Boys Nation, a conference at Marymount University just outside of Washington, DC. After the conference ended, he came up to my office to say hi to everybody because he made great friends here. I was fortunate enough to be having a party for my summer interns at my home that night. We were having a barbecue at the house, so I invited Josh over to join us. He fell right in with this group of new Alaskans he hadn't met, but by the end of the evening it was obvious everybody enjoyed him as much as I had. It was a wonderful conversation. We were talking about what it is he wanted to do when he grew up, where he wanted to go next. He actually had aspirations of attending my alma mater in Washington, DC, which is Georgetown. Josh was in the process of applying to the university.

What he really wanted to do was return to Washington, DC, to continue his passion for politics. He had seen so much, he had observed so much, and was so stimulated by what he saw around him that he wanted to come back and make a difference. I have no doubt that were he able to, he would have done just that.

In addition to being a great young man everybody liked, he was a great student. He was at the top of his class, ranking 15 out of 262 seniors. He scored over 1500—actually, 1510—out of a possible 1600 on his SAT exam. He was an incredible singer. I had the privilege of being serenaded, if you will, by his singing choral group in Fairbanks. I looked over and said, wait a minute, don't I know that boy from somewhere? It was during the summer months. He left DC as a page and he was then back in Fairbanks. I looked over and I thought, wait a minute, that is Josh. What is he doing singing like a bird. It was beautiful, just gorgeous.

Josh was a dynamic young man, a gifted young man who had a future that I think we can look to and say he was making a difference. It is a tragedy Josh's life was cut short. He was truly an extraordinary young man who brought so much joy and so much pleasure to everybody who was around him. I personally feel blessed to have known him, to have been able to share some of his short time with him. I ask that we remember his friends, and particularly his family, who are grieving for this loss at this particular time.

But as we reflect on the life and contributions of a young man such as Josh Boycott, I suggest all those who are able to serve us here as pages in the Senate look at this as a gift, an opportunity to be in a place of service, to be in a place where you can learn, and you can give back so much at a later point in your life.

So, again, I am blessed to have known Josh. I know many in this Chamber feel the same way. I mentioned yesterday in the cloakroom that I was going to be speaking about Josh, and everyone in the cloakroom remembered him. He has been gone from the Senate Chamber now for over 6 months. All the Senate pages look alike—in terms of their dress, that is—yet Josh had distinguished himself.

So it is with great love and respect that we pay tribute to this fine young man and to his family during this time of mourning.

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

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

PRESCRIPTION DRUG BENEFIT

Mr. FRIST. Mr. President, health care affects each of us in very personal ways. As a physician, but also being majority leader, people will come to me and ask: What are you doing about this particular health care issue? It might be a senior who asks: Why don't I have access to prescription drugs as I did when I was 60 years of age and employed by a company, and all of a sudden it disappears when I go into Medicare?

That is the type of question to which this body has responded and, indeed, we have passed a prescription drug benefit appropriately coupled with health care—Medicare specific—modernization, in the sense that it brings the Medicare Program up to today's standards, the type of health care to which other people have access.

We are addressing in the conference between the House and the Senate this Medicare prescription drug package. We had two meetings today with the various conferees, in a bipartisan way—the House and Senate together working through the details of marrying the House and the Senate bill. I am absolutely confident that under the leadership of Chairman Bill Thomas in the House and Vice Chairman Chuck Grassley in the Senate that this conference will deliver a bill in October that will accomplish that goal of health care security and access to prescription drugs for all seniors.

People also ask me: What about those people who do not have access to health insurance, those people who are not in Medicare at all? Medicare is our program for seniors and individuals with disabilities. What about those who are not in Medicaid, which is our unique Federal-State partnership through which health care is delivered for the underserved and the impoverished or poor of the Nation? What if one is not in an employer-sponsored plan as I mentioned?

