came through Medicare Part A hospital insurance.

In 2000, the average American spent $435 a year on prescription drugs. Today, Medicare beneficiaries need protection from unlimited out-of-pocket prescription drug costs.

John C. Rother, policy director of AARP, was quoted today in the New York Times as saying:

> Another possibility is for Medicare to provide catastrophic coverage for prescription drug expenses over a certain threshold, perhaps $4,000 to $6,000 a year, with no premium. This could be combined with additional help for low-income beneficiaries and a government-authorized drug discount card.

So reported the New York Times today as a quote from Mr. Rother, the policy director of AARP. What Mr. Rother states is exactly what this bill does.

How would this program work? There are two major components to our bill. First, all participating beneficiaries

would be protected from unlimited out-of-pocket drug expenses through a cap on their private expenditures. The annual out-of-pocket limit would depend on their income. That would go as follows: For annual income levels below 200 percent of poverty, the annual expense would be no more than $1,500. That is a little more than a $100-a-month cap on out-of-pocket expenses. For those with annual income levels 200 percent to 400 percent of poverty, it would be capped at $3,500—no more, regardless of the need. For those incomes between 400 percent and 600 percent of poverty, out-of-pocket expenses would be capped at $5,500—no more. And for those who wanted to subscribe—this is a voluntary program, open to all Medicare beneficiaries—with incomes above 600 percent of poverty, their out-of-pocket expenses would be capped at 20 percent of their income.

Again, to give some relevancy to help understand those numbers, the 2002 Federal poverty level is $8,860 for an individual and $11,940 per couple. Beneficiaries with the lowest incomes would have their out-of-pocket expenses on prescription drugs limited, as I said, to about $100 a month. And almost half of all Medicare beneficiaries live on incomes lower than 200 percent of poverty.

The second part of our program would be that every beneficiary would be able to choose to enroll or not to enroll in a discount drug card program, giving them access to privately negotiated discounts on prescription drugs.

Who would administer this program? The Secretary of Health and Human Services would administer the program through the Centers for Medicare and Medicaid Services, CMMS. The Secretary would negotiate with private companies to deliver the benefits. What that means is no new Federal bureaucracy, no new Government program to administer these benefits.

I would like to point out that two-thirds of all seniors already have some type of private prescription drug coverage that they like and want to keep. Seniors would not be forced to drop supplemental coverage, and employers would be encouraged to retain and even improve existing coverage under our plan.

Our bill would allow employer-sponsored plans—all employer-sponsored plans: Medicare supplemental plans, Medicare+Choice plans—pharmaceutical benefit managers—PBMs—pharmacists, and even States working with private companies to deliver the benefits.

By structuring our program this way, we do not create an expensive and new, expansive Government bureaucracy or the subsequent redtape that follows. We would use the market system in place.

These private market tools, such as consumer choice and competition to control costs without limiting innovation, are critical to the future development and innovation of prescription drugs.

How would seniors participate? Seniors would enroll with an approved provider and pay an annual fee of $25, which would be waived for beneficiaries with incomes less than 200 percent of poverty, individuals with incomes of less than $17,720. Once beneficiaries had met their out-of-pocket limit on prescription drug expenses, they would pay a small copayment of no more than 10 percent of the cost of each prescription drug. Seniors would not have to pay monthly premiums for deductibles.

When would the program start? Our program would take effect January 1, 2004. Other bills that were considered would not have taken effect until 2005 or even later. And our benefit is permanent; we do not sunset the program.

Why do we structure the program this way? Any realistic Medicare prescription drug proposal must not only be affordable for seniors, but it must also be affordable to the taxpayers, future generations of Americans who are going to have to pay for this program. Why is that important? It is very important because if we begin a program and obligate and commit the next generations of Americans to this program, then we owe them. We have a responsibility of giving them all the facts and structuring a program that is accountable and responsible.

Let's examine something carefully. Projected Federal deficits now are seen for at least the next 2 years and probably longer. So as opposed to a couple of years ago when we looked out onto the horizon and saw surpluses as far as the eye could see, we are now in a different dynamic, a different environment. No one really knows how long we will be in deficit, so any new Federal program and entitlement that is added, someone must pay for that.

We are not operating under a new budget resolution, so, as of October 1, we will no longer be subject to budget caps. The two previous prescription drug bills we debated did not attain the 60 votes needed today in order to overcome a point of order raised because both violated the budget resolution cap of spending no more than $300 billion over the next 10 years. That was an important point. Both of the bills we debated that did not attain those 60 votes needed were in excess of the $300 billion cap that the Budget Committee of the Senate, this Senate, this body, voted for last year. But after October 1, there are no caps because we are not operating under a budget.

Finally, the underlying Medicare Program is still in danger of becoming insolvent. Let me pass on an interesting number. When Medicare was passed in 1965, Part A hospital costs for 1990 were projected to be $9 billion. In 1990, Medicare Part A actually spent $67 billion.

So from the projection, in 1965, out 25 years, as to how much Medicare Part A would cost, all the actuaries said then—all the smart people, all the medical care people—we would be spending, including inflation, and the rates of increase in costs—all the dynamics that are part of health care—$9 billion in 1990 when, in fact, we spent $67 billion in 1990.

We should pay attention to this number. I do not know of a Federal program—especially entitlement programs—that did not go far beyond any projections, partly because we always, for the political benefit, understate the numbers. But the numbers I have just recited are real numbers.

We ask, why should we be concerned about costs? I see a lot of young people sitting in the galleries. You better be concerned about some costs. You better be very concerned about what we do on prescription drugs because if we do not pay attention, and we are not concerned and enact an accountable, responsible, affordable program, I do not know how you are going to afford it—because you are going to pay for it. You will be paying for my prescription drug costs.

So we must act in a responsible, accountable way. Each of us who has the high privilege of serving in this body is but a passing, fleeting steward of your interests and the interests of this country. That is our highest responsibility.

According to a preliminary actuarial analysis—we are getting CBO scores on our amendment—our proposal would cost less than $200 billion over the next 10 years. In fact, the numbers are coming in at around $160 billion. That stays within the $300 billion budget resolution that this body, this Senate, voted for last year. The Congressional Budget Office will give us those exact numbers by the end of the day.

We have a tremendous opportunity to pass a responsible bill, to provide all Medicare beneficiaries with a permanent prescription drug benefit that would start January 1, 2004. We have that now within our grasp.

The debate we have had over the last 4 days has been good debate, relevant debate, important debate. All sides, all perspectives have had an opportunity to lay this out, as we should, as we are embarking upon this great new entitlement program. And we need this program. Make no mistake, this program is necessary. We need to deal with this issue.

This amendment that we offer today is not perfect. However, what we offer today is a real-world solution to a real-world problem.

Our amendment will give beneficiaries the protection they need most. And we focus on those who need it most, those who are without prescription drug insurance, those who are at the bottom of the social-economic ladder, those who have to make hard choices about their lives.

We can do this. We must do this. But it must be in a way that is accountable and responsible.

As the New York Times editorial phrased it this morning:

The most important short-term priority should be the needs of the fairly narrow, and politically uninfluential, band of Americans

who have very low incomes and very high drug prices.

They have said it accurately. They have stated it correctly. They have focused on those who need it most. This amendment does that.

Mr. President, I am grateful for an opportunity to propose this amendment and debate it. We will have a vote on it tomorrow. I know a number of my colleagues wish to speak on this amendment.

So I yield the floor to my cosponsor on this amendment, who has worked long, hard, diligently, and understands the issue as well as anyone in the Senate. I am very proud we have teamed up, along with a number of our other colleagues, to present something we think is important for our country that is workable, doable, and responsible.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I thank the co-author of this amendment, the Senator from Nebraska, for the great work he has done; and, by the way, that both of our staffs have done in coming up with an amendment that we think is fiscally responsible and that meets the needs of those seniors who need it the most.

We have heard a lot of examples during the House debate, and during the Senate debate, about those seniors who are having to choose between paying rent and paying for prescription drugs, or paying their food bills and being able to pay their drug bills. We have heard about a lot of heartbreaking stories. Those are real stories that are out there. We have those stories in my home State of Nevada. We get letters from those people all the time.

I got an e-mail a few weeks ago from a lady who sent this e-mail at 11:20 p.m. West Coast Time. She was up thinking—and probably looking through her medical bills—and just crying out for help, asking if I would be willing to take a moral stand to help seniors who need the help the most? Our amendment does exactly that. It helps those seniors who need help the most.

But this morning, I was also thinking about our responsibility to our children and the next generation of young people coming up who are going to be working for a living and paying taxes.

Will Medicare and Social Security be there for them? Will this country be there for them? Somebody has to pay for all of these programs that we are talking about.

People have not wanted to means test Medicare and Social Security because they believed that they have earned this benefit, that they have paid in for this benefit.

