time after the break. I point out that the National Association of Insurance Commissioners study shows that in 2000—the latest year for which data is available—the total insurance industry profits, as a per average premium for medical malpractice insurance, were twice as high as overall casualty and property insurance profits. In fact, malpractice insurance was a very lucrative area for the industry, averaging a 12 percent profit. Over a 10-year period, their premiums went up 1.9 percent, and they are making 12 percent on that.

This is about the insurance industry; it is not about the doctors. We will have more to say about this. This is a lucrative aspect of the insurance industry—everyone knows it—and they just want to cash in on this opportunity at the present time.

Mr. President, I see our leader on his feet at this time in anticipation of a consent agreement, so I withhold further comments.

Mr. REID. Mr. President, I ask unanimous consent that the time from 2:15 p.m. this afternoon until 2:45 p.m. be equally divided between Senators KENNEDY and MCCONNELL or their designees and that at 2:45 p.m. Senator REID of Nevada or his designee be recognized to move to table Senator MCCONNELL's amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

RECESS

The PRESIDING OFFICER. The hour of 12:55 p.m. having arrived, the Senate stands in recess until the hour of 2:15 p.m. today.

Thereupon, the Senate, at 12:55 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mrs. CARNAHAN).

GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS ACT OF 2001—Continued

AMENDMENT NO. 4326

The PRESIDING OFFICER. Who yields time?

The Senator from Kentucky.

Mr. MCCONNELL. Madam President, it is my understanding that I have 15 minutes remaining.

The PRESIDING OFFICER. The Senator is correct.

Mr. MCCONNELL. Madam President, I yield 5 minutes to the Senator from Tennessee who, as we all know, is the only physician in the Senate.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. I thank the Chair.

Madam President, I rise in support of the McConnell amendment on medical malpractice to the Greater Access to Affordable Pharmaceuticals Act. It goes to the heart, I believe, of an issue that has reached crisis proportions in the United States.

Much of the argument and debate on Friday and a little bit yesterday and today centered on how best to frame this debate. Our opponents to the McConnell amendment have tried to frame this as a debate focused on corrupt insurance companies and HMOs.

What is absolutely critical for my colleagues and the American people to understand is that this debate is not about insurance companies. This debate is about patients, patients who are suffering today and, even more important, unless we act on this crisis, will be hurt in the future.

It is about patients versus skyrocketing medical liability insurance premiums that, in large part, are driven by the current medical liability system. This amendment strikes right at the heart of that problem.

Why is this debate important? I go back to patients. How do patients suffer because of these skyrocketing insurance premiums? They suffer in two ways: No. 1, lack of access to health care. If in the future you are a patient, you will see a decrease in access when you want to go to a physician, such as an obstetrician or a neurosurgeon or an orthopedic surgeon. They have all seen these skyrocketing premiums, and these doctors are not going to be there. Why? Because they happen to live in Mississippi where their premiums are $50,000 or $100,000 or in Florida where an obstetrician premium might be $150,000 or $200,000. They might decide, A, to pack it up and leave and go to another State or, B, to stop practicing or, C—and this is what we see happening all over the country—to stop delivering babies. If your doctor delivered your first baby and you want him to deliver your second baby, you had better call far in advance. Because of these skyrocketing premiums, many physicians are leaving that specialty.

In addition we saw what happened in Nevada where the trauma surgeons basically said, we cannot stay in business, we cannot keep delivering these services, because malpractice premiums are too high. They were actually forced to close down shop for a period of time. Thank goodness it was just for a few days.

I mention the impact on doctors because this is important. For example, if one is an obstetrician and he pays $200,000 a year for his insurance premiums, as in Florida, and he delivers 100 babies, which is the average for an obstetrician in Florida delivers, that means for every baby the doctor delivers there is a $2,000 tax or premium.

Now, one might say that this is the worry of the doctor. Well, the doctor can leave. He can switch specialities. He can relocate or retire, early retirement, none of which is very satisfactory. But if a doctor is going to stay in practice, ultimately the doctor is going to pass the cost on to the patient. Who else will pay it? It has to be passed on to the patient.

Americans are watching this debate and they hear the ranting and raving against the bad insurance companies. Let's go back to the effect of the problem, which is on that individual patient. Then let's look at the root cause, which is this runaway tort liability system, which this amendment takes the first step at fixing.

Patients are hurting in two ways. First, they suffer from a lack of access to care. Specialist are leaving areas, and doctors are refusing to deliver babies.

The second way patients suffer is the overall cost of defensive medicine. Ask your physician right now: Do you practice defensive medicine? According to a recent Harris poll, 76 percent, or three-fourths, of physicians believe concern for medical liability litigation has hurt their ability to provide quality care in recent years. Eighty percent of physicians say they ordered more tests than they thought were medically necessary because they worried about malpractice liability. It is called defensive medicine. It is something the consumer does not see, the patient does not see, but America pays for it. How much? Fifteen, 20, 30, 40, 50—about $50 billion.

I close by stating my strong support for the McConnell amendment and look forward to continued debate during the course of this afternoon.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I yield 7 minutes to the Senator from Illinois.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I thank the Senator from Massachusetts for yielding the time.

I readily acknowledge the expertise of Senator FRIST. He is a widely respected heart surgeon. He certainly is a man who understands the practice of medicine, unlike anyone else in the Senate. I do not come as an expert on the practice of medicine. If I have any expertise, it is in trial practice because before I was elected to Congress, I was a trial attorney. I made my living defending doctors and hospitals, and suing doctors and hospitals. I understood medical malpractice then, but as I read this amendment I am troubled.

Let me acknowledge first, yes, there is a national problem with medical malpractice insurance across America. It costs too much in many areas, and we are finding that in many parts of the country doctors cannot afford to continue to practice because of the cost of premiums. But the answer from Senator MCCONNELL on the Republican side is to suggest that the reason the premiums are so high is because of jury verdicts.

They overlook the obvious. Let me point to a source of information not considered liberal in nature, the Wall Street Journal, which on June 24 of this year published an article. I ask unanimous consent that this article be printed in the RECORD.

There being no objection, the article was ordered to be printed in the Record, as follows:

[From the Wall Street Journal, June 24, 2002]

DELIVERING MS. KLINE'S BABY

(By Rachel Zimmerman and Christopher Oster)

As medical-malpractice premiums skyrocket in about a dozen states across the country, obstetricians and doctors in other risky specialties, such as neurosurgery, are moving, quitting or retiring. Insurers and many doctors blame the problem on rising jury awards in liability lawsuits.

''The real sickness is people sue at the drop of a hat, judgments are going up and up and up, and the people getting rich out of this are the plaintiffs' attorneys,'' says David Golden of the National Association of Independent Insurers, a trade group. The American Medical Association says Florida, Nevada, New York, Pennsylvania and eight other states face a ''crisis'' because ''the legal system produces multimillion-dollar jury awards on a regular basis.''

But while malpractice litigation has a big effect on premiums, insurers' pricing and accounting practices have played an equally important role. Following a cycle that recurs in many parts of the business, a price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims.

Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year.

''I don't like to hear insurance-company executives say it's the tort [injury-law] system—it's self inflicted,'' says Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California.

What's more, the litigation statistics most insurers trumpet are incomplete. The statistics come from Jury Verdict Research, a Horsham, Pa., information service, which reports that since 1994, jury awards for medical-malpractice cases have jumped 175 percent, to a median of $1 million in 2000. During that seven-year period, the median award for negligence in childbirth was $2,050,000—the highest for all types of medical-malpractice cases, Jury Verdict Research says. (In any group of figures, half fall above the median, and half fall below.)

But Jury Verdict Research says its 2,951-case malpractice database has large gaps. It collects award information unsystematically, and it can't say how many cases it misses. It says it can't calculate the percentage change in the median for childbirth-negligence cases. More important, the database excludes trial victories by doctors and hospitals—verdicts that are worth zero dollars. That's a lot to ignore. Doctors and hospitals win about 62 percent of the time, Jury Verdict Research says. A separate database on settlements is less comprehensive.

A spokesman for Jury Verdict Research, Gary Bagin, confirms these and other holes in its statistics. He says the numbers nevertheless accurately reflect trends. The company, which sells its data to all comers, has reported jury information this way since 1961. ''If we changed now, people looking back historically couldn't compare apples to apples,'' Mr. Bagin says.

Some doctors are beginning to acknowledge that the conventional focus on jury awards deflects attention from the insurance industry's behavior. The American College of Obstetricians and Gynecologists for the first time is conceding that carrier's business practice have contributed to the current problem, says Alice Kirkman, a spokeswoman for the professional group. ''We are admitting it's a much more complex problem that we have previously talked about,'' she says.

The upshot is beyond dispute: Pregnant women across the country are scrambling for medical attention. Kimberly Maugaotega of Las Vegas is 13 weeks pregnant and hasn't seen an obstetrician. When she learned she was expecting, the 33-year-old mother of two called the doctor who delivered her second child but was told he wasn't taking any new pregnant patients. Dr. Shelby Wilbourn plans to leave Nevada because of soring medical-malpractice insurance rates there. Ms. Maugaotega says she called 28 obstetricians but couldn't find one who would take her.

Frustrated, she called the office of Nevada Gov. Kenny Guinn. A staff member gave her yet another name. She made an appointment to see that doctor today but says she is skeptical about the quality of care she will receive.

In the Las Vegas area, doctors say some 90 obstetricians have stopped accepting new patients since St. Paul Cos., formerly the country's leading provider of malpractice coverage, quit the business in December. St. Paul had insured more than half of Nevada's 240 obstetricians. Carriers still offering coverage in the state have raised rates by 100 percent to 400 percent, physicians say.

Dr. Wilbourn says his annual malpractice premium was due to jump to $108,000 next month, from $33,000. The 41-year-old solo practitioner says the increase would come straight out of his take-home pay of between $150,000 and $200,000 a year. In response, he is moving to Maine this summer.

Dr. Wilbourn mourns having ''to pick up and leave the patients I cared for and the practice I built up over 12 years.'' But in Maine, he has found a $200,000-a-year position with an insurance premium of only $9,800 for the first year, although the rate rises significantly after that. Premiums in Maine are relatively low because a dominant doctor-owned insurance cooperative there hasn't pushed to maximize rates, the heavily rural population isn't notably litigious and its court system employs an expert panel to screen out some suits, says Insurance Commissioner Alessandro Iuppa.

Until the 1970s, few doctors faced big-dollar suits. Malpractice coverage was a small specialty. As courts expanded liability rules, malpractice suits became more common. Dozens of doctor-owned insurance cooperatives, or ''bedpan mutuals,'' formed in response. Most stuck to their home states.

St. Paul, a mid-sized national carrier named for its base in Minnesota, saw an opportunity. An insurer of Main Street businesses, St. Paul became the leader in the malpractice field. By 1985, it had a 20 percent share of the national market. Overall, the company had revenue of $8.9 billion last year, with about 10 percent of its premium dollars coming from malpractice coverage.

The frequency and size of doctors' malpractice claims rose steadily in the early 1980s, industry officials say. St. Paul and its competitors raised rates sharply during the 1980s.

Expecting malpractice awards to continue rising rapidly, St. Paul increased its reserves. But the company miscalculated, says Kevin Rehnberg, a senior vice president. Claim frequency and size leveled off in the late 1980s, as more than 30 states enacted curbs on malpractice awards, Mr. Rehnberg says. The industry's rate increases turned malpractice insurance into a very lucrative specialty.

A standard industry accounting device used by St. Paul and, on a smaller scale, by its rivals, made the field look even more attractive. Realizing that it had set aside too much money for malpractice claims, St. Paul ''released'' $1.1 billion in reserves between 1992 and 1997. The money flowed through its income statement and boosted its bottom line.

St. Paul stated clearly in its annual reports that excess reserves had enlarged its net income. But that part of the message didn't get through to some insurers—especially bedpan mutuals—dazzled by St. Paul's bottom line, according to industry officials.

In the 1990s, some bedpan mutuals began competing for business beyond their original territories. New Jersey's Medical Inter-Insurance Exchange, California's Southern California Physicians Insurance Exchange (now known as Scpie Holdings), and Pennsylvania Hospital Insurance Co., or Phico, fanned out across the country. Some publicly traded insurers also jumped into the business.

With St. Paul seeming to offer a model for big, quick profits, ''no one wanted to sit still in their own backyard,'' says Scpie's Mr. Zuk. ''The boards of directors said, 'We've got go grow.''' Scpie expanded into Connecticut, Florida and Texas, among other states, starting in 1997.

As they entered new areas, smaller carriers often tried to attract customers by undercutting St. Paul. The price slashing became contagious, and premiums fell in many states. The mutuals ''went in and aggravated the situation by saying, 'Look at all the money St. Paul is making,''' says Tom Gose, President of MAG Mutual Insurance Co., which operates mainly in Georgia. ''They came in late to the dance and undercut everyone.''

The newer competitors soon discovered, however, that ''the so-called profitability of the '90s was the result of those years in the mid-80s when the actuaries were predicting the terrible trends,'' says Donald J. Fager, president of Medical Liability Mutual Insurance Co., a bedpan mutual started in 1975 in New York. Except for two mergers in the past two years, his company mostly has held to its original single-state focus.

The competition intensified, even though some insurers ''knew rates were inadequate from 1995 to 2000'' to cover malpractice claims says Bob Sanders, an actuary with Milliman USA, a Seattle consultancy serving insurance companies.