Most people who are not in Medicare and Medicaid, the overwhelming majority get their health care through employer-sponsored plans. What if somebody is not in one of those plans today? What if one is not in the SCHIP program, the program that originated in our Congress that reaches out to children predominantly run by States, or if one is not in a Government program or not in the private program and thus uninsured? What are you doing, Senator FRIST, and what will you do?

This week, the Census Bureau confirmed what many of us felt and feared, and that is that the number of people without health insurance increased last year to over 43 million. That is about one out of every seven Americans under the age of 65. That represents a 5.7 percent increase over 2001. So the uninsured number is increasing, and there are a lot of reasons why. We have talked in our various conferences and committees and debated why that number is increasing. One can parse the statistics and numbers and say that is how many do not have insurance over a period of time, and 6 months later many of them will have insurance.

Putting all that aside, I argue that the uninsured are among the greatest health care challenge we have in the United States of America today. Thus, I believe we have a real obligation not to say we have so much else going on that we cannot address that but that we do have really a moral obligation to address this issue of the uninsured and to do it in a systematic way.

As I mentioned before, very much of our focus has been on Medicare today. I will mention shortly some of what we have been doing with regard to the uninsured, but there is still a lot we need to be doing. If we step back and look at our economy, although the economy itself is improving—and maybe not as quickly as a lot of us would like, but the economy is getting better each day—in spite of that, the budget pressures at the State level and the job losses from last year combined in a very complex way to increase the number of uninsured to 43 million people. To me, this is one of the most daunting health challenges—I would say it is even beyond health policy challenges—that we have affecting our Nation.

I say that in part because of personal experience. I have had the opportunity to treat Medicare and Medicaid patients and the uninsured through the transplant program in which I had the opportunity to participate in Nashville. Both in the acute care and in the chronic care, it is obvious that if one has no health insurance, no help with being able to access health care with a lowered financial burden, one's quality of health care suffers. It is not as good as the health care of people who have some type of insurance, private sector or public insurance.

The uninsured are four times less likely to receive dental care and necessary medical care. They are five times less likely to obtain prescription drugs. They are four times more likely—and this really makes sense—to access the emergency room for routine care rather than the more efficient, and arguably more effective, channels

of being able to see a physician or go to a doctor's office.

The lack of affordable health care is also one of the key factors that affects what we call health care disparities among the underserved or minorities themselves; that is, where a person of one race has different health care outcomes than those of another race or one socioeconomic level versus another socioeconomic level. It does not explain it all, but it is clearly one of those variables we can affect, and we have to do it in a coordinated way because our health care system in America, which is the best in the world, no question about it, overall health care in the United States is of higher quality than anywhere in the world.

If we do look at the numbers that were released this week, they were a year old, and since they were compiled—because they are historical data, being a year old—the economy has improved over that year, and indeed almost all economists expect that, depending on how one looks at the statistics, we will have annualized growth of nearly 4 percent in the coming months. It may go higher than that and come back down a little bit, but we will have good, significant growth in the coming months.

Indeed, the Associated Press this week reported:

> America's consumers, flush with tax cuts that left them with extra cash in their wallets, ratcheted up their spending by a strong .8 percent in August, helping to power an economic resurgence.

So I think we are seeing improvements in our economy. That is only just beginning to be reflected in jobs. We did have encouraging news earlier this morning from the Labor Department that U.S. companies show a net increase of 57,000 jobs. That is good news for the economy, but also that is good news overall for health insurance or medical insurance. Why? Because most Americans in this country get their health care through their employer, through jobs. Thus, as we grow the economy and add jobs to the economy, we do have an expansion in medical coverage.

While the recovery takes hold, it is clear that we have an obligation to respond with policies and that as we look at the future agenda in health care, we need to focus on the uninsured.