Realistically speaking, this new prescription drug benefit would not been earned by anybody that is going to get it, at least early on. Frankly, it is a straight giveaway to seniors. It is taking it out of the pocket of younger people who are paying into the system now and putting it into the pocket of older people who, while they were working and paying taxes, paid for a Medicare program that did not have a prescription drug benefit

All of us feel a great responsibility to our parents and our grandparents, to take care of them in their golden years. But we must do this in a way that does not put such a burden on young people in our society that they cannot prosper.

Why should their tax rates have to be so high just because we in the Senate wanted to get reelected, so we voted for things that just kept spending these young people's money? Ultimately, they will have no choice but to pay high taxes because politicians pay attention to the senior citizens because senior citizens vote. We need to pay strict attention to what we are doing here and whose money we are doing it with.

Once we add a benefit to Medicare, we will not be cutting that benefit in the future. So whatever we do, we better do in a fiscally responsible fashion.

Senator HAGEL and the rest of the team that has put this amendment together believes that we have done exactly that: We have provided help to those seniors who need it, but we have done it in a fiscally responsible manner.

I want to talk a little bit about the amendment and how it works. Senator HAGEL has covered some of this, but I want to reemphasize a couple points and to use a chart for those who need to see it. I am kind of a visual learner and need a chart to understand things sometimes, to actually be able to see the numbers on a piece of paper so I can put them in my head.

The way our bill works, first of all, is that we cap—this is catastrophic coverage—we cap the amount of out-of-pocket, expenses a senior citizen is going to have to pay. We do that based on income. The people who are have the lowest income get the most help. It goes up from there based on your income level. That seems to make sense if you think about it. Should a person like Ross Perot, who would qualify for this benefit, get the same help as somebody who makes $15, $16, $17,000 a year—a senior citizen? Should they get the same level of help? I think most people would say they should not get the same level of help.

Our bill says that if you are lower income, you are going to get more help. It also says that the sicker you are, the more help you get because those seniors who are very sick or who have a chronic condition such as heart disease, diabetes—and we will talk about a few examples later—pay much more per year in prescription drug costs and our plan limits their out-of-pocket spending. Those are the people our bill actually helps more than the leading Democrat proposal or the so-called tripartisan proposal.

For people who make $17,720 or less a year, up to 200 percent of poverty and below, we cap their out-of-pocket expenses at $1,500. This is a little over half of the seniors in this country. If you make between $17,721 and $35,440 per year, your out-of-pocket expenses are capped at $3,500, and it scales up from there.

Once again, our program is completely voluntary. I have heard that in 1987 the Senate passed, and actually enacted into law in 1988, a catastrophic drug benefit plan. We hear people—and I am not sure if they were referring to our plan or not—saying seniors opposed the 1988 plan so much, that they repealed it the next year. They were not opposed to it because of the catastrophic coverage, they were opposed to it because one, they were forced to join; and, two, their Medicare premiums went up. Ours is a voluntary program, and it only has an annual enrollment fee of $25 per year. That is strictly to take care of administrative costs. We figure about $25 per year is what is necessary to handle these costs per enrollee.

When you pay that fee and sign up for the program, you will get a drug discount card. You will be able to sign up for various plans in the area, and pharmaceutical benefit managers will have a list of pharmacies that are participating. They will have a formulary or a list of drugs that are offered. You will go through those, and you will say: I have this disease, or, I like that particular formulary; maybe I will get together with some of my fellow seniors or I will get together with my doctor and say, Which one of these plans do you recommend? Then you will sign up for that plan that best meets your needs. It is the competition between the plans and the volume buying that will allow the average senior to save somewhere between 25 and 40 percent on the drugs they buy with this drug discount card.

Right upfront, they save 25 to 40 percent. Then, we cap their out-of-pocket expenses. So it is a two-pronged approach. We believe that because the senior pays initially out of pocket—about $100, $120 a month for the low-income seniors—that they will shop for their drugs and take advantage of the lower prices that are being offered as a result of competition between the participating entities.

I want to give a couple of real-life examples of those cases we always hear about—those cases that tug at our heartstrings.

James is a 68-year-old man who has an income of about $16,000 per year. He is being treated for diabetes. These are the various medications he is taking: Glucophage, Glyburide, Neurontin, Protonix, Lescol, and Zoloft. He has monthly prescription drug costs of $478.04, and a yearly cost of $5,736.48—so James is paying out of his own pocket over $5,700 right now. Medicare doesn't cover anything.

To compare the various plans, first of all, under the Graham-Miller plan, James' out-of-pocket expenses would

be $2,940.00. Under the tripartisan plan, he would pay $2,341.65. Under the Hagel-Ensign plan, he would pay $1,923.65. So for the low- to moderate-income person who has a serious disease, the Hagel-Ensign plan gives that person more help than any of the other bills. And example after example has been heard on this floor about has been this type of a case.

If you don't like this one, we will give you the next one. Doris is a 75-year-old and has an income of around $17,000 a year. She suffers from diabetes, hypertension, and high cholesterol, which is not unusual for a senior. Her medications are Lipitor, Glucophage, Insulin, Coumadin, and Monopril, for a total cost of $304.03 a month, and $4,648.36 a year.

Once again, here is how Doris would fare under the various plans Under the Graham-Miller plan, the leading Democrat plan, she would pay $2,220.00 a year out of pocket; under the tripartisan plan, she would pay $2,086.36 a year; and, under our plan, she would pay $1,714.84 a year. Once again, this person does better under the Hagel-Ensign plan more so than either of the other two plans which were voted on and failed to get the 60-vote point of order.

To reemphasize, the plan we have all worked on together, including Senator GRAMM of Texas, provides a Medicare prescription drug benefit in a much more fiscally responsible way and takes into account future generations.

There is a third example I want to talk about. Betty, who is a 66-year-old, has an income of $15,500 per year. She is being treated for breast cancer. She is still receiving low-dose radiation therapy with Nolvadex. Her medication profile is as follows: Morphine, Paxil, Dexamethasone, Aciphex, Trimethobenzamide, and Nolvadex—monthly total of $668.33 and $8,019.96 per year.

These are three real-life cases from Nevada. The names have been changed to protect their privacy.

Betty's medications, under the three different proposals, once again: Under the Graham-Miller plan, the leading Democrat plan, she would pay $3,180.00 out-of-pocket expense; under the tripartisan plan, $2,570.00; and under the Hagel-Ensign plan, $2,152.00 out-of-pocket expense.

The person who is the sickest, who is moderate to low income, is the person our plan benefits more than any of the other plans. That is why we think our plan is superior, because when we hear about people, when they go on the talk shows, when they talk in front of seniors groups, when we are hearing all these horror stories, these last three examples are the type of people about whom they are talking.

So if my colleagues really want to help those seniors who need it the most, they should support our plan. The other thing is—and I will conclude with this—that we have had two other plans voted down today. The two plans that were voted down, because they did not get the 60-vote point of order, are pretty much dispensed with at this point. Senators should ask themselves if they want to get a bill done this year. If they do, this is your best chance of doing it.

If we pass this plan in a bipartisan fashion, lay aside the politics—and we said we are going to put seniors ahead of politics, and ahead of being a Republican, or ahead of being a Democrat—we can pass a plan now. We should put seniors ahead of a political issue in this November's election. This Hagel-Ensign bill is the bill that offers that opportunity for people.

So I encourage my colleagues to support our bill. It will be voted on tomorrow. We have a great chance and a great opportunity for the American people, and especially for those seniors and disabled people who are on Medicare, to really get the help that they need.

Mr. President, I ask unanimous consent to add Senator ALLARD as a cosponsor of amendment No. 4315.

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

Mr. ENSIGN. I yield the floor.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mr. SCHUMER. Mr. President, I am not going to speak very long, but I know my colleagues, the Senator from Nebraska and the Senator from Nevada, put forward their plan. I thought I would make a few points in regard to it. I commend them for their effort. They are trying to do something that is extremely difficult. They are trying to be both responsible in a plan in terms of how much they will provide, in terms of helping people who need help, but at the same time, they are trying to be as fiscally, I guess they would say responsible—I would say as minimal as possible. I would say, yes, if you just look at the plan and say which one should cost the least, the Hagel-Ensign plan is there.

If you look at all the other things we do in the budget and then say we don't have any money for this, repeal of the estate tax comes to mind, which I believe both of my colleagues have supported—and most have supported—and ask if it is an either/or proposition if you want to be fiscally responsible, which would people choose? A more generous plan. I think that cost us $600 billion in the President's budget to make that permanent. Putting together a generous plan and not repealing the estate tax, or repealing the estate tax and having this minimal plan, my guess is that 80 or 90 percent of the American people would reject the plan put forward by my colleagues from Nebraska and Nevada.

I guess if I had to think of the rubric of the plan, they are trying to be compassionate conservatives. It is a hard thing to do, a difficult thing to do. I respect their real effort to do it.