In at least one case, aggressive pricing allegedly crossed the line into fraud. Pennsylvania regulators last year filed a civil suit in state court in Harrisburg against certain executives and board members of Phico. The state alleges the defendants misled the company's board on the adequacy of Phico's premium rates and funds set aside to pay claims. On the way to becoming the nation's seventh-largest malpractice insurer, the company had suffered mounting losses on policies for medical offices and nursing homes as far away as Miami.

Pennsylvania regulators took over Phico last August. The company filed for bankruptcy-court protection from its creditors in December. A trial date hasn't been set for the state fraud suit. Phico executives and directors have denied wrongdoing.

In the late 1990s, the size of payouts for malpractice awards increased, carriers say. By 2000, many companies were losing money on malpractice coverage. Industrywide, carriers paid out $1.36 in claims and expenses for every premium dollar they collected, says Mr. Golden, the trade-group official.

The losses were exacerbated by carriers' declining investment returns. Some insurers had come to expect that big gains in the 1990s from their bond and stock portfolios would continue, industry officials say. When the bull market stalled in 2000, investment gains that had patched over inadequate premium rates disappeared.

Some bedpan mutuals went home. Scpie stopped writing coverage in any state over

than California. ''We lost money, and we retreated,'' says the company's Mr. Zuk.

New Jersey's Medical Inter-Insurance Exchange, now known as MIIX, had expanded into 24 states by the time it had a loss of $164 million in the fourth quarter of 2001. The company says it is now refusing to renew policies for 7.000 physicians outside of New Jersey. It plans to reformulate as a new company operating only in that state.

St. Paul's malpractice business sank into the red. Last December, newly hired Chief Executive Jay Fishman, a former Citigroup Inc. executive, announced the company would drop the coverage line. St. Paul reported a $980 million loss on the business for 2001.

As carriers retrench, competition has slumped and prices in some states have shot up. Lauren Kline, 6½ months pregnant, changed obstetricians when her long-time Philadelphia doctor moved out of state because of rate increases. Now, her new doctor, Robert Friedman, may have to give up delivering babies at his suburban Philadelphia practice. His insurance expires at the end of the month, and he says he is having difficulty finding a carrier that will sell him a policy at any price.

Last year, Dr. Friedman says he paid $50,000 for coverage. If he gets a policy for next year, it will cost $90,000, he predicts, based on his broker's estimate. ''I can't pass a single bit of that off to my patients,'' because managed-care companies don't allow it, he says.

Dr. Friedman says he is considering dropping the obstetrics part of his practice. Generally, delivering babies is seen as posing greater risks than most gynecological treatment. As a result, insurers offer less-expensive policies to doctors who don't do deliveries.

Mr. Golden of the insurers' association argues that whatever role industry practices may play, the current turmoil stems from lawsuits. The association says that from 1995 through 2000, total industry payouts to cover losses and legal expenses jumped 52 percent, to $6.9 billion. ''That says there are more really huge verdicts.'' Mr. Golden says. Even in the majority of cases in which doctors and hospitals win—the zero-dollar verdicts—there are still legal expenses that insurers have to pick up, he adds.

Industry critics point to different sets for statistics. Bob Hunter, director for insurance at Consumer Federation of America, an advocacy group in Washington, prefers numbers generated by A.M. Best Co. The insurance-rating agency estimates that once all malpractice claims from 1991 through 2000 are resolved—which will take until about 2010—the average payout per claim will have risen 47 percent, to $42,473. That projection includes legal expenses and suits in which doctors or hospitals prevail.

While the statistical debate rages, pregnant women adjust to new limits and inconveniences. Kelly Biesecker, 35, spent many extra hours on the highway this spring, driving from her home in Villanova, Pa., to Delran, N.J., so she could continue to use her obstetrician. Dr. Richard Krauss says he moved the obstetrics part of his practice from Philadelphia because malpractice rates had skyrocketed in Pennsylvania. Ms. Biesecter, who gave birth to a healthy boy on June 5, says Dr. Krauss was the doctor she trusted to guard her health and the health of her baby: ''You stick with that guy no matter what the distance.''

Dr. Krauss, 53, left Philadelphia last year only after his malpractice premium rose to $54,000, from $38,000, and then was cancelled by a carrier getting out of the business, he says. After getting quotes of about $80,000 on a new policy, he moved. New Jersey hasn't been a panacea, however. His policy there expires July 1, and the carrier refuses to renew it. The doctor says he hopes to go to work for a hospital that will pay for his coverage.

Mr. DURBIN. The article points out the reason the premiums are rising so high is because the insurance companies miscalculated. They went into the business without adequate reserves. They have seen their investments plummet, as everyone else has on Wall Street, and they are trying to make it up with new malpractice insurance premiums at the highest possible levels. So, instead of blaming the juries that find a doctor or hospital at fault, let us also take into account the insurance companies' economic and accounting problems which have led to this crisis today.

Let's look specifically at this amendment. Senator MCCONNELL is consistent. When we brought up the bill about corporate corruption, he offered an amendment relating to trial lawyers. He believes that trial lawyers are the root of all evil. That amendment did not pass.

Now we come to a bill involving the cost of prescription drugs. Senator MCCONNELL returns with another amendment related to trial lawyers.

It is said that if the only tool you own is a hammer, every problem looks like a nail. It appears that when it comes to the issues in the Senate, for some Senators the answer to every problem is to go after the trial lawyers.

I suggest that when we take a look at the McConnell amendment, there are at least four areas that should be troubling to everyone following this debate. First, Senator MCCONNELL limits the period of time when someone can discover an injury or act of malpractice and bring a lawsuit. If they wait too long, they lose their chance to go to court. That is something we ought to think about long and hard.

Secondly, Senator MCCONNELL says that once someone has discovered that they have an injury caused by a doctor or a hospital and go to find an attorney, he limits in this amendment the amount of money that an attorney can receive for a contingency fee. A contingency fee is the poor man's ticket to the courthouse. If injured victim is not a millionaire, the only way that an attorney will take a complicated medical malpractice case is for a percentage of what they ultimately recover. If they recover zero, they are paid zero. But if they recover a substantial amount, they receive a percentage. Senator MCCONNELL wants to limit the contingency fee to limit the number of attorneys who will take these cases to court.

The third issue is this: Senator MCCONNELL creates a new tax on punitive damages. What he says is, if someone has done something so outrageous or deliberate, with conscious malice and disregard, that a jury would impose punitive damages on that doctor or hospital—and I can give a litany of possibilities—Senator MCCONNELL says, sorry, the Government is going to take away half of the punitive damages verdict; albeit, for good reasons. But nevertheless, this is a new tax created by Senator MCCONNELL on a jury verdict.

Finally, what the Senator says in this bill is, if one had the foresight to buy medical or life insurance, for example, to cover their health or life, and they are injured or killed because of medical malpractice, any jury verdict will be reduced by the amount of the insurance payment that one happens to receive from the policy they took out on their own life. These people invest in insurance and pay for it over a lifetime. But the amendment would take away part of that amount from a jury award. Those four things are fundamentally unfair.

We have talked in the corporate corruption debate about accountability. We have said corporate officials should be held accountable for their conduct. The same is true of people in the practice of medicine. They should be held accountable, too. If they are guilty of wrongdoing, injuring innocent people, then they should be held accountable.

Unfortunately, the McConnell amendment goes too far and takes away accountability. It is certainly the type of an amendment which insurance companies are happy to see. It reduces their ultimate exposure, but what it does is close and limit the courthouse doors for ordinary people who have become victims.

To give one illustration from my State: A young woman in April of 1989 went into a hospital for treatment for breast cancer. The doctor inserted a 16 centimeter-long catheter in her vein in her upper chest. After her chemotherapy was completed, the catheter was supposed to be removed. In July of the following year, the doctor removed the catheter, but he did not take it all. In December 1991, over 2 years after her initial treatment, she went in for an X-ray and discovered that 9 centimeters of this catheter was lodged in her heart, causing pain, causing her discomfort all of the time.

Ultimately, the doctors decided it was too risky to engage in surgery to remove the fragment, and so they decided to let the catheter piece remain lodged inside her heart. She will live with that foreign object inside her for as long as she lives. The doctor's mistake will be a pain that she feels every moment for the rest of her life.

Under Senator MCCONNELL's amendment, there is a serious question as to whether or not she could have ever brought the lawsuit. Did she wait too long? It took more than 2 years to discover this situation. She would have to fight, under the McConnell amendment, to prove that this was a reasonable amount of time, that the pain should not have alerted her sooner.

Secondly, the amendment limits the attorney's fees. If this woman goes to consult an attorney and says, ''I am in pain; the doctor did something wrong; I

have the X-ray,'' Senator MCCONNELL would say her attorney cannot be paid more than a limited amount on contingency fees to go to the courthouse. Is that reasonable?

Fortunately, those provisions in the McConnell amendment did not apply and this lady went to court. She ultimately was awarded $1.5 million for pain and suffering, and an additional $500,000 for the increased risk of future injury.

Sadly, there are cases such as this that happen every day in America. The vast majority of doctors in our Nation are conscientious, hard-working, wonderful people, but mistakes are made. Sometimes they are tragic, sometimes they show gross negligence, and sometimes they are intentional, such as the removal of the wrong kidney when they leave a cancerous kidney in a person and remove the wrong one. What Senator MCCONNELL is saying is that person who has been aggrieved and injured would be limited in their opportunity to recover.

I urge my colleagues to oppose this amendment.

Mr. LIEBERMAN. Mr. President, I rise to address the pending McConnell medical malpractice amendment. I have long agreed with my colleague from Kentucky that our legal system needs reforming, and I have joined him in supporting a bill in many ways similar to this amendment in the past. But I cannot support him today, because I do not believe that this prescription drug debate is either the right time or the right place to address the medical malpractice issue.

The Senate has been debating the critical and urgent issue of how to provide seniors with prescription drug coverage for 2 weeks. As my colleagues know, we are having a very hard time finding common ground on the issue. The last thing we need now is to inject into this debate a highly controversial issue which we all know for a certainty will prevent us from ever fulfilling our goal of giving seniors the prescription drug benefits they need. We should be focused on debating and passing a prescription drug bill, not other issues. For that reason, I will vote to table this amendment.

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

Who yields time?

The Senator from Kentucky.

Mr. MCCONNELL. Madam President, I will address several of the myths that have been stated during the course of this debate. Myth No. 1 is that average medical malpractice premiums in California are higher than they are in States that have not enacted medical malpractice reform.

Obviously, that statement is absurd on its face. The fact is, the opponents of my amendment cited numbers from the Medical Liability Monitor arrived at by some playing of games with the numbers to prove a predetermined result. The editor of that publication, the Medical Liability Monitor, takes issue with the manner in which the other side has fudged the numbers. She states unequivocally that: We do not believe an average premium exists, nor do we attempt to produce such a spurious number. She concludes in her letter to Senator FRIST: I find it particularly offensive, especially when I have spent my entire career pursuing objectivity, honesty, and balance in everything I produce.

She also noted in a recent National Journal article that insurers in California hold the lines fairly well because they have tort reform in place.

Myth No. 2: Medical malpractice premiums are not a burden on health care costs. It has been said on the other side, they account for only .6 percent of all health care costs—so it is said.

First, the studies cited by my Democratic friends do not take into account large segments of the medical malpractice community. Moreover, a 1996 study by two Stanford economists found that commonsense medical malpractice reforms, many of which are included in my amendment, could reduce health care costs by 5 to 9 percent without jeopardizing quality of care. Using this study, the Department of Health and Human Services projected that reducing the practice of defensive medicine would save Federal taxpayers between $23 and $42 billion.

Myth No. 3: It has been stated that companies have to raise premiums because they lost money on bad investments such as Enron. The fact is, the American Academy of Actuaries states insurers typically invest the vast majority of premiums in fixed income investments, not stocks. They also state that insurers do not set rates to recoup investment losses.

It has been suggested that somehow the door to the courthouse will be closed because there is a reasonable cap on attorneys' fees, which of course would guarantee that the victim got more of the money and the lawyer a little bit less—but certainly not enough to make them unwilling to take cases.

My friend from Illinois says contingency fees are the poor man's ticket to the courthouse. Apparently our trial lawyer friends will only punch the ticket if they can get more than a third of their clients' awards. My amendment limits the lawyer's fee to 33 percent of the award up to $150,000 and 25 percent above $150,000. So the suggestion is being made that if the lawyers do not get more than a third of the money involved, they somehow will not represent the injured victim.

One of our colleagues on the other side in a previous life got an award of $27 million, as the Washington Post reported. Under my formula, he would have gotten only $6.75 million, plus costs. I don't think that is much of a disincentive to represent an injured victim.

Mr. KYL. Will the Senator yield for a request?

Mr. MCCONNELL. I yield.

Mr. KYL. Directly on this point, I learned in law school sometimes it is hard for people to get a lawyer to take their case if they do not have a very good case. Lawyers charge a higher and higher and higher contingency case. But if the case was a pretty good case, back when I was in law school, contingency fees were pretty low.

As I understand your amendment, limiting the contingency fee to one-third of what is recovered is a pretty high contingency fee. Under the Federal Tort Claims Act, since the late 1940s, the limit has been 25 percent, and there has been no dearth of cases. It is actually higher than we already have under the Federal Tort Claims Act.

Continuing this line of thought, if you have a good case, then the contingency fee tends to be lower. The worse the case is—the less likelihood of succeeding—generally, the higher the contingency fees.