Some of what we are doing now in this body, in response to what we recognize is a major problem and one that is growing, are the following: Last month, the Senate passed the Labor, Health, and Human Services appropriations bill. In that bill, we had $1.6 billion for community health centers. We met the President's request for an additional $122 million in funding over last year, which was an increase over last year. This response by this body enables us to move toward the President's goal of enabling community health centers to serve an additional 6 million patients by the year 2006.

We all have community health centers in our States, districts, and regions, and we know the vital role they play in reaching out to the underserved or those without health insurance today.

I say we all know, and I say that in part because I have been so involved in health care issues, being a physician, but I think we need to shine a light on them. They serve a tremendous need and respond in an innovative, flexible way that is locally driven, which is something that cannot be praised enough.

Second, as I said, many people get their insurance through Federal programs or joint Federal-State programs. There is a program called SCHIP. Basically when you hear SCHIP, think health care for children. In July, the Senate fulfilled the President's request to extend the availability of $2.7 billion in Federal SCHIP funds that either expired at the end of 2002 or will expire in the current fiscal year. These funds will be available to allow States to continue the program without which, if we had not acted, as many as a million children would have lost health coverage. That has now become law.

In addition, in terms of looking at what we are doing, focusing on this whole issue of the uninsured, if you look to the jobs and growth package, the 2003 jobs and growth package that we passed—people always talk about the tax cuts, tax relief which is so instrumental in pulling us out of this recession and stimulating our economy, but in there as well was $20 billion in fiscal relief that goes directly to the States, and about $10 billion of that was specifically targeted at enabling the States to maintain gains they had made in health care for the poor through their Medicaid Programs through a tool or through the technique of the enhanced Medicaid Federal match rate. That is the technical way of saying the Federal Government, in an enhanced way, helps the States with funds that go directly to the State.

I mentioned those two or three examples because it is important for our colleagues and others on the other side of the Capitol, in the other body, and really our constituents, to understand that we in the Senate are addressing the issues of the uninsured. President Bush has made tax credits, what we call refundable tax credits for low- and middle-income families, a major part of his proposal to address the issues of the uninsured and to expand health coverage. He also has consistently supported medical savings accounts and promoted the expansion of medical savings accounts in other ways that can offer affordable health care options to those who might not have insurance today.

The President and we, or many of us—about half of us; not all of us—in this body continue to fight hard for medical liability reform, medical litigation reform, malpractice reform. The reason for that is not to in any way jeopardize the very good system we have, that if there is harm and injury there is just and fair compensation, but the purpose for that is to get rid of the unnecessary lawsuits, the excessive lawsuits that drive up the costs of health care that ultimately are passed on to patients, driving up the cost of health insurance for everybody. Meaning, if you don't have sufficient resources, you simply give up your health insurance or you can't get it in the first place. Again, it is an important part of the President's initiative, as well as our own initiative on this floor. For my colleagues, I will say we will keep coming back to address this whole issue of medical liability.

The cause of 43 million people who lack insurance today is difficult to characterize, in terms of a generalization. It does take a targeted approach to identify who the 43 million people are and then target specific approaches to them. Therefore, it has to be comprehensive but it is also very complex by its very nature.

I think the tone of a lot of the debate today on the uninsured has been polarizing. Because of that polarizing framework, a lot of people have been hesitant to put it out front and to put an agenda out front. I wish to share with my colleagues my commitment to work to find workable solutions to a problem that is increasing, a problem that directly affects the health care of 43 million but indirectly affects the health care, really, of us all.

In that regard, I have asked Senator JUDD GREGG, our colleague from New Hampshire, to lead a Senate Republican task force on uninsured and access to affordable health care coverage. I have asked Senator GREGG and his task force to propose a series of recommendations to address the uninsured issue so we can both debate, discuss, and through committees but also on the floor attack this problem head on.

The task force will be looking at all options, including new ideas. I look at it as a place that ideas can be brought, that we can debate and discuss, and hopefully we will look at many of the ideas that have been proposed in the past but also reach out and obtain new ideas, creative ideas, ideas we may not yet have thought about or that we haven't addressed in the past.