If my colleagues think this is a generous or adequate plan, it clearly is not. In fact, some have argued that this would be a step backward. That is not CHUCK SCHUMER, Democrat of New York, but it is AARP. I will read some excerpts from the AARP letter on this plan sent to Senator HAGEL on July 23. I ask unanimous consent that it be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

DEAR SENATOR HAGEL: Enacting a comprehensive prescription drug benefit in Medicare this year remains the top priority for AARP. Our members are counting on the Senate to pass a meaningful drug benefit that is available and affordable to all beneficiaries. Our members were promised in the last election that a comprehensive drug benefit would be a priority, and we are counting on you to make good on that promise this year.

We appreciate the intent of your bill, S. 2736, the ''Medicare Rx Drug Discount and Security Act of 2002,'' to provide a prescription drug discount card and stop-loss protection to Medicare beneficiaries. However, in addition to our substantive objections, we are concerned that by offering this scaled-back proposal today, you would effectively derail bipartisan discussion and compromise on more meaningful comprehensive approaches. We believe Congress should focus its efforts on enactment of a more comprehensive drug benefit this year.

In addition to the timing of your proposal, AARP has concerns about the approach taken in your bill, including:

Catastrophic coverage—While AARP has not opposed income-relating premiums, income-relating the Medicare benefit changes the nature of the program. This would set an extremely dangerous precedent in Medicare. Further, the stop-loss levels set in the bill do not provide enough protection for lower income beneficiaries. A low-income couple could spend 25 percent of their income just for drugs before this plan offered assistance. Thirdly, there are a number of issues involved in using tax returns to determine program eligibility levels, and we believe other options should be explored.

Discount card—While AARP supports the use of a discount card program as a building block for a Medicare prescription drug benefit, your proposal lacks the necessary specifications to guaranty the level of discount, what level of discount would be passed to beneficiaries, and the degree of consumer protections required of plans.

Given these concerns, AARP opposes your amendment. We remain fully committed to developing a comprehensive drug benefit for all Medicare beneficiaries and we look forward to working with you on legislation that our members can support.

Sincerely,

WILLIAM D. NOVELLI,
Executive Director and CEO.

Mr. SCHUMER. Let me quote from the letter to Senator HAGEL:

Our members are counting on the Senate to pass a meaningful drug benefit that is available and affordable to all beneficiaries.

AARP goes on to say that while they appreciate the intent of S. 2736—this is their quote—they are

. . . concerned that by offering this scaled-back proposal today, you would effectively derail bipartisan discussion and compromise on more meaningful, comprehensive approaches.

That is exactly the problem. I think when seniors from one end of this country to the other hear the exact specifics of the Hagel plan, they are going

to be shocked. I think they even probably think that the most generous of the plans—the Graham-Miller-Kennedy plan—doesn't go far enough in terms of help that they need. To hear this one—and I will get into some of the details—I think they would say: Gee whiz, what the heck did they do? If we went home and said we passed a prescription drug benefit and passed the Hagel-Ensign bill, most of our constituents would say—correctly—no, you didn't, and don't you claim that you did because you are not helping the vast majority of people who desperately need the help.

I will go on with the AARP letter. They are worried about the catastrophic nature of the Hagel-Ensign bill. Quoting them:

> While AARP has not opposed income-relating premiums, income-relating the Medicare benefit changes the nature of the problem. This would set up an extremely dangerous precedent in Medicare.

That is exactly right. Anybody who thinks this bill is helping middle-class people hasn't read it. The vast majority of our constituents who struggle with the cost of drugs, who may be making $20,000 or $25,000 and paying a couple thousand dollars—not $6,000, but $2,000—are left out in the cold by this bill. They are far more typical than the examples my good colleague from Nevada has brought up in his chart.

So to think that this is comprehensive, to think that it covers most, is wrong. We do have a choice. It is a value choice. How much are we willing to spend to help people? You cannot have it both ways. You cannot say we are passing a comprehensive prescription drug benefit and not spend the money for it. These drugs are wonderful, but they are expensive, and you cannot avoid that conundrum. You have to decide which side of the fence you are on.

With some regret, and I say it in admiration for their bold essay, the Hagel-Ensign amendment says we are on the side not of providing broad, comprehensive coverage but, rather, doing a little bit. And, again, as I said, put into the context of all the other things we spend money on, put in the context of the desire on the other side to continue with tax cuts, which takes their budget and puts it in a warped and pretzel-like way, it is not what the American people want.

So I am going to conclude with this quote:

> Given these concerns, AARP opposes your amendment. We remain fully committed to developing a comprehensive drug benefit for all Medicare beneficiaries, and we look forward to working with you on legislation that our members can support.

What AARP said to my colleagues I say as well. Let me just go over some of these things. This is the Hagel bill. Senior citizens with an income of $9,000—in parts of my State, that is not enough to pay rent, we would make that senior citizen with a $9,000 income pay $1,500 before the benefit outlined in the Hagel-Ensign bill—before they got any help at all. Now, is that fair? Is that right? Even taking the basic philosophy of Hagel-Ensign—and I disagree with it, but I respect it, helping the very poor who need the help—when you have a $9,000 income in most parts of America, you cannot afford to pay $1,500 in prescription drugs. You will never get there. That will be 17 percent of somebody's income. That is wrong.

Now, my friend from Nevada took one side of the line. I am going to take the other side of the line. He used a $17,000 example. Let's say you go to $18,000 in income. Nobody is rich on $18,000, whether you live in Nebraska, Nevada, or in Manhattan. It is harder in Manhattan than anywhere else. Your standard of living is different with the same income level there.

Listen to this: A senior making $18,000 would have to pay $3,500 before they receive any help. That is not the kind of benefit the American people are asking for whether they be senior citizens or younger people with parents. That is 20 percent of their income. If your income is $18,000, you pay $3,500 first? What they would say in New York is: Forget about it. What they would say to the rest of the country is: Please go back and try to do a little better.

Even a senior citizen with an income of $35,000—once you are at $35,000 and you are a senior citizen, hopefully your kids are out of the house and you are not doing that badly, although, again, in parts of New York, $35,000 does not stretch too far when you have an average rental payment of $1,000 a month or $800 a month. That eats a lot of it, and then you take taxes and other expenses. That person would have to pay $5,500, 16 percent of their income, before they got any help.

My guess is that 98 percent of all senior citizens at that level of income—hardly a very high level—would not qualify for this program at all. The number who pay that huge amount for prescription drugs—and that is the amount they would need before the program begins—is small.

I would not call this insurance. I would not call it Medicare. If it would become law, poor senior citizens would still be choosing between food on the table and the medicines they need to survive. That senior citizen who is making $9,000 and paying $1,500 for their much-needed prescription drugs is still choosing between food on the table and medicine.

Middle-class senior citizens who are willing to pay a little more in copayments and monthly payments would not get a benefit that they would find worthwhile at all. It would not affect most of them.

To all of my colleagues, this bill is more fiscally tight, stingier, if you will, than the House Republican bill. It is more inadequate than either of the two bills voted for in the Senate. I do not know a single organization of the elderly or the disabled that supports it, and I do not believe it deserves the support of the Senate.

The fight for a real Medicare prescription drug benefit does not end today. In fact, I argue that we made some progress today. Fifty-two votes for the Graham-Miller-Kennedy bill is a lot of progress, and, in fact, should we adjust the Budget Act next year, that 52 votes might be adequate to actually pass the bill. Once we forget these notions of spending money on things that virtually nobody wants, except a small rarefied few, we will be able to do it.

We made progress today. I am not despairing. I compliment the Senator from Georgia, as well as the Senator from Florida and the Senator from Massachusetts, who will be here shortly, for putting together a proposal that I think does much more of both: It is still fiscally within our means but really is broad and comprehensive and deals with people's needs.

To vote for Hagel-Ensign I think would be a cop-out. In fact, the argument was made by my friends—again, I salute the sincerity of their effort; I really do. This is an honest proposal and I thank them for that, but they admitted themselves: We will not do much after this.

I would rather go back to the drawing board and try to pass something that far better meets the American people's needs, such as the bill proffered by the Senators from Florida, Georgia, and Massachusetts. I urge my colleagues to defeat this amendment, and let's keep working on this issue until we get it right.

I yield the floor.

The PRESIDING OFFICER (Mr. MILLER). The Senator from Texas is recognized.

Mr. GRAMM. Mr. President, I am not going to get into an argument with our dear friend from New York. I will say, I think in New York if you make $9,000 a year, you qualify for Medicaid. So you are completely covered.

I also have to say, if we are going to take the approach the Senator from New York takes, and that is ''how much are they willing to spend to help you,'' then we get into a debate not about what works, not about what is feasible, not about what we can afford, but who is willing to spend more money?

In truth, we have already been in that debate. I want to show my colleagues this, because this is frightening to me.

In 1999, just before he left office, President Clinton proposed a comprehensive drug benefit—let me start earlier. We had, through a legislative act of Congress, a bipartisan commission appointed with Senator BREAUX as chairman. I was on that commission. Part of what we did is we put together a proposal to modernize Medicare through the use of competitive marketplace forces.