What would you say to the argument that we have to have no limit on the contingency fees or cases will not be taken?

Mr. MCCONNELL. I say to my friend from Arizona there is no evidence that there are not lawyers willing to take the cases. What this underlying amendment is about is protecting the victim and giving the victim more of the money and giving the lawyer a little bit less without taking away any incentive.

Statistics indicate the poor victims, on the whole, get about 48 percent of the money; 52 percent goes to the lawyers and the costs and the courts. This is a pro-victim amendment that benefits these injured parties over whom many have expressed so much concern.

Mr. KYL. One final question: Your amendment in no way limits the amount that the individual can recover in economic damages, or pain and suffering damages, at all, but it would put at least an upper limit of one-third on a contingency fee that the lawyers could charge for that plaintiff or victim?

Mr. MCCONNELL. My amendment would cap attorneys' fees at 33 percent of the first $150,000 awarded and 25 percent of the award above $150,000.

Mr. KYL. I think the amendment is an excellent amendment in support of victims, and therefore I am very pleased to support it.

Mr. MCCONNELL. I thank my friend from Arizona very much.

This is a national problem that affects States all across the country. It has been caused by the failure of the National Government to act. The Federal Government is the single biggest purchaser of medical services. It buys $400 billion in medical services each year. The purchase and delivery of medical services substantially affects interstate commerce. Patients and doctors routinely cross State lines. Parties buy medical services from doctors and hospitals in other jurisdictions. And doctors and hospitals sell medical services to citizens from different

States. Indeed, our most famous hospitals, such as the Mayo Clinic, are known for this.

Does anyone deny this is a substantial commercial activity? Thus, there is a commerce clause and a spending clause basis for the Federal Government to act.

Regardless of the problem caused by our civil justice system, some of our colleagues will point the finger at anyone but big personal injury lawyers. No matter what the trial lawyers do, no matter what abuses they may commit, some colleagues absolutely refuse to admit that there are any abuses or excesses in our civil justice system. Some of our colleagues say they are for accountability and responsibility in helping average Americans. They say that is what the debate is all about on corporate governance and prescription drugs. But when it comes down to it, some of our colleagues are for accountability and responsibility and helping average people only when it does not affect the interests of big, wealthy, powerful trial lawyers. In short, they are about accountability for everyone but the personal injury bar.

Our friends who share that view will do anything that will impede big personal injury lawyers being able to run rampant through our legal system. We have seen them over the last few weeks. They will protect big, powerful trial lawyers over American victims of terrorism when it comes to punitive damages. We have seen that those colleagues will shield big, powerful trial lawyers from having to disclose basic information about their fees and costs to their clients. We have seen that some will not restrict big, powerful trial lawyers from ambulance chasing victims by reserving a respectful period of bereavement before soliciting business. And now we have seen those same folks urging the Senate not to help medical professionals by adopting the most modest of pro-victim reforms to our medical malpractice liability system. The AMA would like to go further than this amendment goes.

And now we've seen that my Democrat friends urging the Senate not to help medical professionals by adopting the most modest of pro-victim reforms to our medical malpractice liability system. Again, my amendment is pro-victim because it: doesn't limit pain and suffering one penny; ensure that the victims, not their lawyers, get most of the compensation; allows them to get punitive damages; and improves overall patient care by providing that half of a punitive damages award goes to improving medical standards and practices.

My colleagues: this is a chance to do something to help doctors, to help patients, to help our medical delivery system without capping by one nickel a patient's pain and suffering damages. The question, then, is whether you are going to vote with the trial lawyers or are you going to vote with the doctors and their patients.

If my Democrat friends are serious about doing something to improve the delivery of medical services, they'll break with the trial lawyers for a change and listen to the medical community and adopt my amendment—an amendment that has already passed the Senate once.

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

Mr. KENNEDY. Madam President, we have 6½?

The PRESIDING OFFICER. Yes.

Mr. KENNEDY. I yield a minute and a half to the Senator from Delaware.

Mr. CARPER. I thank the Senator for yielding.

Mr. MCCONNELL. I ask that Senator ENZI be added as a cosponsor to the amendment.

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

Mr. CARPER. The Senator from Kentucky and I agree on a variety of issues that relate to what we are talking about. Tomorrow, the Senate Judiciary Committee holds hearings on class action reform. I think it is a situation that calls for a national or a Federal solution.

Many of us heard from our constituents around the country that we as a Congress need to do something to address asbestos reform legislation because there are a lot of folks who are being hurt from asbestosis and they are not getting anything out of it. Their damages are not being covered. Meanwhile a lot of people who are not sick, will never be sick, are diluting the money that should be going to people who really have asbestosis or diseases related to asbestos. Those are issues that I think cry out for a national solution.

The one we are talking about here today, medical malpractice, is a problem in a number of States—I will acknowledge that—but it is a problem that can be fixed in a number of States. Delaware is one of those States in which legislation is pending today to address this issue and where it is most appropriately addressed.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I yield myself the remaining time.

At a time when the American people are calling for greater corporate accountability, it is unbelievable that our Republican colleagues would bring to the floor an amendment which would do just the opposite. The McConnell amendment would allow the entire health care industry to avoid accountability for the care they provide.

The Amendment would deprive seriously injured patients of fair compensation. At virtually every stage of the legal process, the amendment systematically rewrites the rules of civil law to tip the balance in favor of defendants. It would arbitrarily shield health care providers and their insurance companies from basic responsibility for the harm they cause.

While those across the aisle like to talk about doctors, the real beneficiaries will be insurance companies. This amendment would enrich the insurance industry at the expense of the most seriously injured patients; men, women, and children whose entire lives have been devastated by medical neglect and corporate abuse.

This proposal would also shield HMOs that fail to provide needed care, nursing homes that neglect elderly patients, drug companies whose medicine has toxic side effects, and manufacturers of defective medical equipment.

It would drastically limit the financial responsibility of the entire health care industry to compensate injured patients for the harm they have suffered. When will the Republican Party start worrying about injured patients and stop trying to shield big business from the consequences of its wrongdoing? Less accountability will never lead to better health care.

Substandard medical care is a growing problem. The Agency for Healthcare Research and Quality at HHS found that the number of adverse effects from medical treatment has more than doubled in recent years, rising from 302,000 in 1993 to 710,000 in 2000. A Healthcare Research and Quality study also found that adverse effects of medical drugs have increased by more than 44 percent in recent years, rising from 657,000 in 1993 to 992,000 in 2000. A 1999 study, by the Institute of Medicine at the National Academy of Sciences determined that at least 44,000 patients, and perhaps as many as 98,000 patients, die in hospitals each year as a result of medical errors. That is more than die from auto accidents, breast cancer, or AIDS each year. Despite these alarming numbers, less than one-half of 1 percent of the nation's doctors face any serious sanctions from Medical Review Boards each year.

These statistics make clear that we need more accountability in the health care system, not less. In this era of managed care and cost controls, it is ludicrous to suggest that the major problem facing American health care is ''defensive medicine.'' The problem is *not* ''too much health care,'' it is ''too little'' quality health care.

The restrictions on compensation for seriously injured patients which the McConnell Amendment seeks to impose would not even result in less costly care. The cost of medical malpractice premiums constitutes less than two-thirds of 1 percent 0.66 percent of the nation's health care expenditures each year. Malpractice premiums are not the cause of the high rate of medical inflation. Over the decade from 1988 to 1998, the cost of medical care rose 13 times faster than the cost of malpractice insurance. Did you get that? The cost of medical care rose 13 times faster than the cost of malpractice insurance.

The restrictions in this amendment are not only unfair to patients, they are also an ineffective way to control medical malpractice premiums. There

is scant evidence to support the claim that enacting malpractice limits will lower insurance rates. There is substantial evidence to the contrary. Malpractice premiums are no higher on average in the 27 States that do not place limitation on malpractice damages, than in the 23 States that do have such limits.

Do we understand that? The premiums are no higher where you do not have these kinds of limitations than in the States that do. And you know what that means. The doctors are paying the higher premiums. Who do you think is keeping the difference? The insurance companies. The insurance companies. They are the ones that are making out.

The evidence clearly demonstrates that placing arbitrary limitations on the malpractice damages does not benefit the doctors it purports to help. Their rates remain virtually the same. It only helps the insurance companies earn even larger profits.

The malpractice premiums are not affected by the imposition of the limits on recovery, so it stands to reason the availability of physicians does not differ between the States that have limits and the States that do not.

I will use the chart that shows the difference between the States that do have limits and those that do not.

Physicians In Patient Care: States without caps on damages, with 233 per 100,000 residents; the States with caps on damages, 223—virtually identical.

The point here, in summation, is accountability and responsibility in the whole area of the health care industry and the profits that are going to result if this amendment is successful. It will not mean better health care. It will mean, less attention to protecting patients all the way through the health care system.

It will mean larger profits. It will mean larger profits for an industry. It will mean less corporate responsibility. I hope this amendment will not be successful.

Since malpractice premiums are not effected by the imposition of limits on recovery, it stands to reason that the availability of physicians does not differ between states that have limits and states that do not. AMA data shows that there are 233 physicians per 100,000 residents in states that do not have medical malpractice limits and 223 physicians per 100,000 residents in states with limits. Looking at the particularly high cost specialty of obstetrics and gynecology, states without limits on damages have 29 OB/GYNs per 100,000 women while states with limits have 27.4 OB/GYNs per 100,000 women. Clearly there is no correlation.

If this amendment were to pass it, it would sacrifice fair compensation for injured patients in a vain attempt to reduce medical malpractice premiums. Doctors will not get the relief they are seeking. Only the insurance companies, which created the recent market instability, will benefit.

Even supporters of the industry acknowledge that enacting tort reform will not produce lower insurance premiums:

Victor Schwartz, the American Tort Reform Association's General Counsel, told Business Insurance,

> . . . many tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'

Debra Ballen, Executive Vice-President of the American Insurance Association even released a statement earlier this year (March 13, 2002) acknowledging,

> [T]he insurance industry never promised that tort reform would achieve specific premium savings . . ..

A National Association of Insurance Commissioners study shows that in 2000, the latest year for which data is available, total insurance industry profits as a percentage of premiums for medical malpractice insurance was nearly twice as high 13.6 percent as overall casualty and property insurance profits 7.9 percent. In fact, malpractice was a very lucrative line of insurance for the industry throughout the 1990s, averaging profits of 12 percent per year. Recent premium increases have been an attempt to maintain high profit margins despite sharply declining investment earnings.

Insurance industry practices are responsible for the sudden dramatic premium increases which have occurred in some states in recent months. The explanation for these premium spikes can be found not in legislative halls or in courtrooms, but in the boardrooms of the insurance companies themselves.

There have been substantial increases in recent months in a number of insurance lines, not just medical malpractice. In 2001, rates for small commercial accounts have gone up 21 percent, rates for mid-size commercial accounts have gone up 32 percent, and rates for large commercial accounts have gone up 36 percent. According to industry sources, auto insurance rates are projected to climb by 23 percent between 2000 and 2003, and homeowners insurance is projected to climb by 21 percent over the same period. These increases are attributable to general economic factors and industry practices, certainly not medical liability tort law.

Insurers make much of their money form investment income. During times when investments offer high profit, companies compete fiercely with one another for market share. They often do so by underpricing their plans and insuring poor risks. When investment income dries up because interest rates fall and the stock market declines, the insurance industry then attempts to increase its premiums and reduce its coverage. This is a familiar cycle which produces a manufactured crisis each time their investments turn downward.

One of the leading insurance industry analysts, Carol Brierly Golin, editor of Medical Liability Monitor, concluded:

> As the economy enjoyed a magic carpet ride in the 1990s, insurers kept rates artificially low because they earned more money investing than by writing policies . . . The insurance companies wouldn't be in this position if they hadn't been so hungry for investment profits . . . (Dec. 19, 2001).

This analysis of why we are seeing a sudden spike in premiums was confirmed by a June 24, 2002 Wall Street Journal article describing what happened to the malpractice insurance industry during the 1990s.

> Some of these carriers rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year.
>
> I don't like to hear insurance-company executives say it's the tort [injury-law] system—it's self-inflicted, says Donald J. Zuk, chief executive of Scpie Holdings, Inc., a leading malpractice insurer in California . . .
>
> The losses were exacerbated by carriers' declining investment returns. Some insurers had come to expect that big gains in the 1990s from their bond and stock portfolios would continue, industry officials say. When the bull market stalled in 2000, investment gains that had patched over inadequate premium rates disappeared.

Proponents of the McConnell amendment justify the extreme restrictions they would place on the rights of injured patients as necessary to control medical malpractice premiums. The real beneficiaries of the amendment would be the insurance industry, which would pocket the money it saved on claims. The insurance premiums which doctors pay would not significantly change. The real losers, of course, would be the most seriously injured patients, who were denied fair compensation for their life-altering injuries. I strongly urge my colleagues to reject this amendment.

The PRESIDING OFFICER. All time has expired.

The Senator from Nevada.

Mr. REID. Madam President, I move to table the McConnell amendment. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is 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.

I further announce that if present and voting the Senator from North Carolina (Mr. HELMS) would vote ''no.''

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

The result was announced—yeas 57, nays 42, as follows:

The result was announced—yeas 57, nays 42, as follows:

[Rollcall Vote No. 197 Leg.]