I do intend to take these recommendations and use them as a basis in establishing a legislative agenda so we can on this floor systematically address the issue of the uninsured.

In closing, I appreciate Senator GREGG's willingness to take on this task. I look forward to working with him and his task force in addressing this pressing issue. I am confident that out of this task force we will get new ideas, innovative thinking, dynamic ideas that will allow us to deliver real solutions to the American people who do not have health insurance today.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Before he leaves the floor, I say to the distinguished majority leader how much I have enjoyed working with him over the years on this issue of health care. As he knows, Senator HATCH and I have worked for many months on a bipartisan proposal that we would like to be part of the discussion he is going to launch. I have come to the conclusion that, as pressing as the financial issues are with respect to health care, the social and ethical issues are going to be even more important as we face this demographic tsunami of millions of baby boomers who are retiring in 2010 and 2011. So I am grateful the majority leader continues his interest in health care.

I continue to have a bipartisan interest in working with the majority leader, who has spent so much time on those issues over the years. I know I speak for Senator HATCH in this regard as well.

We have to break the gridlock on this issue. Literally for 60 years, if you look at the parallel between what Harry Truman tried in the 81st Congress in 1945 and what was tried in 1993 and up to this day, we see, unless we find a way to take a fresh approach, as the distinguished majority leader said today, we are not going to break this gridlock.

So I welcome your statement today. I am anxious to work with you and the chairman of the committee, Senator GREGG, to pursue these proposals.

Mr. FRIST. Mr. President, just briefly responding through the Chair, I very much appreciate those comments because, just as we have done with Medicare, it is going to take strong bipartisan support to get good, effective legislation through.

Second, the point about why now versus 10 years ago, 20 years ago, or 30 years ago—I agree wholeheartedly. We have this huge demographic shift that didn't occur 10 years ago or 20 years ago or 30 years ago or 40 years ago, that we are realizing right now. It gives us a perfect reason for all of us to come together to address these problems—the uninsured is a major one for both of us—in a way that may be unprecedented, at least in the last 10, 20, or 30 years.

I very much appreciate those comments and look forward to working with my colleague.

IRAQI GASOLINE PRICES

Mr. WYDEN. Mr. President, I come to the floor this afternoon because I am troubled by what appears to be a request by the Bush administration in the Iraq supplemental that would have our citizens use their hard-earned tax dollars to subsidize the cost of gasoline in Iraq so Iraqi citizens would only have to pay 10 cents a gallon.

The questions I am going to raise this afternoon with respect to this proposal can all be found essentially on page 29 of the report with respect to the request for the supplemental funds for rehabilitation and reconstruction of Iraq.

For those who are following this discussion, this is under the question of the purchase of oil products at page 29 of the request for the supplemental.

I want to begin asking some questions about the fairness of this Bush proposal and about how this subsidy program that is in this report would work if it was actually to be funded by the Senate.

Today I also intend to send a letter to the President trying to get answers to some of these questions. But I would tell the Senate that here is what we know at present.

The Bush administration has included in its Iraq supplemental funding request an estimated cost of $900 million to cover the difference between "Iraqi demand and refinery production to establish and maintain a 30-day reserve in all major petroleum products to ensure no interruption in basic services due to terrorist activity."

The administration's funding request specifies:

> $600 million will be needed in the first quarter of 2004 to compensate for the large difference between demand and production and to build this 30-day reserve.

The first question is, How much is going to be spent on creating this reserve, and how much is going to be spent on purchasing gasoline for Iraqis? Using demand data from the Energy Information Agency's latest report on Iraq and current market conditions, it is estimated the establishment of a 30-day fuel product reserve would cost approximately $200 million. If that amount is correct, that would mean roughly $400 million would be spent to purchase gasoline and other petroleum products for Iraqis in the first 90 days of next year. Iraq is importing about 750,000 gallons of gasoline a day, according to recent statements by senior oil ministry officials.