For example, if you have a cane with four little legs on it and you buy it

through Medicare, the average Medicare cost is $40. The VA, which has never been thought of as the world's most efficient buyer, buys it for $15. The Breaux commission put together a proposal to modernize Medicare and to use some of those savings to help people get coverage for pharmaceuticals, and the way they got it was opting into a more cost-effective system.

That proposal actually saved money because reforms in Medicare save more money than providing the pharmaceuticals cost within this more competitive environment.

President Clinton, who had us all down to the White House, looked us in the eye and said: Don't let this process fail because of you. I was one of the members of this commission. President Clinton looked us right in the eye and said: Don't let it fail because of you. And then all four of his appointees voted no at the last minute. We needed 11 out of the 17 to make a recommendation to Congress, and we only got 10.

At that point, incredibly, providing pharmaceuticals not only did not cost money, it was part of a reform program where the savings we would have gotten with Medicare reform would have paid for the pharmaceutical benefit.

That is where the debate started, and we failed to act because of one vote on the bipartisan commission, when all four of the President's appointees voted no. In fact, they had a press conference at the White House denouncing the plan before we had the vote.

At that point, at the end of his administration, President Clinton said: We can have a comprehensive benefit for $168 billion. That was in 1999 just as President Clinton was ending his term.

Then Congress in 2000 had a proposal. Former Senator Robb from Virginia was the author of that proposal, and it cost $242 billion. If you went back and looked at that debate, everybody who was for that plan said: We can solve this problem. If you will just give us $242 billion, we can solve the problem.

Then you will remember the budget debate we had last year, the Baucus amendment. I could quote 20 Democrat Senators who said: We can provide all the benefits we need for $311 billion.

I could quote Senator BAUCUS, I could quote the distinguished majority leader, but it is never fair using people's words against them. I do not do it, but I could.

In the budget debate last year, $311 billion would have done everything we wanted to do. This year in the budget we said: No, that is not enough. That is being tight fisted with the elderly. We do not want $311 billion. In the budget we said $500 billion. The budget did not pass, but that is what the budget had.

Now we come to the floor with a proposal that says: We cannot spend $500 billion; that is being tight fisted with our seniors. How dare we to have thought of $311 billion? What was wrong with Senator Robb's tightness at $242 billion? Was Bill Clinton a person who did not love the elderly at $168 billion? What a heartless man he was. Today, we said: No, it is going to take $600 billion—not $311 billion but $600 billion.

Mr. SCHUMER. Will my colleague yield?

Mr. GRAMM. Let me finish this point, and I will be happy to yield.

Mr. SCHUMER. I thank the Senator.

Mr. GRAMM. The $600 billion would not pay for a real program. It starts in 2005. It ends in 2010. So if one does not live until 2005, they get no benefits; if they live past 2010, they get no benefits—and it still cost $600 billion.

Now, where do we think we are going? Where does all of this end? We are asking people to look and see who cares the most. And you can measure that by how much money they are willing to spend.

Where does this end? Will it not go on forever? I am going to yield to the Senator, but let me make this point to sort of bring it together.

Forget this red in the chart. That was about this bill that I was talking about when I made the chart. Just look at the yellow on this chart. I want to try to impress this one figure on people's minds. Today, Medicare, which has an unfunded liability in present value terms of $17 trillion—when you discount it above the present value of the revenues we are going to collect, today it is taking 2 percent of the economy. If we do not pass any drug benefit and we just leave Medicare as it is, by 2030 it is going to take 4 percent of the economy. Today the payroll tax for Medicare and Social Security is 15.3 percent. If left unchanged, meaning we do not cut it and we do not increase it, the payroll tax will have to more than double by 2030 to over 30 cents out of every dollar earned by every worker to pay for Social Security and Medicare. That is without a prescription drug benefit.

Some people estimate that if the bill had been adopted that we sustained a point of order against today, this would go not from 2 percent of the economy to 4 percent but from 2 percent to 6 percent. We would literally be looking at over 40 cents out of every dollar earned by every worker to pay for Social Security and Medicare.

I understand all of these people who want these benefits are writing these letters saying we do not love them enough—that $170 billion is not enough. They say these people who want to spend $600 billion love us more. Of course, they are going to love us even more next year with $900 billion. There will be lots of love next year.

The point is, does anybody care if young workers 28 years from today are paying 40 cents out of every dollar they earn on Medicare and Social Security? How much love can we afford? That, I think, is a critical point.

So I beg my colleagues, let us not get in the business where we measure a program simply by how much it costs.

Others I am sure want to speak, but I am going to talk about how this program gets you a lot for every dollar you spend. I am happy to yield.

Mr. SCHUMER. I thank my colleague.

First, our colleague from Texas has been on the floor a whole lot lately on all of the various issues which we have been debating. He has always been a great warrior and a great debater, but since he announced his retirement, he is a happier warrior. Every argument he makes, he has a twinkle in his eye. I compliment him for that. It is a pleasure to listen to him, as much as I disagree with him. I do not know if this would happen to the rest of us if we also announced we would not be here, we would be much happier in our arguments, but I want to make three points and ask them to form the question.

First, I ask my colleague from Texas if he knew that the Medicare level in New York is $599, which is $7,200 a year. I ask him if he knew that.

Mr. GRAMM. If I were from New York, I would be trying to change that.

Mr. SCHUMER. Well, we will, maybe with the help of the Senator from Texas. In any case, that person in the example does not qualify.

The second question I ask my colleague is this. I like his chart. It sort of fits my argument because that last number is $600 billion. As I understand it, if we did not make the estate tax repeal permanent, something my colleague from Texas has fought very long and hard over, that would be about $670 billion, as I understand it. That is how much it would cost over the same 10-year period. So we are not talking about the ability of the Government to pay this; we are talking about size of government. That is one of the great debates we have. But it is not that my colleague says we cannot afford it; rather, he is using it for different purposes.

At least to me, when I go from one end of my State to the other, the number of people who ask for estate tax repeal is much smaller than the number who ask for a comprehensive prescription drug plan for Medicare.

So I ask my colleague, aside from the ideological and philosophical argument about size of government and all of that—on which we have had nice debates on both the floor and in our various committees that we share—but certainly within the contemplation of my good friend from Texas, if we did not take that money for estate tax reduction, we could put it into this program; am I right about that? This is a simple value choice.

Mr. GRAMM. I am going to answer that point. Was there a third point?

Mr. SCHUMER. Yes. The third point is this: When we compared the programs, the $168 billion, the $242 billion, and the $311 billion, that was apples and oranges, as I understand it. The benefit I remember from the Robb program that my friend from Texas pointed out did not have the same level of benefit, the same generosity of benefit, as the plan proffered by the Senators

from Florida, Georgia, and Massachusetts. So we are really comparing apples and oranges.

It is not that anybody thought the original plans did everything, it was just the amount of money they were willing to spend, and in fact, as I recall it, the Robb plan was sort of objective because people thought for the amount of money it cost compared to the amount of benefit, it was not quite worth it, at least in political terms, using politics in the finer sense in terms of people's value choices.

Those are my three questions to my colleague, and I welcome the answers he will give with the same twinkle in his eye.

Mr. GRAMM. Let me begin with No. 3 first. We are comparing apples and apples. In 2001, in the political bidding war we were in then, $311 billion represented a sufficient number of apples to engage successfully in the bidding contest. Today, it is $600 billion and heading up. My point is that, beginning with the chairman of the Finance Committee and the majority leader, we had Members saying last year that $311 billion would provide a wonderful program. The problem is, this year it is $600 billion, and that is a wonderful program. And it is not apples and oranges, it is a lot more apples.

Secondly, I think where my colleague is leading on the death tax thing is kind of a circular argument. If you are willing to take away people's money, the only limit you get as to how much you can spend on Medicare or anything else is the amount of money that can be extracted without destroying the productivity of society.

The point I had made earlier was that you are already committed under the existing program to take 30 cents out of every dollar everybody earns to pay for Social Security and Medicare. If you adopted your program, by some estimates you would be paying 40 cents out of every dollar that people earn, and the question is: Is that something that the economy can bear, and is that fair to young people?

In terms of the death tax, we have a very different view of the death tax. Nobody in my family ever paid any death tax, and nobody ever bequeathed anybody anything because they did not have anything. But when somebody works a lifetime to build up a farm or a family business, the view of the Senator is that that belongs to the Government and my view is it belongs to the people who build it up. They build it up for their family, and it is not right for us to force their family to sell off their business or sell off their farm or sell off their life's work to give the Government 55 cents out of every dollar they earn.

It is a perfectly legitimate position to say they ought to have to do that, but it is not something of which I am supportive. I think it is fundamentally wrong.

There are other people who want to speak.

Mr. SCHUMER. I am not yielding but thanking him for the answers.

Mr. GRAMM. Let me also say one thing that has happened about which I am worried. Many of my Democrat colleagues, knowing that this tax cut that we adopted is temporary—because of this quirk in the budget, unless something changes it goes away in 10 years—almost seem determined to spend and spend and spend until we have to take the tax cut away.