YEAS—57

Akaka
Allen
Baucus
Bayh
Biden
Bingaman

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

NAYS—42

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

NOT VOTING—1

Helms

The motion was agreed to.

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

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

Mr. REID. 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. 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, the amendment that is going to be the subject of discussion this afternoon is being copied, and it takes a few minutes always to do that.

I ask unanimous consent that during that period of time, the Senator from California, Mrs. FEINSTEIN, be recognized to speak as in morning business for up to 15 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. Reserving the right to object, is it my understanding the piece of legislation which increases spending by $400 billion over the next potentially 8 or 10 years is not available for us to read?

Mr. REID. I say to my friend, the amendment which is a step in the direction of helping senior citizens who need prescription drugs is available. It is just being copied. The Senator's floor staff asked for a copy of it, and Senator GRAHAM did not have an extra copy. It is hot off the press right here.

Mr. GREGG. It is good to know we are going to have a chance to take a look at this piece of legislation.

Do we expect to vote on this piece of legislation that is just hot off the press today that is a $400 billion expansion of the expenditure of the Federal Government over the next 10 years?

Mr. REID. I say to my friend, it is our purpose to allow the Senate to vote on a good prescription drug benefit for senior citizens, something that is long overdue and, as the Senator knows, in 1965 when we passed Medicare, there was not a prescription drug benefit. This will be a downpayment for that. Yes, we would like to vote on it today.

Mr. GREGG. I thank the Senator.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from California is recognized for 15 minutes.

The PRESIDING OFFICER. The Senator from California.

Mrs. FEINSTEIN. I thank the Chair.

(The remarks of Mrs. FEINSTEIN pertaining to the submission of S. Con. Res. 133 are located in today's RECORD under "Statements on Submitted Resolutions.")

Mr. KENNEDY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. REID. Mr. President, the next amendment to be offered is from the Senator from Nevada, Mr. REID. I have an amendment that we have worked on for a couple of years dealing with prescription drugs and allowing those people who have health insurance plans to have prescription drug benefits for contraceptives. I am not going to be able to do that because this legislation is, of course, winding down one way or the other. Everyone seems to have focused on a prescription drug benefit for Medicare. That does not take away from how important I believe my amendment is.

I am terribly disappointed, and I suggest there are advocacy groups all over America that are disappointed as they hear me say this. Members of my own staff are terribly disappointed because they have worked on this sometimes days at a time. We have been able to get little bits and pieces of it over the years.

Federal employees, for example, have a benefit that other people in the country do not have; that is, in their prescription drug plans, their health care, they can have contraceptives under the benefits of their plan. That should apply to everyone in America. We are not going to be able to do that today, and I am disappointed.

I am happy, though, to designate Senator GRAHAM to offer the amendment on which he has spent such an inordinate amount of time. Senator GRAHAM and I came to the Senate together. He was a very successful and popular Governor. It is said that he is probably the most popularly elected official to ever come from the State of Florida. Whether that is true or not, I do not know. I do know he is a great legislator. The work he has done on this amendment has been exemplary. There is not anyone who understands Medicare and the tax aspects of it better than the Senator from Florida. He has spent not hours, days, or weeks; he has spent months on this legislation. Always available to anyone who has a question, he explains it in detail so it is understandable.

I would only say that the people of Florida are well served by the work he has done, and I hope this amendment that he is going to offer would pass the Senate. It is something that not only the people of Florida need but the people of Nevada, Delaware, and our entire country need. It is not everything that I want, but it is certainly a giant step forward. So I, under the unanimous consent order that is now in effect, designate my spot to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida.

AMENDMENT NO. 4345 TO AMENDMENT NO. 4299, AS AMENDED

Mr. GRAHAM. I wish to express my appreciation for the graciousness of our colleague from Nevada for his very kind remarks. I share his sense of the importance of the debate we are about to begin. It is a debate which has been waiting for 37 years.

As history would have it, it was exactly 37 years ago today, July 30, 1965, President Lyndon B. Johnson signed the law that created the Medicare Program. President Johnson did not sign the legislation in Washington, but he went to Independence, MO, the home of an American who had spent much of his political career attempting to secure a health care benefit for older and poorer Americans, President Harry S Truman, and his wife Bess. He wanted them not only to be able to witness the signing of the Medicare legislation, but President Johnson then went the next step and gave to President Truman and his wife the first two Medicare cards.

President Truman had been fighting for decades for help for insurance for America's senior citizens, most of whom had been denied private insurance coverage because of preexisting conditions. In his remarks at the signing of the Medicare legislation, President Johnson declared: No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime, so they might enjoy dignity in their later years. No longer will young families see their own incomes, their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents and to their uncles and to their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.

There was one thing left out of the law President Johnson signed on that day 37 years ago. That was prescription drug coverage. Today, because prescription medications are so much more vital to health care in the 21st century and, frankly, because they are so expensive, we have the opportunity and the challenge to finish the job. Today we are poised to give this, the greatest generation, what they deserve. Today we can add a meaningful prescription drug benefit to the Medicare Program so that nearly 40 million older and disabled Americans who rely on Medicare are not choosing between medicines and the necessities of life.

In 1965, the average older American spent on prescriptions $65. That was not $65 a week or $65 a month but $65 for an entire year. What is happening today, July 30, 2002?

Today the average senior American spends $2,149 on prescription drugs each year. The average senior today has to worry about what will happen to his or her health and financial security if, like about 20 percent of Medicare beneficiaries today, his or her prescription drug needs escalate, grow to a level of $3,300 or greater.

The average senior today has to work because the options for prescription drug coverage are few and those that are available are withering.

Medigap coverage is expensive and generally is capped. Medicare+Choice coverage is available only to some, and it is almost totally unavailable in rural areas of America. Employer-funded retiree coverage has been shrinking dramatically over the last decade.

The Senate has been debating a Medicare prescription drug benefit for the past 2 weeks. It has been actively considering such a benefit for the past 6 years. In 2000, I was proud to vote for a comprehensive prescription drug benefit for all Medicare beneficiaries. It lost. In 2001, I introduced another version of a comprehensive, universal bill. It lost. With my friends and colleagues, Senators MILLER and KENNEDY, I introduced an amendment a week ago today in hopes of again providing a comprehensive, affordable prescription drug benefit for all seniors. This proposal gained 52 votes, a majority of the Senate, but we did not have the 60 votes necessary to prevail against the point of order.

What now? One thing we know, time is not our friend. It is certainly not America's seniors' friend. In another year, if we put this off from 2002 to 2003, the average senior will be spending $2,439 on drugs. If we wait 2 years, the average senior will be spending $3,059 on prescription drugs. In another year, the percentage of seniors spending more than $3,300 on drugs will not be the 20 percent today but will exceed 24 percent. By 2005, the number will have grown to about 35 percent of our seniors. In another year, Medigap coverage will be more expensive, fewer seniors will have access to Medicare+Choice, and fewer seniors will be covered by a previous employer's retiree program.

There is no basis for delay. Whatever we do, the time to act is now. I am offering a proposal, and I am joined by Senators GORDON SMITH—and I thank Senator SMITH for the great contribution he has made to the development of this proposal—ZELL MILLER, who has been a stalwart for months in this effort, and Senators LINCOLN, BINGAMAN, KENNEDY, and STABENOW. Together, we are offering this amendment which will make a significant difference in the lives, the health, and the financial security of our grandparents, our parents, our aunts and uncles, our neighbors, the people we love the most, who will be affected the most by this legislation.

The bipartisan Medicare Prescription Drug Costs Protection Act is estimated by the CBO to cost $390 billion over 10 years. It offers all seniors protection against catastrophic drug bills, and it provides special assistance for seniors with the lowest income.

What will this plan do? First, for a low annual fee of $25, this legislation will offer all seniors who decide to voluntarily enroll up to 30 percent discounts and Federal supplements on the drugs they purchase—a very substantial benefit. This will also bring to all seniors the peace of mind in knowing, if I should have that heart attack, if I should be diagnosed with cancer or diabetes or any of the perils of old age, I will have, once I have paid $3,300 out of my pocket, or in conjunction with a stated prescription drug benefit, beyond that, I will have my prescription drugs paid, with only a $10 copayment per prescription. That will give enormous peace of mind to our seniors who are fearful of that catastrophic health event that will drive them into economic poverty.

Moreover, this legislation will offer to those seniors who are the neediest, coverage for all of their costs. It will cover all seniors who are 200 percent, or lower, of poverty in their income. That means for an individual who earns less than $17,720, or a couple with an income of less than $23,880, all of their costs will be covered except for a copayment of $2 for each prescription which is generic, $5 for a brand name prescription.

According to some recent information submitted by the Urban Institute, in the year 2002, a 200 percent of poverty standard would represent 47 percent of the almost 40 million Medicare beneficiaries in the United States.

There is also an important consideration of the effect of this legislation on employers. Today, the largest segment of seniors who get some assistance with their prescription drugs, do so because a previous employer is providing that assistance. More people get assistance through that means than through a Medicare+Choice, HMO, or through a Medigap policy they have purchased. So it is very important that employers have a continuing commitment to participate in the health care costs of their retirees.

I am pleased, therefore, to State that the Congressional Budget Office predicts that no employer will drop existing coverage because of the benefit that is in this legislation. This is a very important assurance for seniors who are receiving assistance today.

I might say that competing plans have been evaluated by the Congressional Budget Office as causing up to one-third of the seniors who are currently receiving employer retiree benefits with their drug costs to lose those benefits.

Is this proposal the perfect Medicare prescription drug benefit? I must admit it is not. I had hoped we could provide a more comprehensive and more affordable drug benefit which would be universally applicable to all seniors. This proposal is a responsible step towards providing what seniors want and need. While providing assistance for all seniors, it targets the seniors who need help the most—the sickest and those with the lowest income.

There are always, here, voices for delay: Why do we need to do this on July 30? Why can't we wait? Why can't we wait until September? Or why can't we wait until next January? Why can't we put off the hard decisions?

If we wait until January of 2003, and if we start this process again in the next Congress, and if we go to the Congressional Budget Office and say, then: Here is the same plan that was introduced on July 30, 2002; please tell us what it is going to cost over the next 10 years—we have been told as of today it will cost $390 billion—the estimate is that same bill in January of 2003 will be given a 10-year cost of $470 billion.

Why? Why in the world would the same plan just 6 months later cost approximately $80 billion more over 10 years? The answer is, the perfect storm of economic circumstances. It is the convergence of, first, the fact that the cost of prescription drugs, including both inflationary cost of the drugs, plus increased utilization has been going up at a rate of approximately 18 percent every year. You just ask the people who buy substantial amounts of prescription drugs what their costs are today in comparison to what their costs were just 12 months ago. And the number of seniors who will be participating is increasing dramatically.

I was born in 1936. The year 1936 was the second lowest birth rate year in the 20th century in the United States. The reason? We were in the middle of a depression. Not very many families were adding to their size in 1936. So last November, when I reached 65, had I not been employed here in the Senate, I would have become a Medicare beneficiary. But you know what? I would not have had to have stood in a very long line to sign up because there are not a lot of people who became 65 in November of last year because there weren't very many people born in November of that year 65 years ago. But if

we wait another 10 years, we are going to be on the leading edge of one of the most significant bubbles of population in the history of the United States of America.

Today, we have 40 million Americans eligible for Medicare. Do you know how many Americans we are going to have eligible for Medicare in the year 2013? Fifty-one million. That is what is driving these costs. Every year that we delay, it becomes that much more expensive to initiate the program, to look at a 10-year window of how much this is going to cost. The time for the Senate to act is now.

If we act now, in July, we will have the full month of August to work with our colleagues in the House where a bill has already been passed, a bill that is substantially different than the one we will be considering in this amendment but one which I think is the basis of reasonable compromise.

Just a few hours ago the President signed corporate governance legislation. I know my good friend, Senator SMITH, was at the signing of that legislation. I commend him for his role in the creation and passage of that legislation. Many people thought that it was going to be impossible to reach agreement between a different House bill and a Senate bill. But, in fact, it was only a matter of a few days when serious, conscientious people came to such an understanding. I believe we can do the same thing with our conference with the House on this legislation, but we need to use the month of August as the time to begin to build that consensus towards a common piece of legislation.

There is no benefit in the cry for delay, delay, delay. We need every day that we can have to see that we arrive at a consensus that will lead the Congress to develop legislation which it can pass and the President can sign into law. We need to avoid adding yet another year of inflation and millions of additional seniors coming into the Medicare population, so we can pass this at today's price of $390 billion and not wait until next year when the same program is going to cost $470 billion.

This is the type of good-faith compromise that I hope will bring all parties together. It has the best chance of becoming the law of the land and providing to our grandparents and parents and all of our loved ones who depend upon Medicare this critical additional benefit.

In closing, I would like to remind all of you of something else that President Johnson said 37 years ago today when he signed the Medicare bill into law:

> Many men can make many proposals. Many men can draft many laws. But few have the piercing and humane eye which can see beyond the words to the people [those words] touch. Few can see past the speeches and the political battles to the doctor over there . . . trying to tend to the infirm; to the hospital that is receiving those in anguish, or feel in their heart the painful wrath at the injustice which denies the miracle of healing to the old and to the poor.

This debate is not about specific concepts. It is not about economics. It is not about public administration. This debate is about real people, people, as President Johnson said 37 years ago, who served this Nation with honor and dignity. The lives of almost 40 million of our fellow citizens are going to be impacted by the vote we are going to cast today. They are America.