Based on those statements, Iraq would need about 67.5 million gallons during the first quarter of 2004. If that estimate is correct, U.S. taxpayers would be paying almost $6 per gallon for the gasoline that is provided to Iraqis by the United States in the first quarter of 2004.

The question I ask today and in the days ahead will be: Why does it cost $6 per gallon to provide gasoline to Iraqis when the cost in neighboring countries such as Saudi Arabia and Kuwait is less than $1 per gallon and below the $2 per gallon cost almost everywhere in our country?

According to an article in the Houston Chronicle on September 28, the United States has already spent hundreds of millions of dollars to provide gasoline to Iraq under the contract previously issued with Halliburton. My question here would be: What is the cost of gasoline that has been sent to Iraq by the United States? What was the wholesale price involved here that Halliburton paid for the gas sent to Iraq at taxpayer expense?

Of course, I think our citizens would want to know what profit was made on these deliveries.

The Houston Chronicle also reported that in Iraq the low-octane government-subsidized gasoline sells for less than a dime a gallon.

I ask unanimous consent that the article from the Houston Chronicle entitled "U.S. Taxpayer Footing Bill for Cheap Iraqi Gasoline" be printed in the RECORD.

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

[From the Houston Chronicle; Sept. 28, 2003]

U.S. TAXPAYERS FOOTING BILL FOR CHEAP IRAQI GASOLINE

By Michael Hedges

BAGHDAD, Iraq.—Mahmoud Ali, a gap-toothed 15-year-old, worked steadily under a penetrating sun at his rather monotonous job outside the large Mansur filling station here.

Taking turns with his two uncles, Ali waited in line in the family's 1982 Chevrolet to get a tank of cheap gasoline, which the locals call benzene, at the station subsidized by the Iraqi Oil Ministry.

After filling up the faded white Chevy, the men pulled the vehicle to a curb. There, they siphoned the fuel into 20-liter plastic jugs to sell at triple the posted price to other drivers too frustrated to wait in the lengthy lines.

Then, one of the men drove the Chevy back to the line to sweat it out until another full tank of fuel could be secured.

Selling fuel at three time its state-set price about 100 yards from a line of 14 working pumps would be a hard dollar to earn in another economy.

But it works here in Iraq, because the low-octane, government-subsidized fuel sells for less than a dime a gallon. Even working-class Iraqis earning a few dollars a day are willing to pay outrageous mark-ups to avoid the line.

"Benzene is cheaper than water here," local journalist Qais Al-Bashir said Friday.

What it is costing American taxpayers is another story.

Since the fall of Saddam Hussein's regime last April, Iraq's resuscitated oil industry has been unable to produce enough gasoline, cooking oil and other petroleum products to meet the country's needs.

So far, U.S. taxpayers have spent some $562 million under the Halliburton contract to bring in gasoline and other fuels and make needed repairs to Iraq's gas distribution network, according to the Army Corps of Engineers. In fact, that effort has accounted for nearly half the $1.22 billion worth of work that Halliburton has performed in Iraq since the war.

"The benzene we sell here comes from Turkey, Kuwait and Saudi Arabia," said Majed Mohammed, 44, who manages the Mansur station for the Iraqi Oil Ministry.

"Before the war," he said, " it was 100 percent from Iraq. But now we have problems with sabotage of the pipelines. The refineries are working at far less than capacity."

Mohammed, who has worked for the Oil Ministry for 21 years, said artificially low fuel prices are nothing new to his country.

"The cost is subsidized by the ministry," he said. "It was like that before the war when Saddam was here, and it is the same now. We are obliged to do it because of the needs of the people. If we didn't, there would be major problems and even more anger at the Americans."

Iraq is importing about 750,000 gallons of gasoline a day, according to recent statements by senior Oil Ministry officials. Expectations by the Bush administration that