I remind my colleagues, throughout American history the highest sustainable tax rate that we have been able to sustain over long periods of time was taking 19 cents, on average, of every dollar created in the economy. When we adopted the tax cut last year, the Government was taking 22 cents out of every dollar produced in the economy. That was a record high that only had one year higher. That was 1944 at the peek of the war effort. I hope people do not believe we should go back to a 22-percent tax burden.

The final point I make, the Senator acts as if death taxes would pay for Medicare. We all know Medicare is funded by payroll taxes. If you are working in some factory somewhere—I don't imagine you are watching this debate, but if you are and say you are taking a coffee break and this is the only thing they have on in the factory—don't think that some rich guy is going to be forced to sell off his farm to pay for your Medicare. You are going to have to pay for it with higher payroll taxes. Don't be confused.

Now, I have talked longer than I had intended. Let me make a couple of points. First, I read a quote, from John C. Rother, policy director of AARP. In recognizing that the two big plans would be defeated, he said: Another possibility is for Medicare to provide catastrophic coverage for prescription drug expenses over a certain threshold.

And he notes also that we could have a Government-authorized discount card.

Now, let me make my points about this bill and stop. First, I had virtually nothing to do with writing this bill. Two Senators have been principal authors of it. I recognized, in simply looking at it, that it was the best plan around. They came up with it.

Why is it the best plan around? First, it is within budget. Now, it is hardly some insignificant amount of money. Somewhere between $140 and $170 billion is what this costs. That is a lot of money.

What it does is provides the most help to people who fall into two categories: A, you don't have very much income; and B, you have high drug bills. I submit those are the people who need the help the most.

The problem with the other two proposals—let me make my criticism bipartisan—the problem with the other two proposals is that they spend 80 percent of their money helping people who don't need help. When you take the view that the Government ought to have a program that pays at least 25 percent of the drug bill for Bill Gates and Ross Perot—that it is not a universal program unless they are covered—you are going to end up spending huge amounts of money paying for people who don't need the help. You end up paying for the roughly two-thirds of people who already have health insurance for pharmaceuticals, because you substitute the taxpayer for the private insurance policy they already have as part of their retirement program.

The point I am trying to make is you are spending 80 cents on people who either almost have the benefit or don't need it to get 20 cents on the target to people who do need it.

The advantage of the Hagel-Ensign bill is that it puts every dollar on the target. This is what it says. Again, you can spend more money; God knows you can spend more money. But just listen to what it does. Let me take a retired couple. If their income is $23,000, they would have to pay roughly $100 a month in drug bills themselves, but at slightly above $100 a month this program kicks in and they get full payment except, possibly, a very small, little copayment per prescription.

Now, our colleague from New York said a huge number of seniors, 80 percent I think he said, would reject this program. I don't believe it. My mama's drug bill is $400 a month. She does not want help in 2005. She does not know if she will be alive in 2005. She wants help now.

The advantage of this program is that it provides help right now. What it would mean in her case is she would have to pay a little over $100 a month and now she is paying $400 a month.

Now, if your income goes up, then the deductible goes up. For example, if you are making $46,000 a year, your deductible is $3,500. If you are retired, most retirees who make $46,000 a year own their own home. What this bill says is, if your expenses on pharmaceuticals get up really high, the Government is going to come in and help you. If you make $69,000, you have to spend $5,500 to get the payment by the Government. So it is tied to your income.

And for Bill Gates and people who are very wealthy, they have to spend 20 percent of their income on pharmaceuticals. Bill Gates will never get a benefit and he shouldn't. He doesn't need it, and he doesn't want it. He might not even take it.

That is not the only help you get, by the way, because immediately this program would let private companies contract through Medicare to represent Medicare beneficiaries in negotiating for their pharmaceuticals. So each of these companies would compete in buying the drugs you buy. You would buy from whoever could sell them to you the cheapest, and it is estimated that they would save you somewhere between 25 percent and 40 percent of the cost of your drug bill.

In my mama's case, this would mean spending much less than $400 a month—

it is estimated that these companies, because they have more buying power, would get the best price. She goes to the same pharmacy because it is the one convenient to her house. These companies could go all over the country to find her drugs and buy them the cheapest. They could save her $100 on average just simply by being competitive.

Remember I told you about the cane with four legs on it—Dr. FRIST, you have seen them—lots of people have them in hospitals. Medicare pays $40 for that cane on average. The VA buys that cane for $15 because they go out and engage in competitive bidding. These companies would do the same thing. Then, anything above $100 per month, the Federal Government would pay.

If you said to my mother and anybody else's mother: Would you rather have the Government pay the whole thing? The answer would be yes. She would rather the Government pay the whole thing. But the point is, this is a reasonable, responsible program that would help real people.

Finally, Senator ENSIGN has presented three or four times—you can never do it enough—cases of people who have real high drug bills, and remarkably he has shown that his program is cheaper for them than these very expensive programs. Before somebody runs down here to the floor to answer me and says: How is it possible? We spend $600 billion and Senator ENSIGN spends $170 billion and you are saying it is cheaper? You are saying it is cheaper under Senator ENSIGN's program. How can that be when he doesn't spend as much money?

The answer is very simple. He doesn't cover everybody. If you do not have high pharmaceutical bills—and in any given year a substantial number of seniors do not—and if you do not have moderate income, he helps you get competitive purchase of your drugs, which saves you between 25 percent and 40 percent. But the Government does not pay if you do not fall in this category of people. You don't get help under those circumstances.

Now you say everybody should get help. The point is, this bill helps the people who need the help the most. This is a good proposal.

I remind my colleagues, we are at an impasse here. There are some people already talking about spending more money to break the logjam. The logical thing to do now, if we want to act this year, is to take this proposal and adopt it. That will help people who need the help most and help them now. Then we can come back next year. We can look at the budget situation, we can see where we are, and in the process we can supplement this if we want to.

Let me give you one example because Senator ENSIGN has done it better than I could possibly do it. This is somebody who lives in Nevada. He calls her Betty Smith. She is 66 years old. She has an income of $15,000 per year. She is being treated for a whole bunch of things.

Her drug bill is $8,000 a year. My mother's drug bill is $4,600 a year and, thank God, she doesn't have these kinds of problems. So it is easy to believe an $8,000 bill.

Here is the point. Look at the Hagel-Ensign bill under exactly this situation. Your income is $15,500 and you are being treated for breast cancer and you are taking all these drugs and you have a $8,000 bill, so you are spending over half of your income on drugs. This is literally somebody. We all talk about this cliche of people being forced to choose between medicine and food. I hope her children are helping her. If they aren't, they ought to be. But she would literally—if she didn't have any children, didn't have anybody helping her—she would literally be choosing between eating and drugs.

Now, here are the three bills. Two of them we voted on, and one we are about to vote on. The point that Senator ENSIGN has made is that under the bill that costs $600 billion and covers everybody, this lady would have to pay $3,180 a year. Under the tripartisan bill, she would have to pay $2,570 a year. But under the Hagel-Ensign bill, she would pay $2,152. In other words, for a lady who is very sick and who has a very moderate income, she would be better off under this plan.

But for people who say how is that possible when it only spends $170 billion, the way it is possible is it is focused to help exactly people like this lady. It does not take the view that we have to provide the Government program for everybody. It just helps people who need the help. And it provides this system of competitive purchase for everybody.

So, I urge my colleagues, do not get into this business about saying this cannot be as good as that because that costs so much more money. Some of the best things in life are not necessarily the most expensive. Remember, we are going to have to pay for it. Not ''we'' being Members of the Senate. We are not going to pay for it. We don't pay for anything. We are going to be covered by the Government insurance program when we get out of here. But that blue collar worker on that assembly line is going to have to pay for it.

I congratulate my colleagues. This bill ought to be adopted. There is a budget point of order against it but not because it is over budget. It is because we wrote in the budget that the bill had to come out of the Finance Committee. The Finance Committee refused to report a bill, so no bill could come out of the Finance Committee. So every bill had a budget point of order. If it had gone through the Finance Committee, no point of order would have lied against this bill. However, if the Graham-Kennedy bill had gone through the Finance Committee, two points of order would still have lied against the it, a section 302 and a section 311 point of order, as well as the tripartisan bill.

But this bill is not subject to a point of order because it spends too much money. It is subject to a point of order because the Finance Committee was not allowed to do its job.

So I hope people will look at this and decide we can help a lot of people, and we can do it right now. The purchasing discounts would start immediately. We do not have to wait until 2005. And this is something we can afford. We could come back and do more next year if we had the money.

I appreciate my colleagues listening, and I commend this program to them.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. BROWNBACK. Mr. President, I ask the sponsor of the amendment to yield to me 10 minutes to debate the issue.

Mr. HAGEL. I yield to the Senator from Kansas 10 minutes off our time, Mr. President.

Mr. NELSON of Florida. Might I inquire of the Chair how much time is remaining on this side?

The PRESIDING OFFICER. Sixteen and a half minutes.