On our behalf, I ask all our colleagues to support this legislation. On behalf of the cosponsors, I send to the desk the amendment and ask it be immediately considered. The sponsor's names are Senator SMITH of Oregon, Senator MILLER, Senator LINCOLN, Senator BINGAMAN, Senator KENNEDY, and Senator STABENOW.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

> The Senator from Florida (Mr. GRAHAM), for himself, Mr. SMITH of Oregon, Mr. MILLER, Mrs. LINCOLN, Mr. BINGAMAN, Mr. KENNEDY, and Ms. STABENOW, proposes an amendment numbered 4345 to amendment No. 4299 as amended.

Mr. GRAHAM. I ask unanimous consent the 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. GRAHAM. Mr. President, I ask unanimous consent to have printed in the RECORD the preliminary Congressional Budget Office estimate of the proposal to establish an outpatient prescription drug benefit in Medicare.

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

PRELIMINARY CBO ESTIMATE OF GRAHAM-SMITH PROPOSAL TO ESTABLISH AN OUTPATIENT PRESCRIPTION DRUG BENEFIT IN MEDICARE

[In billions of dollars]

	2003–2012
As a stand-alone bill:	
Medicare	306.9
Refinancing	−126.8
Low-Income Subsidy	187.6
Other	22.0
Total	386.6
Prescription drug benefit after interaction with Edwards' generic-drug proposal:	
Medicare	302.3
Refinancing	−126.8
Low-Income Subsidy	184.7
Other	22.0
Total	382.1
Budgetary Effect of Combination of Graham-Smith and Edwards	
Direct Spending:	
Edwards' Generic Drugs	−5.9
Graham-Smith Medicare Drug Benefit	382.1
Total	376.2
Revenue, on-budget	1.5
Revenue, off-budget	0.7
Revenue, combined	2.2
Effect on Surplus:	
On-budget	374.7
Combined	374.0

CBO staff have not reviewed the legislative language of the Graham-Smith proposal. This preliminary estimate is subject to revision upon such review.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. SMITH of Oregon. Mr. President, I rise today to urge my colleagues on both sides of the aisle to support the Graham-Smith amendment. This is our best and perhaps our last opportunity to come together and actually pass a meaningful prescription drug benefit in the Senate this year. I admit that this is a difficult issue. It is a privilege to work on it, though, because I hear of no single issue more on the minds of the American people—particularly our senior citizens—than this issue. It is critical that we give them more than a war of words for yet another year—we must give them some results that work toward wellness rather than just rhetoric.

I know I have colleagues on the left who don't believe we are spending enough. I know I have colleagues on the right who do not like the delivery system that is provided in this bill. But I believe it is critical we clear the 60-vote hurdle because if we don't, the seniors will get nothing for yet another year. That I think is unacceptable.

We are running out of time. Seniors are running out of money to pay for their prescription drugs. They can't afford to wait another year for us to reach a compromise. We simply have to act now on a proposal Senator GRAHAM and I bring to the floor that is affordable for them and affordable for the Government.

I believe this is a focused plan that we all ought to support so we can at least keep this process going to get something to conference, so then we can get something to vote on in September, and so that our seniors can get the medicine they need.

To review this bill: First and foremost, it is voluntary and it is comprehensive. Our bill focuses on providing a comprehensive benefit to our neediest low-income seniors—people who are least able to pay for their prescription drugs. Those who are below 200 percent of the Federal poverty level will never have to choose between food and lifesaving drugs again.

I think that is a remarkable and significant proposal in itself. We voted on different iterations of that before. We are bringing it together again in this amendment.

The latest figures from the Urban Institute say 47 percent of our Nation's seniors live with incomes below 200 percent of poverty, which translates into $17,720 for individuals and $23,880 for couples. We don't have the money for us to do everything in the world, to enact a prescription drug benefit that covers every cost for everybody. But under our plan, low-income seniors receive the most help because they need the most help, and they need it today. But even they have a copay. Some will say it is too small. But it is, I believe, enough to at least get the attention of low-income seniors when you ask them to pay $2 for a generic drug prescription or $5 to get a branded product. I think that promotes good consumerism among our seniors.

Second, our proposal addresses the fear that millions of seniors feel every day—the fear that the loss of their

health will result in the loss of their home. Our bill will ensure that no senior, no matter what their income, will ever have to pay more than $3,300 per year in prescription drug costs. I think that is significant. Some will describe it as a doughnut; others will say it is a cliff.

But I will tell you that I believe seniors in this country appreciate that in this bill they will get a discounted price, a discount card, and those in combination may equal up to 30 percent of the cost of a prescription. Moreover, they get an insurance policy that says you don't have to lose your home if you lose your health because, as to your prescription drug costs, the Government will be there to make sure that doesn't happen. The Graham-Smith amendment will ensure that they don't have to spend themselves into poverty, but it does ask them to pay something in addition to the copay. Each American who voluntarily signs up for this bill will pay $25 per year. In terms of discounted prices, a discount card, and an insurance policy against catastrophic illness, $25 is a well priced policy.

Finally, with this, every senior can expect, as I indicated before, somewhere between 20 percent to 35 percent of the cost of each of their drugs to flow to them in a discount. That is because we are using the delivery system—as all Republicans, or nearly all the Republicans, already voted on—in the Hagel-Ensign bill.

The Graham-Smith amendment would allow all employer-sponsored plans, the Medicare supplemental plan, the Medicare+Choice plan, pharmaceutical benefit managers, PBMs, pharmacies, and even States working with private companies to compete to deliver the benefits. This market-based competition, which so many of my Republican colleagues have already supported, will generate lower prices for all of our seniors.

Another provision we took from the Hagel-Ensign bill—a provision that was critical if this was to win my support—which all of my colleagues on this side of the aisle have already supported, was the Hagel-Ensign formulary language.

When I first talked to Senator GRAHAM about this, I told him my reluctance to vote for his bill in the first instance was, in large measure, over the formulary issue because, as set out in the bill previously before us, it essentially took 90 percent of current prescription drugs available to seniors and said they are not available under this plan. So 10 percent of available drugs, in my view, is too restrictive.

While under the Hagel-Ensign language there is a formulary which is a part of this bill, we make no such restriction, but leave to the experts the ability to make a more liberal formulary plan that will serve the health needs of our seniors. We did not want to limit drug choices for seniors. I think this is an important part of this bill that ought to attract the support of many of my colleagues.

Americans across the country are asking for our help. There are Americans who cannot afford to wait one more year because we have been unwilling to compromise on a prescription drug plan. This is our last chance to keep this process moving forward. I need 60 votes, America needs 60 votes on this bill, because seniors deserve more than lip service from the Senate. They deserve a prescription drug benefit from the U.S. Government—and a process and a plan that build on what we already have at a cost we can afford, at a cost that allows seniors to be included, and in a way that seniors themselves can afford this plan as well.

It is critical that we do this now, so that during the August recess we stop the haggling over whether we have a bill in the Senate, but get something to conference so that we can work out with the House and the White House the kind of bill that ultimately will win the support and the hearts and the minds of the American people.

I say to all of my friends in this body—whether you are a Republican or Democrat, whether you like this bill or not—it is the last train leaving the station, in my view. It has enough in it that ought to attract your support because it keeps the train moving instead of derailing it, to the great disadvantage and harm of the senior citizens of this country.

I plead with you for your support. If we can get it up and get past 60 votes, we can make amendments. We can make improvements. Then we will get to the House of Representatives and a conference, and to the kind of product that ultimately can pass muster for the White House, the House, and all of us.

I thank you for the time. I plead with my colleagues: Don't lose this opportunity.

I ask for their votes and yield the floor.

The PRESIDING OFFICER (Mr. CORZINE). Who yields time?

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DASCHLE. 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. DASCHLE. Mr. President, 37 years ago today President Lyndon Johnson traveled to Independence, MO, to the home of Harry Truman to sign Medicare into law. In signing the bill, LBJ said:

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they may enjoy dignity in their later years. . . .

No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, to their uncles, and their aunts.

Medicare, he stated, would provide light and hope to older Americans "fearing the terrible darkness of despair and poverty."

To a remarkable degree, Medicare has fulfilled that promise.

But today the high cost of prescription drugs, combined with seniors' increasing need for such drugs, is once again destroying the life savings and threatening dignity and security of millions of older Americans.

We have debated many important questions over the last 2 weeks, but the fundamental question facing us is, Are we willing to work together constructively to renew the promise of Medicare? Or will we refuse to help even the most hard-pressed seniors with prescription drugs?

We have considered three very different plans so far. The bill I supported, the Graham-Miller-Kennedy bill, was the only true Medicare prescription drug benefit among the three plans. It would have created a guaranteed Medicare prescription benefit for all seniors. It included reasonable premiums of $25 a month. It included affordable copays of $10 for generic prescriptions and $40 for brand name ones.

Our Senate Republican colleagues offered a very different plan, not a guaranteed Medicare benefit. It would have forced seniors into HMOs to get prescription drug coverage and given HMOs billions of dollars in taxpayer subsidies and seniors' premiums to entice them to offer seniors a prescription drug plan.

There were no guarantees. HMOs and insurance companies would decide who gets prescription drug coverage, what coverage is included, and how much it costs. The plan used accounting gimmicks to hide huge costs to seniors. A coverage gap meant millions of seniors would have no coverage at all over a period beyond a few hundred dollars, even if they continued paying premiums. A new $10 copay for home health visits was also required. But basically and fundamentally their premise was that HMOs could deliver prescription drug benefits and all health care better than Medicare.

Well, HMOs don't even exist for the most part in South Dakota and rural States. In areas where they do exist, HMOs have proven to be a poor fit with health needs of seniors. More and more HMOs are pulling out of Medicare+Choice. Many that are not leaving the program have dramatically cut benefits or increased premiums or both.

Two fundamentally different plans, one fundamental similarity: Neither plan got 60 votes. Our proposal, the Medicare benefit, got 52 votes, a majority of the Senate. Their plan to create pharmaceutical HMOs received 49 votes.

But still, we didn't give up. The Hagel-Ensign bill was offered, and for the first time Medicare would have linked seniors' benefits to their incomes, which was a major concession. The Hagel-Ensign bill did not get 60 votes either.

Now we are considering a fourth proposal, the Graham-Smith amendment. It is not the comprehensive coverage that Democrats all voted for, but it is an important first step. The Graham-Smith proposal offers real protection for every senior for just $25 a year. Let me emphasize, $25 a year. Seniors get up to a 30-percent discount on all prescriptions, coverage against catastrophic expenses over $3,300 a year. Low- and moderate-income seniors would receive extra help. The program would pay for all of their benefits for just a small copay on prescriptions of $2 for generic drugs and $5 for brand name drugs.

CBO predicts that the Graham-Smith proposal would result in few or no employers dropping retirees prescription coverage, versus an estimated one-third of seniors who would have lost benefits under the Republican plan.

I have to say that the two Senators responsible for this plan deserve a great deal of credit for their persistence, for their effort to come up, yet again, with another approach, with a recognition that perhaps there are those unwilling to spend more than about $400 billion in resources on a drug plan. They have come up with a way to address health benefits for all seniors, yet recognizing the limited resources we have to do so. I don't know that you could come up with a better framework than the one they have proposed.

I will say this: I met a woman in Mitchell, SD, a few weeks ago when I was home in Mitchell. Her name is Margaret McBrayer. She is 75 years old. She and her husband raised 11 children. Since 1956, she has had 21 surgeries, 3 aneurisms, and 1 stroke. She takes 11 prescriptions a day. Her average prescription costs are $814 a month, if she takes all brand names. If she uses generic brands, she can still spend $625 a month, two-thirds of her total monthly income.

Medicaid used to pay all but $2 per month per prescription. But this past February, Mrs. McBrayer lost her husband to bone cancer. She also lost her Medicaid coverage. As a widow, rather than half of a couple, her income is now too high for Medicaid—less than $12,000 a year, but too high for help.

So Margaret McBrayer is left to figure out how to pay for her own prescriptions. Her children help, but she is worried that they will end up spending all of their retirement savings on her prescription drugs, too.

Some doctors who know Margaret McBrayer call her ''the Miracle Woman'' because of all the health difficulties she has overcome, and the courage and dignity with which she has done it.

Fortunately, it doesn't require a miracle for us to help her—and Medicare's 40 million other beneficiaries—with the high cost of prescription drugs.

The reason LBJ traveled to Independence 37 years ago today to sign the Medicare bill was to honor Harry Truman—the man who had begun the fight for medical insurance for seniors 20 years earlier.

In his remarks that day, LBJ said Americans loved Harry Truman not because he gave 'em hell, but because he gave people hope.

We can walk away from this effort and give each other hell—blame each other for failure—or we can accept good-faith compromise and give the American people hope, and continue working to provide an affordable, reliable prescription benefit for all seniors. the choice is in our hands this afternoon.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, I rise to join my colleagues on both sides of the aisle in support of this very important downpayment on a comprehensive Medicare prescription drug benefit.

First, I commend my friend, the senior Senator from Florida, for his tremendous leadership on the comprehensive proposal that received 52 votes, as well as this proposal to move it forward in the right direction. He has been a stalwart. I commend Senator GRAHAM and his staff, who have worked very hard in pulling all this together. Also, I thank Senator SMITH of Oregon for his willingness to step forward in a bipartisan way and work with us to do what can be done.