Mr. NELSON of Florida. Mr. President, I would like to be recognized at the appropriate time.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I thank my colleague from Nebraska for allowing me the time and for his proposal. I think it is an outstanding proposal and one that we can do and one that we can afford and one that can provide benefits to some people who really need this help and need it now. It is something I think we could build on in the future.

Remember now, we are talking about a group of people who do not have pharmaceutical benefits and need them, people with low income but above Medicaid; low income, and this is taking a big portion of their income. They have to have these pharmaceutical drug benefits. They need it. Here is a proposal where we can do it.

If I can just make an observation at the outset: This process cries to go back to the Finance Committee and come out of the Finance Committee. This has not been taken through the Finance Committee. It clearly should have been. This is the largest—this will be the largest new entitlement program that I will have voted on since I have been in the Congress, either the House or the Senate, by far. I think at the end of the day, when the dollars are tallied up, you are looking at a multi-trillion-dollar program because once we start a benefit, we do not stop it. This is something that we will start, and will do, and it is going to continue for a number of years. It is something we need to do.

But if you are going to start, at the end of the day, a trillion-dollar program in all probability, you need to take it through the right process. It needs to come through the committee that looks at the numbers and figures out how to pay for it.

To just pass a benefit and say we are going to do it, and we will figure out how to pay for it after the bills come due, is the height of irresponsibility on our part.

I have two charts. I do not want to overburden everyone with lines on a chart, but I want to point out, this is where we are today with these various proposals. This black line represents the total income for Medicare. I call this chart ''The Great Medicare Accounting Scandal'' because I do not think we are accounting for the real cost of these programs.

We are being critical of people—and rightfully so—in corporate America for not accounting for real costs and for sliding things around saying: Well, OK, we will capitalize this, but it should have been a direct expenditure and expense. We are criticizing them—and rightfully so—for doing that.

What are we doing here? What are we doing here on our accounting? The black line is the amount of money we have coming into Medicare. The red line is the Graham-Kennedy benefit proposal. You can see, in year 1 of the benefit, in the year 2005, the expenditures are more than the income we have coming in from Medicare. In the first year out of the box, you are spending more money than you have coming in in Medicare. That does not count the accumulation that you are going to have up until 2010, when the program, theoretically, ends. But, of course, it does not.

We do not terminate benefit programs. It is going to continue past 2010, into 2011, which is the first year the baby boomers start retiring. So you have this group of soon-to-be seniors—72 million baby boomers—in America. Count myself amongst them. That is kind of the big lump in the python coming through, the pig in the python, in the demographic charts in the United States, starting in 2011, where the program is supposed to end in 2010. Of course, it isn't going to happen.

On this chart, where would this red line be in the year 2011, when you start getting this large group of retirees coming into the system? It is going to be much higher and be an accounting scandal for us.

So how are you going to pay for this? You are either going to cut benefits, which I do not think we are going to do, you are going to raise payroll taxes, which I would think would be the wrong thing to do—we already load so much on people working in the system—or are you going to try to take this from somewhere else in the system, or raise the deficit? Probably you are going to do all of those things, other than cutting benefits. But we are not talking about that in this system right now.

Look here, on this chart, at the various other proposals that we have.

The purple line shows the total expenditures today, without a benefit. The Hagel-Ensign proposal is shown by the green line.

Of the proposals that are coming forward—and I think we need to have a prescription drug benefit—this is the most responsible one that we can handle and that we can do. And we, clearly, should do something.

The process cries out for us, right now, to do something now and not just to have something for campaigns. Here is the Democrat proposal. Here is the Republican proposal. But you cannot take those as prescription drugs. That is not income to you. You cannot eat promises. That is what we have sitting out there now. And that is where it seems the debate is heading, unless we can take it back to the Finance Committee and have a legitimate process, one where we would come out with a benefit that people can afford and need to have today.

This one has been a very disappointing discussion, to me, in the sense that there is a clear compromise that sits out there that is available to do, and we could cobble together different proposals of any of these bills and figure out how to make it work, and get a bipartisan proposal that we would all support, that would include a prescription drug benefit.

That sits out there to be had. That can take place. Instead, we are just saying, no, we are going to take it through this different process. We are going to bypass the Finance Committee on the most expensive entitlement program that I will have voted on as a Member of this body. We are going to bypass the normal process. We will just have a political debate on it that I do not think is edifying for the body and is not the right way to go.

On the particular proposal, the Hagel-Ensign proposal, of which I am pleased to support, I also note that it is supported by AARP. Unlike my colleague from New York, who said the AARP does not support it, in today's New York Times, John Rother, policy director of AARP, said this:

> Another possibility is for Medicare to provide catastrophic coverage for prescription drug expenses over a certain threshold, perhaps $4,000 to $6,000 a year, with no premium. This could be combined with additional help for low-income beneficiaries and a government-authorized drug discount card.

That is not my speech supporting Hagel-Ensign. That is from the policy director of AARP in the New York Times today. He is saying: Look, you have the parties. Each have a proposal. They are at a standoff on this proposal. What could we get done so we can move this forward for the benefit of seniors in America? And he describes the Hagel-Ensign proposal. That is what we should do.

That is the type of proposal we need to move forward. It would be an appropriate proposal for us to move forward, so we can provide a benefit, we can get it done now, and provide it to people who need it now. They do not need promises. They need action by us. And they could have the action. This is something we need to do, and we need to do it this way today.

This chart shows the various lines depicting where the assets in the proposals go. You can see the current projected Medicare trust fund assets, and also the projected Medicare trust fund assets under Graham-Kennedy. You can see where we are taking this proposal. This line is going south, fast, if you get a benefit that you cannot afford.

I ask a rhetorical question of all my colleagues: Would we rather encounter the first wave of baby boomer retirees with $660 billion in the Medicare trust fund or would we rather encounter retirees having spent all but $250 billion? That is what these lines point out.

We know we have the baby boomer generation hitting in 2011. They start jumping into the retirement pool in 2011. We want to face them with some money built up at that point in time and still have a prescription drug benefit like what is in Hagel-Ensign, or even the tripartisan bill. We can get there with more assets in the bank and still provide today a prescription drug benefit for those who need it today. And they need it today.

I really think we should set our Republican and Democrat caps aside and say we can provide this to people who need it today. For the 27 percent of the public who do not have a prescription drug benefit of some type, who are in a low-income category, who need this, we provide a discount drug card or discount card, such as in the Hagel-Ensign proposal. We do that today and still save some money for when the baby boomers start retiring in 2011.

I hope we will all look at that and say that is the right thing to do, to provide that benefit. It is the responsible thing to do. And as we look to our future, it is the right thing for workers coming up in this system so that they are not stuck with this huge lug on their shoulders when the baby boomers retire.

The PRESIDING OFFICER. The Senator has spoken for 10 minutes.

Mr. BROWNBACK. Thank you, Mr. President, very much. And I thank my colleague from Nebraska for yielding time to me.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. Mr. President, I rise to speak in opposition to the amendment. I want the Senator from Nebraska to know of my personal affection and respect for him. There are certain people in a body to whom you just naturally gravitate and you naturally like, and he is certainly one of them.

I rise in opposition, not because he does not have an excellent, substantive proposal, but I would offer my objection as has been articulated by the AARP today in a letter to Senator HAGEL in which they state:

In addition to our substantive objections, we are concerned that by offering this scaled-back proposal today, you would effectively derail bipartisan discussion and compromise on more meaningful comprehensive approaches.

That is what I want to discuss today. What this Nation is begging for is a comprehensive approach, not a piecemeal approach. What the senior citizens of this Nation are yearning for is that we modernize Medicare to provide a prescription drug benefit.

If any of us were designing a Medicare system, which is a health insurance system for senior citizens, funded by the Federal Government, if we were devising it today in the year 2002 instead of the year 1965, when it was enacted, would we include prescription drug benefits? The answer to that is, obviously, yes.

Medicare was set up in 1965 when the condition of health care was centered around acute care in hospitals. But with the miracles of modern medicine, with the advent of prescription drugs that can increase the quality of our lives, that can take care of chronic ailments and that, indeed, add to what we would say, in the street vernacular, is preventive maintenance, then, clearly, if we were designing a health insurance system funded by the Federal Government for senior citizens today it would clearly include prescription drugs.

That is the question that is before this body. But because of the rules of the Senate, we have to get 60 votes in order to pass anything here which, with competing plans, makes it very difficult.

Although I think the Senator from Nebraska has some excellent ideas, it is injected in this debate at the wrong time because in the words of the AARP, as articulated in their letter today:

> We are concerned that by offering this scaled-back proposal today, you would effectively derail bipartisan discussion and compromise on more meaningful, comprehensive approaches.

We have to keep trying. We have just been unable to get the 60 votes on two different substantive approaches to prescription drugs in the votes that occurred earlier today. We have to keep trying to forge a compromise. The compromise is not this scaled-down version.

I wish to speak about the substantive alternatives that are here. One of the alternatives, as suggested by what has been voted out of the other body, the House of Representatives, utilizes the private sector and private sector insurance companies in which they offer the prescription drug benefit.

I had a little bit of experience as the elected insurance commissioner of Florida for 6 years before coming here. I point out that you can get some glimpse of the enthusiasm of insurance companies to offer this prescription drug benefit if you look to the States.

For example, 4 years ago, the State of Nevada passed a prescription drug benefit. It was to be offered by private insurance companies. Within 2 years after the passage of that law, not one insurance company had come forth to offer that prescription drug benefit.

On the basis of that experience, that is certainly not what we want to be offering to senior citizens of our country on something that is so important to them, a benefit that would be illusory, that would not be there. That is why we ought, in whatever compromise we strike, to come closer to the Graham-Miller approach, which is a substantial reworking of Medicare, and the prescription drug benefit becomes a part of Medicare. Then it is my hope, once we can find that illusive consensus, we can go on and add additional improvements.

The health care providers of this country are hurting because they are not getting reimbursed for their Medicare procedures at a rate that is commensurate with what they should be reimbursed. One of the items we are going to discuss—and hopefully we would be able to take this base bill and amend it—is an increase of those Medicare reimbursements so that we are taking care of the Medicare beneficiaries, the senior citizens, and we are also helping those who are providing the services, the health care providers, by increasing their Medicare reimbursement.

When we do that, I hope we will also look at some of the practices that because doctors are getting squeezed, in large part squeezed by insurance companies, sometimes regular insurance companies, some called HMOs, which are insurance companies, and because doctors are getting squeezed, they are trying to find ways to keep their income up.

Lo and behold, down in my State of Florida, there is a group of doctors now saying to all of their patients: We are not going to see you anymore unless you pay us an entrance fee of $1,500 per patient per year. But by the way, we still want to take your Medicare reimbursement.

That is simply the beginning of the end for Medicare, because the logical extension of that is that only those who are wealthy enough to afford that entrance fee—in the case of Florida, $3,000 per year per couple—are going to get the access to the doctor they want, that doctor who is being reimbursed by the Federal Government for the services performed for those senior citizens.

That is wrong. It should be changed. It ought to be illegal and yet the Department of HHS has said it is not illegal. So we are going to have to change the law so that a doctor cannot receive reimbursement from Medicare if they are saying to those patients: I will not see you unless you pay me $1,500 a year as an entrance fee into concierge care.

I hope we strike the major compromise, that it is closer to the Graham-Miller bill, that we address Medicare reimbursements because the doctors and other health care providers need it, and that we add the amendment I just talked about which would prevent doctors from limiting patients to seeing them unless they pay an entrance fee while at the same time getting their Medicare reimbursement.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. Mr. President, could the Chair tell me how much time this side has remaining?

The PRESIDING OFFICER. Twelve minutes fifty seconds.

Mr. HAGEL. And how much time does the other side have remaining?

The PRESIDING OFFICER. Five minutes fifty-seven seconds.

Mr. HAGEL. I thank the Chair.

Mr. President, I allocate 5 minutes of our remaining time to the Senator from Oklahoma.

Mr. INHOFE. Mr. President, I know time is now precious and we are down to a few minutes. I will skip a lot of things I was going to say since there has been a lot of redundancy.

My good friend from New York was on the floor and was talking about the relative significance of the inheritance tax and how it wasn't really all that meaningful. I am sure the occupant of the chair would agree because he was one of the rare Democrats who stood up and said we should repeal that unfair tax on money that has already been spent. Also, with the farm crisis we have had out West in my State, I have yet to find one person out there who wasn't more concerned about losing his farm because of the very unfair death tax than even the farm bill. But that is not what we are here to talk about.

I think something the Senator from Texas, Mr. GRAMM, said has to be repeated over and over; that is, this Hagel-Ensign bill is a lot less expensive and does a better job, but there is one major reason. We have a saying out in Oklahoma that ''if it ain't broke, don't fix it.'' That is exactly what the situation is.

We have a lot of people who don't need additional coverage now. If they don't need it, why provide it? Why get into some very large program?

Now, we have had two programs that have been rejected today. The first would not do for seniors what it said it would do, and it would have cost a lot more than we can afford, and it would not have included a lot of the drugs the seniors need. That program, as well as costing too much and not covering enough medications, would sunset in 2010. That means in 2010, people who have been relying on the Medicare prescription drug benefit would have had their coverage taken away. We know better than that.

I remember one of the best speeches that should be required reading for all young people, called ''A Rendezvous With Destiny,'' by Ronald Reagan. He said:

> The closest thing to immortality on the face of this earth is a Government benefit or program once started.

We all know that is the way it would work out and we would end up with some very large, spiraling cost program that we could not get rid of. It is not responsible, reasonable, and it is

not the best we can do for seniors. I am glad it did not pass.

Then we were given a chance to consider a second option, the tripartisan plan. I thought it was too expensive, but I supported it. It is very much like what the House passed. It is something we can go to conference on and have something effective come out of it. Once a person's drug costs reach a higher fixed limit, the Government would have paid 90 percent of the additional cost. Many colleagues supported it, as I did; but it was defeated.

Now we have a chance to give seniors a real prescription drug benefit. This legislation is a responsible, long-term, comprehensive plan which truly takes into account the needs and the situation of individual seniors. Several fellow cosponsors have already spoken to the specifics of the plan, such as low premiums, low overall costs on catastrophic coverage. I will tell you what it means to the people who sent us here.

Senator GRAMM talked about some individuals without identifying them. I will identify the people. The Hendersons are from Okmulgee County, a short distance from where I live in Oklahoma. I told them I was going to use their case. They wrote me to tell me about their struggle with prescription drugs. They had a unique problem—one was a heart problem and one was a cancer problem. The Hendersons have a yearly household income of $24,000 and they spend $9,000 of that on prescription drugs in a single year. The Hendersons' income falls between the 200 percent and 400 percent above the national poverty level. That national poverty level for couples is $11,940 a year.

Under our bill, an out-of-pocket limit on the cost of prescription drugs for people with a similar income to the Hendersons is set at $3,500. If they were between 100 and 200 percent of poverty, that would come down to $1,500. But in the case of the Hendersons, they would have to pay that maximum, and then a copay of 10 percent of the cost of these drugs. Calculate that out. While the remaining cost of the Hendersons' drugs is $5,500, their copays would be no more than $550, and under this bill the Hendersons would pay a total of $4,050 a year for prescription drugs, when they are now paying $9,000 a year. This bill cuts their drug costs by more than half.

The Hendersons, under the Democrat plan, would have faced uncertainty on three fronts: First of all, uncertainty about which drugs were covered, since only two drugs in each therapeutic class would be covered; secondly, uncertainty about how much the prescriptions would cost since the $10, $40, and $60 copayments in the plan were virtually done away with through amendments; and, three, uncertainty about how long their benefits would last even if it didn't sunset. They would not know this. Uncertainty is there.

I believe the Hagel plan is real assistance, and I strongly support it. I believe this is the alternative that is left and the most responsible one.

I thank the Chair.

The PRESIDING OFFICER (Ms. CANTWELL). The Senator from Michigan is recognized.

Ms. STABENOW. Madam President, I yield myself 4 minutes.

Madam President, first of all, I want to speak to my colleague from Oklahoma. My mother grew up in Oklahoma, and I have a great affinity for that State. I have a lot of relatives there.

But I was quite surprised to hear the comment that ''if it ain't broke, don't fix it,'' when we are referring to Medicare. When we look at the Medicare system and the inability to cover prescription drugs for our seniors, when we look at the explosion in the price of the prescription drugs, I would say it is very tough to find a system that is more broken than our inability today to provide low-cost prescription drugs, whether it be through Medicare or whether it be a small business or a farmer trying to get coverage for their family. This system is broken. That is why we are here. It needs to be fixed.

I rise in opposition to the Hagel amendment. I appreciate the desire of my colleagues to find an alternative, but I certainly am concerned that this does not begin to address what it is that seniors in this country are needing or asking them to do. There seems to have been a lot of confusion about where AARP is regarding this issue. So I will read a letter sent to the author of the amendment on July 23—today—which says:

DEAR SENATOR HAGEL: Enacting a comprehensive prescription drug benefit in Medicare this year remains the top priority for AARP. Our members are counting on the Senate to pass a meaningful drug benefit that is available and affordable to all beneficiaries. Our members were promised in the last election that a comprehensive drug benefit would be a priority, and we are counting on you to make good on that promise this year.

We appreciate the intent of your bill, S. 2736, the ''Medicare Rx Drug Discount and Security Act of 2002,'' to provide a prescription drug discount card and stop-loss protection to Medicare beneficiaries. However, in addition to our substantive objections, we are concerned that by offering this scaled-back proposal today, you would effectively derail bipartisan discussion and compromise on more meaningful comprehensive approaches. We believe Congress should focus its efforts on enactment of a more comprehensive drug benefit this year.