As has been indicated, we had two competing proposals put forward last week, with very different philosophies—one with a private sector insurance company, HMO model; the other with a model to expand Medicare as we know it today. One, the Medicare expansion effort, received 52 votes. The other, private insurance, received 48 votes. Neither one had the 60 votes that are necessary to make this law and move it forward.

So we went back to the drawing board and, as is true in this great democracy of ours when you are not able to get exactly what you would like to see happen, you listen to people and you find a way to move forward, to take a step forward in the right direction.

That is what this amendment is. This is a downpayment on comprehensive coverage. It is a step in the right direction. It will lower prices for all of our seniors. Every person who is on Medicare will see the prices, the costs, of their prescription drugs going down. That is important.

I also mention that the underlying bill, and the efforts we have been using to add more competition, will lower prices for everyone, whether you are in business, a farmer, a worker, or part of a family struggling with prices. The goal is to bring down prices for everyone.

This amendment addresses specifically those on Medicare. It has been said that the promise was made 37 years ago today that we would provide for older Americans and the disabled universal health coverage; they would know that health insurance, health coverage, was there for them. Unfortunately, because the way we provide health care has changed, that promise has been eroded; so we are trying to fix that, trying to modernize Medicare so it covers the way health insurance is covered today.

This amendment begins that process. It says to those in the category of up to 200 percent of poverty—and in my home State of Michigan, that involves 46 percent of Michigan's beneficiaries who are on Medicare—46 percent of Michiganians on Medicare will find that, without a monthly premium, without a deductible, with a very small copay of $2, or up to $5, they can receive the prescription they need, the medicine they need. No longer will they have to choose between food and medicine and paying the rent or paying the electric bill.

So we have accomplished one goal in this amendment right off the bat, which is making sure that those with the greatest need are not having to choose between the daily necessities of life and getting their critical medicine.

We then said that for everybody else, we want to make sure we start this downpayment with a discount. That discount will fall somewhere between 20 and 30 percent of the cost of a prescription. That is a good discount to begin the process of lowering prices and creating the kinds of prescription drug coverage that people need and deserve.

Then we have said that, for a simple $25 annual fee—I might say, this is not per month, per week, it is just once a year for $25—you can become part of an insurance policy that says once your out-of-pocket costs equal $3,300 for your prescriptions, you will then be able to get your costs covered. There will be, I believe, a small copay involved. But we are talking about the ability for people to—with a minimum of $10—be able to get coverage for any prescription drugs above $3,300 out of pocket a year.

This is a major insurance policy. There are many seniors who are paying $400 or $500, and some are paying more. I have read stories from constituents paying $700 or $800 a month, who are literally selling their homes, losing their retirement, and are not able to get the medications they need for cancer, for heart conditions, for diabetes, for a variety of other serious ailments. For them, we are saying that you are not going to have to go through that. We will put in place a maximum amount that someone has to spend out of pocket, and, beyond that, they are going to have their prescription drugs

covered. That is very important for those who are the sickest in the country.

So we have addressed both of those aspects—those who are struggling to meet the daily needs of life, those who are the sickest and have the highest bills and are finding themselves in extremely difficult situations. We are also making sure that everyone is getting their prices lowered through substantial discounts.

We have also guaranteed there are no new State costs, and we have addressed a number of other issues raised by colleagues on both sides of the aisle. I simply say again that this is a critical day to get something done.

You know, there are those who have accused folks on both sides of the aisle of playing politics, of just wanting to have an issue, of not wanting to get things done. Well, if that were the case, the votes were taken last week, the issues have been laid out. If that were all this were about, we would have ended it. But we know that people expect more from us. They are tired of talk, tired of another election coming around, with everybody talking about the high prices of prescription drugs and the need to modernize Medicare and still nothing getting done.

So this is an effort on both sides of the aisle to bring people together and do what we can do, to do the achievable, make the downpayment, to take the first step.

I hope we do not lose this opportunity. I believe this is a very important day—in fact, a historic day—for all of us, and hopefully we are going to see colleagues wanting to come together and showing leadership on both sides of the aisle to make an important step forward to begin to modernize what has been a great American success story called Medicare.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I am going to be very brief because Senator MIKULSKI and others wish to speak as well. I actually did not come with prepared remarks, but I do have a bit to say about my State of Minnesota. I will make one or two points and then thank some of my colleagues for their fine work.

There are 644,000 Minnesotans enrolled in Medicare. By the way, one of the reasons I am glad of what we are doing as part of the Medicare framework is that Medicare was an enormous step forward, not just for senior citizens but for our country. Senior citizens means we are talking about our parents or grandparents.

For my mother and father, who never made a lot of money, Medicare made an enormous difference. Both of them have passed away. Both had Parkinson's disease. My father had advanced Parkinson's disease. Medicare was a huge step forward.

A second factor, if you will, is the median income of senior citizens and the disabled enrolled in Medicare is $15,173 in Minnesota.

There is this stereotype about how you have all of these high-income senior citizens who are playing all the swank golf courses around the country. The fact of the matter is, the income profile of senior citizens is not that high. It certainly is not in my State. It certainly is not for the Medicare enrollees.

The impact of this amendment is 644,000 beneficiaries and 258,000 Minnesotans—that is 40 percent of the population—with incomes below 200 percent of poverty are going to be eligible and will receive all the needed drugs for nominal copayments. I do not have such intellectual distance from this issue that I think this is insignificant. That is important. That is very important.

Mr. President, 386,000 Medicare beneficiaries will be receiving the discount which could go from 20 to 30 percent. That is the estimate. Then finally, 119,000 senior citizens and disabled Medicare beneficiaries will benefit from the catastrophic coverage, and that is the catastrophic stop-loss protection.

Of course, it is an insurance policy that means a lot to people who worry: My God, we are going to go under because of catastrophic expenses.

I have two or three points to make. The first one is—and I hope Senator GRAHAM, Senator SMITH, and Senator LINCOLN, who have done so much work on this legislation, believe me—I would far prefer to have a broader, more inclusive piece of legislation. Senator STABENOW, who is leaving the Chamber, has also done tremendous work. I say to Senator STABENOW, I am sorry I did not mention her name from the go.

I would rather this legislation be much broader in scope of coverage, no question about it. We had a bill before us earlier, the Graham-Miller bill, on which we received 52 votes, but we did not get 60 votes. By the budget rules, we were not able to pass it.

We are trying to get 60 votes to pass legislation that will be a first installment. We have to do more. We have to have coverage of all recipients. It has to be broader coverage, and we know that. We are trying to make sure we get something done that is concrete and makes a positive difference in the lives of people. That is why we are here as legislators. That is what this effort is about. That is why it deserves 60 votes. That is my first point.

My second point is, if I have my way—I guess I get to say it once because I am not going to have my way with this proposal, and this would get not 60 votes, I say to Senator GRAHAM, but far fewer—I would have more cost containment so we could cover more people. I still believe—and I want to do a careful examination of how CBO makes some of its analyses—Health and Human Services ought to say to the pharmaceutical industry that has been making these huge what I call Viagra-like profits over the years: We represent 40 million Medicare recipients; we want a discount; we want the best price; we want what you give in Canada; we want the price you give to veterans.

We can get the prices down and cover a lot more people. Someday we are going to get to this whole question of cost containment because that is where this is heading ultimately.

My last point is, if you take this Graham-Smith initiative—and I thank all colleagues. I have been in some of the meetings. I cannot imagine the zillions of hours they have been in meetings. I have been in plenty of discussions.

If we add this to drug reimportation, albeit a little weakened on the floor of the Senate, and we add access to generic drugs, then we have this amendment and the Stabenow amendment that enables States to do better by way of Medicaid and by way of providing a discount for people who do not have any health insurance coverage at all for prescription drugs—if we put that package together, I would call this a significant first step. It is a first step only, but it is an important one. It makes a difference for people. Then we are going to have to build on it and do better in the future.

Last point—I promised that four points ago—I hope this gets 60 votes. I think it should. I think it is obviously an effort to stay under this $400 billion. That is another issue that drives me nuts. I am so glad I did not vote for these Robin-Hood-in-reverse tax cuts. They have eroded the revenue base and have made it impossible for us to make investments in education and health care. We are stuck now with this arbitrary number to keep it under $400 billion. We have done that.

We have tried to bring people together. We have tried to have a bipartisan initiative. We need 60 votes. I hope colleagues will vote for this so we can move forward. As for the naysaying—I am opposed; I do not like it; I do not want it—enough. Let's pass this and then improve it and then leave with legislation of which we can be proud as an important first step.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland.

Ms. MIKULSKI. I thank the Chair.

Mr. President, today I thought very long and hard making up my mind with respect to the legislation we are presently debating. I tell my colleagues that I am going to support the Graham-Stabenow plan.

The reason I am going to support this benefit is that it provides catastrophic coverage for those who have drug bills over $3,300 a year. For a $25 annual fee, it will provide catastrophic coverage for those who have prescription drug bills over $3,300 a year. This is absolutely essential to those seniors who have illnesses that cause them to pay this tremendous amount of money and who fear they could lose their life savings just to stay alive.

This benefit also provides a comprehensive benefit for seniors with meager incomes. For the middle class, it provides a discount, ranging from 20 to 30 percent, plus a 5-percent subsidy.

This bill has three parts to it: Catastrophic coverage, which I really like; help for those with meager incomes, which I think is a national necessity; and discounts for those in the middle class.

For those who worked very hard on this bill, I salute them. It is a beginning. It is the first step. It is a downpayment on a comprehensive drug coverage. But it cannot be the only step.

Today we are giving the middle-class seniors a discount card, but we cannot discount the middle class.

They are the ones who are going to get squeezed between shrinking savings and rising prescription costs, and they are the ones I will fight to help.

I think about ordinary Americans, those in manufacturing whose jobs are either on a fast track to Mexico or a slow boat to China, where they are afraid their companies, like my steelworkers, are going to go into bankruptcy and they are going to lose their pension, they are going to lose their health care. Then I think about the retail clerks who work in little shops, many of whom are in Baltimore, and in my little rural communities. Many of them work for 25 or 30 years, barely making the minimum wage, and though they had some savings, they are now just over the line in terms of qualifying for the benefit. Yet at the same time, we are going to give them a discount. I could go through example after example.

My preference was expressed last week when we voted for a universal Medicare coverage bill, one that was under Medicare, covered all seniors, no means testing, no deductibles, and modest copays. I supported that plan without reservation. We got 52 votes, a majority of the Senate, but we have a new Senate now, and the majority is not good enough. We now need to have a supermajority, or 60 votes, to waive the Budget Act. We did not get those last eight votes because some of my colleagues thought the benefit was too expensive to provide a universal prescription drug benefit.

Last year, many of those same colleagues who now say we do not have the wallet, were the first in line to pass excessive tax cuts. Those tax cuts went to the top 1 percent. Those who got it did not need it, and it certainly did not help the economy. When we were deliberating those tax bills last year, I knew this year would come. I knew we would come to the point where we would not have enough revenue to pass a prescription drug benefit.

I am really agitated about this because for many years, particularly working with President Bill Clinton, we exercised fiscal discipline. I personally worked for balanced budgets. I worked very hard to create a surplus, the first surpluses since the Johnson administration. Why did I work so hard? I mended old ways and old habits. Well, I worked because I knew it was going to be good for the economy and that also one day we would need it for a prescription drug coverage.

Instead, Congress gave the tax cut to the wealthiest, those who live off of expense accounts, while I worry about the middle class who have to live off a budget.

So we cannot afford it? I am not so sure about it because when we have the will, we often find the wallet. Today is not the day where we are going to be able to find that wallet. I believe with the catastrophic coverage for those with the situation over $3,300, we do take a very important step. I think the sensitivity to those meager incomes is what we in America should be all about.

For the middle class, we get them started, but we need to let them know we have to be able to do more.

The limited coverage bill that I am supporting today is not everything I wanted, but it does give seniors peace of mind that an illness with huge drug bills will not push them into financial ruin. For that $25 annual fee, there will be catastrophic coverage.

For some time, the whole issue of the consequences of health care has been an obsession of mine. I know the costs of long-term care. I know that when I came to this Senate the cost of nursing home care was enormously expensive, but to qualify for Government help under Medicaid families often had to push themselves into family bankruptcy, couples made out better if they divorced, or seniors were forced to spend down their savings to get help for nursing home care. Widows were impoverishing themselves so their husbands could qualify for Medicaid and nursing home care. I said then, as I say now, I believe in family and personal responsibility but not family bankruptcy because of the cruel rules of Government. The cruel rules of Government should not force people into family impoverishment.

When it came to long-term care, I wrote something called the Spousal Anti-Impoverishment Act. I made sure the senior could keep the home or the family farm and some savings to get help when a spouse was in a nursing home. That was a very important step. I hope we can do more.

Today, seniors are worried about going broke for their prescriptions. This limited coverage will help lift that fear and ease the burden of many seniors. For that catastrophic coverage alone, this bill is worth voting for.

In closing, later on this week the Senate will be voting on legislation to defend the homeland. It is called homeland security. But I ask, What does the ''homeland'' stand for and what are we trying to make secure?

I absolutely salute our military, law enforcement, and intelligence agencies that are working against terrorism, but I have senior citizens living in terror of whether they can afford their prescription drugs.

I believe not only in universal freedom, I believe in universal public education, and universal health care for seniors. If we want Americans to live free from fear, we need to take the fear away of losing their savings and not keeping up with the cost of prescription drugs. Today is a downpayment. We must do more. I intend to vote for this bill today and return to find other alternatives later.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas.

Mrs. LINCOLN. Mr. President, I rise in support of this amendment, which I have been proud to promote over the last couple of weeks. I want to especially thank Senator BOB GRAHAM of Florida and Senator GORDON SMITH for their leadership in drafting this amendment. The hours and the patience that they have put into this is forthcoming in what we have been able to produce.

I also want to express my appreciation to Senator BINGAMAN for his guiding vision and the eloquence with which he first offered this proposal to our colleagues in meetings last week, and to Senator DEBBIE STABENOW. If we could harness the kind of energy, dedication, and commitment that Senator STABENOW has for our seniors in providing them a quality prescription drug benefit, we would certainly be doing our job for the benefit of the seniors in this country.

I also thank Senator FEINSTEIN who has been very instrumental in making sure that we do not adjourn without helping low-income seniors and those with the highest drug costs. This amendment is the product of many long hours of discussions among many of these Senators and so many others who bridge the spectrum of political philosophies in this body, and I believe that it represents the deliberative process envisioned by our forefathers for what the Senate was intended to do.

Through this debate, I have been firm in my conviction that we must help as many seniors as possible this year—not next year, not the year after, but this year. This amendment allows us to help everyone while providing the most help to the neediest and the sickest.

We have had two opportunities to vote on more expansive prescription drug packages, and I was pleased to support an amendment offered by Senators GRAHAM and MILLER that would have done far more for our seniors. Regrettably, that package did not garner the 60 votes needed to overcome a Senate procedural rule. So we stand today with a new opportunity that I believe offers the best hope for Arkansas seniors.

I have said all along we must help the neediest and the sickest of our seniors and provide drugs at a reduced cost for those in between. I am not willing to tell seniors, who spend more than $3,300 a year on drugs, that we

cannot help them this year. I am not willing to tell the seniors who struggle to live on less than $1,500 a month for their rent, groceries, utility, and health care costs that we cannot help them this year. So I am proud to support this amendment, which will ensure that seniors who are at or below 200 percent of the Federal poverty level will get prescription drugs through Medicare.

For all seniors who spend more than $3,300 a year on drugs, I want to be able to say to those seniors: Stop worrying. The Government will cover the rest of your prescription drug costs with a minimal copay.

What does this mean for the seniors of Arkansas? It means a great deal. Under this plan, one of every two seniors in Arkansas will have all of their prescription drug costs covered under Medicare with a minimal copayment. There will not be any additional paperwork as part of this program, and there will not be fees to enter the program. If you are on Medicare, you can be automatically enrolled in the prescription drug program. That should be welcome news for the 56 percent of Arkansas seniors whose annual income is below the 200 percent of poverty level.

For those individuals who have annual incomes above $17,720 and those couples whose income is over $23,880, there is also a benefit. In addition to the peace of mind that will come from knowing the Government will cover drug costs that exceed $3,300 a year, these seniors will also benefit from drug discounts negotiated by the Government and a 5-percent subsidy. Drug costs could be reduced by as much as 30 percent.

I wish we could do more for this group of seniors, and I publicly pledge to keep pushing until we have done so. Is it an ideal benefit? No, but it is a start. I have always said in this body that legislation is not a work of art; it is a work in progress. That is what this body was intended to do, to deliberate and work through these issues to come up with a solution.

Last week's votes were like a flashing neon sign declaring it is not possible to get a more generous drug benefit this year. A 5-percent subsidy negotiated drug discount and a catastrophic benefit for middle- and high-income seniors is better than no benefit at all, especially considering the ever increasing costs of prescription drugs, an issue we will have to address. We will have to continue to address the ever increasing costs of prescription drugs in the years to come and the cost of what it is going to mean to us and the seniors of this Nation.

We must also remember and never underestimate, with the out-of-pocket limit for all seniors in this proposal, we will be providing for the initiative to bring down the costs of employer-sponsored plans, as well as any supplemental plans, such as Medigap or others. That is a real savings and a benefit to all of these individuals who need prescription drug coverage.

I thank John and Betty Scroggins of Monticello, AR, who took the time over a series of phone calls with my staff to share their health care struggles. The Scroggins are now retired. They worked all of their lives driving trucks. After they pay their drug bill each month, they have less than $1,000 to cover utilities, groceries, and other living expenses. For John and Betty, under this plan, the Government will pay for all of their prescription drugs with a minimal copay.

I also thank Lila Lee Moore, a volunteer social worker at a health care clinic in Little Rock, who told me about a couple whose Social Security income is $1,100 a month but their drug costs exceed $800 a month.

I also send a very special thank you to 18-year-old Jessica Mann of Jonesboro, AR, who wrote asking me to help her grandparents who struggle just to make ends meet due to the high cost of medical care and prescription drug medicines.

Jessica said: I believe that when people such as my grandparents have worked hard their whole lives, they deserve a better and less worrisome time in their retirement years. They have given so much to make it better for my generation, please help us to make it better for theirs.

Each of these people have helped me form the template against which I have measured these prescription drug proposals. The amendment before the Senate helps meet these needs. We are talking about moving forward on behalf of the seniors of this Nation, not saying, once again, that we are going to put it off for another year or another day, but that we are bound and determined to do what we can to make each and every one of their lives a little bit better.

I urge my colleagues to support this amendment and help the Senate move forward in the efforts on behalf of the seniors of this Nation.

I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. I thank my colleague and friend for his courtesy.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. Mr. President, I am here to support my colleague from Florida and to thank him for his leadership, which has been bipartisan in nature. It reflects the bipartisan yearning and desire of the people of this country, and particularly of our State.

Most people understand that Florida has a higher percentage of those over age 65 than the rest of the country. That is true. But wherever you are, age 65 and older, there are seniors who are facing choices in the year 2002 that seniors should not have to face. The choice that many seniors have to face is: Do I buy groceries or do I buy medicine?

It is unimaginable to me that in this land of plenty, in this time of abundance, in this land of beneficence, in this land of great generosity, that we have among us, the generation that we owe so much to, our seniors, the generation that has built the strong economy upon which all now enjoy, the generation that has reestablished and secured the freedoms with which each of us participate in each day and sometimes takes for granted, it is unimaginable to me in the year 2002 that of that great generation there are those who would have to make a choice—because they cannot afford it—between buying groceries to eat and the medicine they need on a daily basis.

Why are we trying to do what we are trying to do? It is because Medicare was set up 37 years ago when health care was centered around acute care in hospitals. If Medicare had not been set up in 1965, but instead, if we were designing a system which would take care of senior citizens by designing a health insurance plan funded by the Federal Government for senior citizens, would we include prescription drugs? The answer is, obviously, yes, because prescription drugs are so much a part of our health care today, so much a part of our quality of life, so much a part of the miracles of modern medicine that give us a greater quality of life. So if that is how we would design it, and yet it was designed 37 years ago, should we not modernize that system? The answer to that is, obviously, yes.

Then it comes to a question of cost. And if the cost is such that we cannot get through this Senate because we have to operate with 60 out of 100 votes in order to pass anything, and we got to 52 votes with Senator GRAHAM's and Senator MILLER's amendment—that was a much more comprehensive plan than trying to find a plan that we can fashion, that we can get 60 votes to get it through this Chamber, this is what we have come up with. Some would say it has two prongs, but it really has three. There is the one that would take care of the most poor; i.e., it would take care of those up to 200 percent of the poverty level. They would have a fully funded Medicare prescription drug benefit. It would also take care of those the most sick. It would take care of the most poor and the most sick, the most sick being those stricken by a catastrophe, who have to spend a lot of money out of pocket. When they get to a certain level, a level in excess of $3,000 out of pocket, the Federal Government is going to take care of that, and, indeed, you are going to be able to buy that protection for $25 a year. That is called catastrophic coverage, and that is a pretty good deal.

There is a third element, or prong, to this amendment. Those who would detract from this amendment would say it doesn't take care of the middle class. It certainly doesn't take care of the middle class as much as the original amendment offered by Senators GRAHAM and MILLER, but of course that costs a lot of money. What does this do

for the middle class besides the catastrophic coverage for $25? It has a system in place that will have discounts up to 30 percent of the cost of those drugs, through a system designed to use bulk buying, plus an additional 5-percent reduction by virtue of a Federal subsidy.

So it takes care of the most needy—that is, the poorest—by taking care of those with incomes up to 200 percent of the poverty level. It takes care of the most sick—when we have a catastrophic illness—for $25 a year, for anything out of pocket over something just in excess of $3,000 per year it takes care of that. And for everybody else it clearly reduces the price, up to 30 percent plus another 5-percent subsidy.

That is not everything we want. That is not a total across-the-board prescription drug benefit under Medicare. But it is clearly a step in the right direction so we go about doing what we need to be doing: Modernizing Medicare that was set up 37 years ago.

That is why I rise to add my voice to the support for this amendment and encourage its adoption.

I yield the floor.

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

Mr. BREAUX. Mr. President, I rise to make a couple of comments—I will not be that long—on the pending business, prescription drugs. It was said before that this is sort of a unique day in the sense that this is the 37th anniversary of the signing of the Medicare Act back in 1965. What we did in 1965 was unique. It was very important. It was very special. What we did in 1965, with Medicare, was to say: We are going to establish a Medicare Program for our Nation's seniors that is going to be comprehensive. It is going to cover all seniors. It is going to be universal, in the sense that all seniors will be eligible for the same benefits under the Medicare Program. So we had a program that said to every senior: We are going to cover you. Regardless of where you live, regardless of your status in life, you are going to be covered for hospital care and other related conditions as well.

We should have, at that time, added prescription drugs. Congress did not. Prescription drugs were not as important in 1965 as a hospital bed was in 1965. So Congress, in its wisdom, at that time said we are going to provide comprehensive coverage for hospitals, and later on it became also coverage for doctors and physicians as well.

The unique feature about that bill is that it covered everybody and it treated everybody equally. I think when you look at a proposal we have before us today that says this program is going to be fundamentally changed. In the sense that it is no longer universal, it is no longer comprehensive, we are going to pick and choose who gets what, and different people who are eligible for Medicare will get different things—I think that is fundamentally breaking faith with the American people who, when they look at Medicare, think of it as being universal and comprehensive. That is the first mistake.

Many people who talked about the tripartisan bill—some of our colleagues on the floor, some in the private sector—said we don't like the tripartisan bill because it has a gap. They called it a doughnut. The gap in the tripartisan bill was between $3,450 worth of drug expenses and $3,700 of prescription drug expenses. If you were poor, you still got your drugs taken care of through that gap, but if you were not under 150 percent of poverty, you did not get coverage in that relatively small gap between $3,150 and $3,700. Why? Because of the extreme cost associated with covering even that small gap.

The point I made is that many people who were critical of the tripartisan bill said: You have a gap, so we can't support it. If we had a gap, this plan has a canyon, because it says to the Nation's seniors: If you are under 200 percent of poverty, we will cover your drugs, but if you make one dollar more, you are in a different category.

I think the figures I have seen indicate it is approximately $17,720 of income as an individual. I think is the number. But if you make one dollar more than 200 percent of poverty, you are in a totally different category, you are in a category that says you have to pay about 95 percent of the drug costs. Ninety-five percent of the drug costs? What kind of help are we giving to someone who makes one dollar above 200 percent of poverty?

One of the charts I saw said 70 percent of seniors are over 200 percent of poverty. Are we going to say to that group of seniors: Somehow you are going to be treated differently than anyone else the Government treats under Medicare because you make one dollar more than 200 percent of poverty? You are going to be required to pay 95 percent, and the Federal Government will pick up 5 percent of your drug costs? Is that fair? That is not what we did in 1965 when we said everybody would have comprehensive, universal coverage and access to a health care plan.

That is not an insignificant number of people you are talking about. I looked at some of the statistics with regard to how many people you are talking about. In my State—and my State is a poor State—it is about 230,000 people making over 200 percent of poverty. What am I going to tell the seniors in Louisiana: If you are poor, you are going to get all this help, but if you make one dollar more, excuse me, you are out of luck?

What are they going to say? They are going to say: I paid taxes all my life, I worked hard all my life, but now, for the first time under Medicare, you are going to treat me differently than anybody else? My State is a poor State, and 230,000 people would fit into that category of being outside of 200 percent of poverty.

Now I have the numbers. In the United States, nationwide—these are the numbers from the Kaiser Family Foundation—there are about 18,450,000 seniors who are eligible for Medicare who are outside the 200 percent of poverty—18 million people plus. We are telling those 18 million-plus seniors they are going to be treated quite differently when they are called upon to pay 95 percent coinsurance on their prescription drugs. Are we telling them that we are giving them something? We are not giving them what we are giving other parts of our society who are seniors. These are working people who have paid taxes and in their retirement think, if you are going to have a National Government program, they should be treated like everybody else.

The 200 percent of poverty is nice to talk about—how many people we are helping. But a substantial portion of the 200 percent under poverty are already covered with prescription drugs under the Medicaid Program. At about 75 percent of poverty, you have coverage under Medicare for prescription drugs already. They already have prescription drugs under the State Medicaid Program. If you are about 75 percent of poverty, in my State, you are covered for prescription drugs—the poorest of the poor.

So we are really saying: Between 75 percent of poverty and 200 percent of poverty, we are really going to give you a great deal of help. But if you are over 200 percent of poverty, you are out of luck.

They say we have a catastrophic plan. I am all for catastrophic coverage. It should be there. But let's be honest about how many people it covers.