In addition to the timing of your proposal, AARP has concerns about the approach taken in your bill, including:

Catastrophic coverage—While AARP has not opposed income-relating premiums, income-relating the Medicare benefit changes the nature of the program. This would set an extremely dangerous precedent in Medicare. Further, the stop-loss levels set in the bill do not provide enough protection for lower income beneficiaries. A low-income couple could spend 25 percent of their income just for drugs before this plan offered assistance. Thirdly, there are a number of issues involved in using tax returns to determine program eligibility levels, and we believe other options should be explored.

Discount card—While AARP supports the use of a discount card program as a building block for a Medicare prescription drug benefit, your proposal lacks the necessary specifications to guaranty the level of discount, what level of discount would be passed to beneficiaries, and the degree to consumer protections required of plans.

Given these concerns, AARP opposes your amendment. We remain fully committed to developing a comprehensive drug benefit for all Medicare beneficiaries and we look forward to working with you on legislation that our members can support.

This is signed by the executive director and CEO of AARP. I simply wanted to enter that into the RECORD to make it clear that AARP joins us in opposition to the amendment.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. HAGEL. Madam President, I ask unanimous consent that Senators FRIST and NICKLES be added as cosponsors of amendment No. 4315. I yield the remainder of our time to the distinguished Senator from Tennessee.

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

Mr. FRIST. Madam President, how much time remains on our side?

The PRESIDING OFFICER. Six minutes twenty-four seconds.

Mr. FRIST. And the time on the other side?

The PRESIDING OFFICER. One minute.

Mr. FRIST. Madam President, will you notify me when I have 1 minute remaining.

I rise in support of the Hagel-Ensign Medicare Prescription Drug Discount and Security Act of 2002. I do so after a long day of debate, discussion, and votes on bills which attempt to reach out with affordable prescription drug coverage for our seniors.

Over the course of the day's debate, we have touched upon what matters most to seniors. That is what I want to address in the next 3 or 4 minutes.

What do seniors who are listening today—38 million Medicare potential recipients who are seniors today and another 5 or 6 million individuals with disabilities—what do they want regarding prescription drug coverage? I think it is three things. The first issue is that seniors want security. They want peace of mind. When you are 65, 70, 75, 80 years of age, the most frightening thought is that in those final years of your life you develop something—whether it is heart disease, chronic lung disease, emphysema, or lymphoma—and all of a sudden you face high prescription drug costs which are skyrocketing. We know this is an issue—we have been talking about that all week long. In essence, paying for prescription drugs bankrupts you in terms of what you can afford and, even worse than that, what your children may be able to afford. The beauty of this particular bill is that it addresses that peace of mind, that security.

The second issue I hear as I talk to seniors as I travel around Tennessee,

and it has been discussed a lot on the floor today, is that, with regard to prescription drugs, seniors want help now. They listen to the debate, and both of the bills discussed earlier today have some very good, substantive issues to them, are comprehensive, and each have pluses and minuses. But the defect that both bills have that the Hagel-Ensign bill does not have is this bill takes effect, in essence, right now. That is what seniors want.

Seniors who are listening may think: Why talk about a bill taking place in 2006 or 2005? I do not even know if I am going to be around 3 or 2 years from now. What they really want is help now. Those who need it want it now. The message they tell me is to do it now. Again, the Hagel-Ensign bill takes effect next year, not 2 years and not 3 years from now.

The third factor this bill does is it addresses prescription drugs in a responsible way. We are not in a world today or in a country today where you can just throw unlimited money and say it will be taken care of by the next generation or by my family 5 years from now. This is especially true when we have a doubling of the number of seniors, the demographic change, the move of the baby boomers coming online in 2008 and 2010. Seniors tell me, whatever you do, do it responsibly. Do it in a way that is just not over a 3-year period, 4-year period and it disappears, you take the benefit away or raise taxes exorbitantly. Do it in a way that can be sustained over time. Do it responsibly.

That is what the Hagel-Ensign bill does. One of the most beautiful aspects of this bill is that we can do it now, and we can do it responsibly. We talk big figures. The dollar figure was $160 billion. It is a lot of money, but it is not the $800 billion or the $1 trillion or even the $370 billion of the tripartisan plan. It takes effect now, giving peace of mind in capping how much money a senior is going to have to pay out of pocket if there is a catastrophe or if a senior develops a disease which requires the miracle medications that are out there today, and it does it in a responsible way.

How does the bill work? We have been through the details. The first issue I mentioned was peace of mind, security, and savings. Instead of what seniors are doing now—going to a pharmacy, placing a prescription on the table, and paying a retail price that nobody in this body, most employer-sponsored plans do not have to—they will be able to go in to a pharmacy with a card that they put on the table and take advantage of mass negotiations.

The PRESIDING OFFICER. The Senator has 1 minute remaining.

Mr. FRIST. I thank the Chair.

Madam President, seniors can take this card in and get discounts, resulting in savings to seniors right now.

Catastrophic coverage gives security, peace of mind. Using marketplace tools is important as we look ahead because it takes advantage of the marketplace in negotiating discounts that are not available today.

Madam President, I close with the statement that I believe the Hagel-Ensign bill brings to a head much of the discussion today in that it reaches out and gives seniors the security they want. It does it now. It does it in a way that is responsible. It is affordable for seniors, affordable for taxpayers, and is permanent.

Madam President, I yield the floor.

Ms. STABENOW. Madam President, can you give us an indication of the time remaining to each side?

The PRESIDING OFFICER. The Senator from Michigan controls 1 minute. The Senator from Nebraska controls 5 seconds.

Ms. STABENOW. Does the Senator from Nebraska wish to take his 5 seconds?

Mr. HAGEL. I want the Senator from Michigan to have my 5 seconds.

Ms. STABENOW. I was looking forward to what the Senator might say in 5 seconds.

Mr. HAGEL. Madam President, the Senator from Michigan has a more difficult case to make. She needs more time.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Madam President, I will simply say in closing that AARP, representing seniors, and other senior organizations across this country do not believe this, in fact, is a good deal. There is no question they want action now, but it has to be real and meaningful.

Discount cards are available now. In many cases, they do not work at all or they are very limited. It is important we be responsible.

I would argue there is a broader responsibility in the Senate. When we debate whether or not the tax cut geared to the wealthiest individuals in the country will be extended another 10 years, we are debating an amount of money that is more than four times any comprehensive Medicare plan that we will have before us.

This is a question of priorities. It is a question of what we believe, as Americans, should be our values and how we act on those in terms of our priorities, and I argue that doing the right thing with the real Medicare benefit is what our seniors are asking for and it is what they deserve. I urge my colleagues to vote no on the Hagel amendment.

The PRESIDING OFFICER. All time has expired.

The Senator from West Virginia.

A TRUE COMMITMENT TO HOMELAND SECURITY

Mr. BYRD. Madam President, the Senate will soon have before it the fiscal year 2002 supplemental appropriations conference report. This legislation provides for the defense of this Nation, both at home and abroad.

Specifically, the bill provides $14.4 billion for the Department of Defense. It allocates $5.5 billion to New York to complete the promise made to provide $20 billion to help recover from the terrorist attacks on September 11. Another $1 billion is for Pell grants, $417 million for veterans' medical care, $400 million for election reform grants, and $2.1 billion for foreign affairs.

The bill also provides $205 million for Amtrak. Amtrak is an integral piece of the Nation's transportation network. For many rural communities, Amtrak represents the only public transportation connection to the rest of the Nation. But without the funding contained in this bill, that connection is in danger of being severed. Because of growing financial pressures, Amtrak needs an infusion of funding soon or else it faces bankruptcy. The $205 million included in this supplemental appropriations bill will stave off bankruptcy and give the passenger railroad, which is under new management, time to craft sound plans for the future.

Most importantly, this bill provides $6.7 billion for homeland security, including $3.85 billion for the Transportation Security Administration. That is why this funding bill is so important. This funding will take steps now—without delay—to plug the holes in our Nation's defenses here at home. Congress has not hesitated when it comes to funding homeland security efforts. In two supplemental bills—the one approved shortly after the attacks and the one before the Senate today—Congress has invested $15 billion to protect Americans from another terrorist attack and to better respond should, God forbid, another attack occur.

The funding initiatives shaped by Congress have helped to hire more border patrol agents, increase the scrutiny of cargo shipments at our seaports, and accelerate the purchase of vaccines against smallpox. We have funded critical training and equipment purchases for local police, fire, and medical personnel. We have helped to train doctors and local health departments to detect and treat a biological or chemical weapons attack.

The money allocated in December has helped to hire more than 2,200 INS border agents and Customs inspectors on the northern and southern borders. The INS is now implementing a system for tracking foreign students in this country—a system funded in the first supplemental bill. The Nation's police, fire and medical personnel are getting better training and equipment for detecting and responding to potential biological, chemical or nuclear attacks. The FBI is hiring hundreds of new agents. 750 more food inspectors and investigators are being hired. The number of ports with Food and Drug Administration investigators is being doubled. 324 additional protective personnel are being hired to protect our