If you look at $3,300 of catastrophic coverage where the Government picks up the lion's share of 90 percent—I take it, in their plan—of the cost of drugs after you reach the $3,300 out-of-pocket costs, how many people is that? I am told approximately 10 percent of the seniors are going to have actual out-of-pocket costs of $3,300 and above on an annual basis, not including insurance, not including a union package, not including a former employer's package, and not including any Medigap coverage they have.

If it has to be out of pocket $3,300, you are talking about approximately 10 percent of the remaining number of seniors. What do we have? We are spending almost $400 billion, and we are selectively saying some are going to get it, some are not going to get it, and some are going to get a little bit more.

The tripartisan bill had about $370 billion of Medicare reform, plus prescription drugs—$340 billion on prescription drugs. That was universal and comprehensive and at a $24-a-month premium. It had a $250 deductible and 50 percent coinsurance. Everybody was treated alike. Everybody would know what they were going to get and how they were going to get it.

Some say: We want a Government-run program. We want private insurance companies delivering prescription drugs.

What are we coming to? It is the exact same system that I have as a Member of the Senate and that 9 million other Federal employees have. Do you think we do not have a Government-run health program? Of course it is a Government-run program. It is run by the Office of Personnel Management—a Federal agency that goes out and solicits bids from private companies, such as Blue Cross and Aetna, to provide 9 million Federal workers with comprehensive, universal health coverage which includes doctors, hospitals, and, yes, it includes prescription drugs.

We are talking about saying that these providers who are big, healthy insurance companies ought to assume some risk. Why do we say that? Because if they are doing the providing and they make a bad deal, they should have to pick up the cost of making a bad deal. That is the risk. That is what makes them negotiate with pharmaceutical companies, to get the best possible deal from pharmaceuticals for prescription drugs at the best possible price.

If I am a pharmacy benefit manager—so-called PBM—and I have no risk other than my contract, why am I worried about what type of price I get for prescription drugs if I know the Government is going to eat the cost of anything over what I bid? There is no risk. If there is no risk, there is not going to be any incentive to go out and get the best possible deal on prescription drugs.

But to get back to the program that we have, some of my colleagues say we have to have a Government-run program. The Government-run program we have as Federal employees is exactly the same program we have recommended under the tripartisan approach. The Office of Health and Human Services' Medicare office would contract. They would do the approvals. They would supervise it. They would make sure it was being run properly. They would make sure no one was trying to scam it. And they would make sure that every part of the country had a competitive model to deliver drugs in their area.

Some have said: I am from a rural area. We are not going to have a lot of private companies coming to the most rural part of the country. We said: All right, we understand your concern. We will modify our bill. We will say that if there is a rural part of the country or any part of the country where you do not have private providers competing to bring prescription drugs to individuals at the best possible price—if that doesn't happen in your area—the Federal Government will do it just as under the Graham model. The Federal Government will contract with the PBM. They will have only the management fee at risk when they have that provision for those drugs. And in the most rural areas, you would be guaranteed a Government-run program just like in the Graham model, if you did not have the private system to be available because they just did not want to go to any part of the country.

As to the concerns that have been expressed about wanting a Government-run program, ours is a Government program that utilizes the best of what Government can do combined with the best of what the private sector can do.

Some on their side of the aisle may say we only need a private sector program. Some on my side of the aisle may say we need a Government-run program. The answer truly is somewhere in between. You need the best of what Government can do merged with the best of what the private sector can do in order to get a delivery system that would have Government oversight, Government supervision, and Government guarantees when the private sector does not participate to make sure the beneficiaries get the product. That is what the tripartisan bill attempted to do.

The final point I will make is that this fight is not over. This proposal, our tripartisan proposal, and the previous Graham proposal—none will have had 60 votes. The fact is that we are not going to be able to do anything unless we find a way to get 60 votes to provide prescription drugs. For the past several years, we have been giving seniors excuses. I daresay this time we are going to give them one more excuse.

The Republicans will say: It is the Democrats' fault that we didn't get this done. The Democrats will say: No. It is the Republicans' fault that we didn't get this done. What we will have given seniors once again is a bucket of excuses. They can't take those excuses to a drugstore and buy one prescription.

It is time that we as Members of Congress try to recognize we have to combine the best of ideas from both sides of the aisle and come up with an agreement that can get the job done. We are dedicated, and we will continue to work in that direction.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, before the Senator from Louisiana leaves the floor, let me just say we have people on both sides of the aisle—especially on this side of the aisle—who look to him for guidance. He knows these numbers, having been a member of the Finance Committee as long as he has, and having served in Congress for as long as he has—both in the House and in the Senate. He does commendable work. His work on this legislation is no different.

Mr. President, the Republican leader is going to be here shortly, I am told.

How long does the Senator from New Mexico wish to speak?

Mr. BINGAMAN. About 6 minutes.

Mr. REID. When the Republican leader shows up, we certainly will——

Mr. GRASSLEY. Can't we go back and forth?

Mr. REID. I don't know. I guess whoever gets recognized. How much time is the Senator talking about?

Mr. GRASSLEY. About 7 minutes.

Mr. REID. Mr. President, I ask unanimous consent that the Senator from Iowa, the ranking member of the Finance Committee, be recognized for 7 minutes; following that, the Senator from New Mexico be recognized for 6 minutes; and following that, the Senator from Texas be recognized forever.

(Laughter.)

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

Mr. REID. I see my colleague from Nevada. I ask unanimous consent that he follow Senator GRAMM.

I ask for the courtesy of both Senator GRASSLEY and Senator BINGAMAN—that when the Republican leader appears, they allow us to move forward with an important unanimous consent agreement.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I rise to oppose the amendment before us. For the third time in as many weeks, a mostly partisan Democrat prescription drug bill is about to fail on this floor. And beyond failing here, today's amendment, from what I've heard of it, fails seniors and taxpayers as well. I still haven't seen the bill language itself. But from what I've heard, it fails seniors because it fails to cover most of them. From what we know of the proposal—and we are only this afternoon getting the details—most middle income seniors will get next to nothing when it comes to prescription drug coverage.

My friends on the other side of the aisle have accomplished quite a feat—they have managed to write a Medicare prescription drug proposal that does less with more money. Their proposal provides generous coverage to beneficiaries below 200 percent of poverty. There is nothing wrong with that. I agree that scarce resources should be used wisely by Congress to target money where it is needed the most.

However, their proposal provides almost no assistance to Medicare beneficiaries whose incomes exceed $18,952 a year. A senior at 201 percent of poverty will receive no meaningful coverage under the Graham proposal until she has spent 17 percent of her income on drugs. A married couple at 201 percent of poverty will spend 25 percent of their annual income on drugs before both gain catastrophic coverage protection. To make matters worse. Three-quarters of seniors above 200 percent of poverty have other prescription drug coverage. Since these plans cover some drug expenses, and because the Graham plan does not have a basic benefit, these folks will receive no help even if they have total drug expenses over $3,300. A typical senior above 200 percent of poverty will receive approximately $6 of assistance every month

toward their prescription drug expenses.

The Congressional Budget Office has given Graham a preliminary cost estimate of $389.5 billion. Keep in mind, though, that CBO did not have legislative language to review at the time they completed their cost estimate. So, depending on what legislative language is included in the Graham proposal—it could cost more than $400 billion.

The tripartisan bill with an official CBO cost estimate of $370 billion provides a solid benefit for all Medicare beneficiaries. Lower-income enrollees are provided with additional protections, which, as I said before, is appropriate.

What the tripartisan bill has that Graham does not is a significant drug benefit for every single Medicare enrollee. Under our 21st Century Medicare Act, enrollees will save on average 50 percent off their drug bills. And, lower-income enrollees will see a 95 percent savings in their drug bills.

The Graham bill fails these people. It fails them badly. Indeed, these failures amount to a massive failure for this body. Under Senator DASCHLE's leadership, Democrats and Democrats alone have tried to write partisan legislation on the Senate floor time and time again this summer.

That has gotten us nowhere. It has led to chaos, to partisanship and, as I said just a minute ago, to failure.

So, where are we now? It looks like we are ready for another mostly partisan vote on a pretty much partisan bill—another vote that will fail to get 60 votes, and will fail to give seniors the help they need.

We could have been somewhere far different from this. The House passed a bill. We could have been in conference with the House at this point. The President wants a bill. We could have been in the Rose Garden. Senator DASCHLE says he wants a bill, but what has taken place here over the last 3 weeks means he really wants something else: an issue.

Had regular order been followed, had the Finance Committee been given the right to work its bipartisan will, we could have had far more than just an issue. We could be far closer to providing real, affordable and universal prescription drug benefits than we are today. The sponsors of the Tripartisan bill, the only bipartisan bill in all of Washington to provide comprehensive, universal coverage on at a cost that is far lower than that in the amendment before us now, were ready and willing to talk to anyone about compromises. We still are.

But we were denied the right to a markup in the Finance Committee. I believe that if it had been given the chance to work its will, the Finance Committee would have reported out a bipartisan proposal, based on the tripartisan 21st century Medicare Act we introduced earlier this month.

I've said it before, everyone in this chamber knows that for anything of this magnitude to pass—and adding a prescription drug benefit to Medicare is the single greatest entitlement expansion in history—it needs to get 60 votes.

And everyone in this chamber knows that the only way to get 60 votes is to have bipartisan support. The proper place to find bipartisan support is in the Finance Committee, not on the Senate floor.

By bypassing the Finance Committee entirely and doing drafting on the floor—literally on the backs of envelopes—the Democrat leadership has led us to where we are today: In shambles.

Mr. President, I urge my colleagues to sweep up the shambles on the Senate floor and start over. We can and should do better.

I ask unanimous consent that a statement by several organizations be printed in the RECORD.

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

JULY 29, 2002.

THE GRAHAM-SMITH PROPOSAL: CHANGING THE NATURE OF MEDICARE IS NO WAY TO CELEBRATE THE 37TH ANNIVERSARY OF MEDICARE

To: Members of the United States Senate:

On June 14, 2002, our organizations sent a letter to Chairmen Tauzin and Thomas in support of their Medicare legislation. We were very clear when we gave our support that our goal was to ensure a voluntary prescription drug benefit which would be available to all Medicare beneficiaries.

The Graham-Smith low-income/catastrophic amendment provides complete drug benefits for only the very poor. The Washington Post reports that ''millions of seniors 'in the middle' would not qualify for any prescription drug benefits at all under the Graham-Smith legislation.'' In short, the middle class would, in fact, receive no meaningful coverage under the Graham-Smith amendment. This means test violates the fundamental principle of Medicare social insurance that it is a universal program, not an anti-poverty program. It is ironic that on the same day that America's senior celebrate the 37th anniversary of the enactment of Medicare (July 30, 1965), the United States Senate will be considering a proposal that takes us a very significant step away from the general entitlement that Medicare has always been.

The passage of such legislation would change the nature and intent of America's 37-year-old Medicare program. We respectfully ask you to oppose this amendment and enact meaningful prescription drug coverage which would give all Medicare beneficiaries access, coverage and choice.

American Osteopathic Association, Kidney Cancer Association, Cancer Research Institute, Pancreatic Cancer Action Network, Pulmonary Hypertension Association, Center for Patient Advocacy, Endocrinology Associates, National Coalition for Women with Heart Disease.

UNANIMOUS CONSENT AGREEMENT—S. 812

Mr. DASCHLE. Mr. President, I ask unanimous consent that notwithstanding the provisions of rule XXII, the Senate at 9:30 a.m. tomorrow resume consideration of S. 812; that there be 90 minutes for debate on the motion to waive the Budget Act with respect to Senator GRAHAM's amendment equally divided between Senator GRAHAM and Senator GRASSLEY; that if the motion to waive fails and the amendment falls, then the underlying Dorgan amendment be agreed to and the Senate vote immediately on cloture on the generic drug bill, S. 812; further that if cloture is invoked, the bill be read a third time and the Senate then vote immediately on final passage of the bill, with the preceding all occurring without any intervening action or debate.

The PRESIDING OFFICER. Is there objection?

Mr. GRAMM. Reserving the right to object, I suggest the absence of a quorum.

The PRESIDING OFFICER. The Senator does not have the floor.

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. DASCHLE. 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. DASCHLE. Mr. President, I again propound the request.

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

UNANIMOUS CONSENT AGREEMENT—EXECUTIVE CALENDAR

Mr. DASCHLE. Mr. President, as in executive session, I ask unanimous consent that later today when the Senate considers the nomination of D. Brooks Smith to be a U.S. circuit court judge, there be a time limitation for debate of 4 hours equally divided between the chairman and ranking member of the Judiciary Committee; that at the conclusion or yielding back of the time, the Senate return to legislative session; that following the vote on final passage of S. 812, the Senate return to executive session and vote on confirmation of the nomination; that the motion to reconsider be laid on the table; the President be immediately notified of the Senate's action; and the Senate return to legislative session; and that the preceding all occur without any intervening action or debate.

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

Mr. DASCHLE. Mr. President, it is also then my intention to invoke the authority given Senator LOTT and I last week with regard to DOD. It would be my intention to move immediately to the DOD appropriations bill, and we will seek a time agreement on that, perhaps sometime tomorrow morning. Let me thank all of our colleagues for their cooperation and I certainly thank the distinguished Republican leader.

Again, let me outline the schedule, as a result of these unanimous consent agreements, tonight and tomorrow.