adopt its business models to new technologies. The industry is now responding to such concerns by developing new products and new distribution channels. The EnFORCE Act will ensure that Federal law allows the music industry to provide consumers with these innovative products and services.

Second, the EnFORCE Act will also resolve two narrow issues relating to statutory damages in copyright infringement litigation. Some accused infringers have tried to avoid liability for statutory damages by challenging the accuracy of the information in copyright registrations; this bill clarifies that courts should resolve such challenges by applying the existing judicial doctrine of fraud-on-the-Copyright-Office. In other cases, disputes have arisen about how many ''works'' have been infringed for purposes of computing statutory damages. These disputes are important for the music industry, which has received inconsistent adjudications about whether an album consisting of ten songs counts as one or ten works for statutory-damages computation. The bill gives courts discretion to conform the law of statutory damages to changing market realities.

Third, and finally, the EnFORCE Act will also enhance both the enforcement and oversight of federal intellectual property law. The bill authorizes appropriations to ensure that all Department of Justice units that investigate intellectual property crimes have the support of at least one agent specifically trained in the investigation of such crimes. The bill also requires the Department of Justice to report to Congress detailed information about the scope of its efforts to investigate and prosecute crimes involving the sexual exploitation of minors or intellectual property.

For the above reasons, I urge my colleagues to support the Enhancing Federal Obscenity Reporting and Copyright Enforcement Act of 2003. I look forward to working with my colleagues in the Senate and the affected public to ensure that this bill achieves its important objectives.

PRIVILEGES OF THE FLOOR

Mr. HATCH. I ask unanimous consent that Grace Becker, a detailee from the Sentencing Commission, be granted the privilege of the floor for the duration of the 108th Congress.

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

Mr. GRASSLEY. Mr. President, I ask unanimous consent that Grant Menke and Brett Swearingen be granted floor privileges throughout the debate on the conference report on H.R. 1.

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

Mr. HARKIN. Mr. President, I ask unanimous consent that Jenelle Krishramoorthy be granted the privilege of the floor for the remainder of the debate today, and the remainder of the debate on this Medicare conference report.

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

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003—CONFERENCE REPORT—Continued

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, this debate so far has been very illuminating, in a way fascinating, to see how different Members of the Senate view the bill that is before us. I hope that America's seniors are watching this debate. I hope they are listening. I hope they will make up their own minds.

There are many groups out there who are going to give their opinions, and I respect them all. But I think if you just go to the debate and you listen to all sides of it, seniors will come up with their own conclusions. As a matter of fact, I also hope people in their fifties and forties are watching this debate because many of the changes that will be made, if this bill becomes law, are going to impact people in their fifties, people in their forties.

Let's face it, Medicare is a program that impacts all families because the children of senior citizens oftentimes bear the burden, if there are health problems. Of course, they care deeply about their families.

We know that Medicare is a nationwide health plan for aged and certain disabled Americans, and it was created 40 years ago for seniors to offer them access to good quality health care. There was a huge debate at that time about whether this was the right thing to do. But people looked around and saw that our seniors were in trouble. They were spending their money on health care, didn't have anything left, oftentimes had to move in with their families. Their families had to pick up their health care bills, and it was very difficult.

This program has fulfilled its promise. Is it perfect in every way? Of course not. What program is? What corporation is? What person is? But Medicare has saved many lives and has made the golden years golden for a lot of our seniors. That is why they feel so strongly about it.

I have been listening to some of the call-in shows. I have heard seniors identify themselves as Republicans, Democrats, and Independents. They are worried about the changes that are about to hit the system, and so am I.

The one thing I think everyone agrees on is that there ought to be a prescription drug benefit. At least I think most of us believe that from both sides of the aisle. We know this cost is heavy on our seniors. We know drug prices are skyrocketing because, unfortunately and very sadly, we don't allow drug reimportation from places like Canada and Mexico, although I have to tell you that in my State, people are going to Mexico.

I received a letter from a constituent of mine from San Marcos, CA, earlier this year. She told me that her annual cost for prescription drugs this year will top $10,000. Think about that, $10,000. How do our seniors deal with this when they are retired?

A retired physician from Marina del Rey told me that a pill he takes for his heart disease went up 600 percent, from $15 a month to $85. For seniors who have to take an assortment of medicines to manage their chronic diseases, the costs really start to add up.

Very sad to say, in this bill there is virtually no cost containment. Even though the House version said reimportation from Canada was a good idea, this has not happened. We will continue to pay the highest drug prices in the world. It is very sad, indeed. The provisions on generic drugs were watered down a bit. We have some in there but not what they should be.

For all the reasons that I talked about—the fact that I feel deep compassion for my constituents who have to pay these huge sums for medicines—I voted for the Senate bill. The Senate bill left here. I thought it made some sense. So let's look at what the Senate bill did for our seniors.

It had about six things that it did that I thought were really important.

First, there was a modest benefit for seniors that were hardest hit by the costly prescription drugs. That benefit was a lot better than the benefit that is currently before us. I will go into the differences. The benefit that is before us is so weak, it barely has a pulse. It is barely worth filling out the forms. It is barely worth your time. You could probably do better if you become friendly with your pharmacy down the road. They will probably give you a better deal.

The benefit before us, unlike the benefit we voted on, is this: If you have $5,100 worth of drug costs, you will pay $4,020 for those drugs. In the meanwhile, you will have to figure out what are your deductibles, what are your copays, filling out the forms, being nervous, getting notified that you no longer have the drug benefit because there is a benefit shutdown, which I will get into later. So think about it. You have a $5,000 drug bill, and you are paying $4,000. And you are going through probably bureaucratic hell to get that thousand dollars off.

So the benefit, when we got the bill, we voted it out. I voted for it. I wanted it. It was a modest benefit but a decent benefit. It was much better than this one. We will get into that later.

Secondly, all seniors were guaranteed a Medicare prescription drug benefit if they didn't have two private plans in their area. So you had a good fallback. If you didn't have two private drug plans competing for your business, could you say: Forget this. I can go to Medicare.

Third, Medicare could have bargained for lower prescription drug costs. Now, why is this important? Just look at the

Veterans' Administration. They can get way lower costs for the drug benefits for their veterans because they represent millions of veterans. Therefore, they have bargaining power. It is not like if I walked into a pharmacy myself and said: Hi, I am a veteran, can you lower my drug prices. And the pharmacist looks at me and says: Well, no. But if I bring millions of people into the store, the pharmacist is going to say: You know, now I can talk to you about some bargain prices.

That is what we have done with the VA. In the original bill that came out of the Senate, Medicare could have bargained. We will talk about the current bill in a minute.

Then, No. 4, there were steps to privatize Medicare, but they were minor steps. They were balanced by a $6 billion sum that was added to Medicare. So while they gave the private plans $6 billion in the Senate bill to ''encourage'' them to stay in the Medicare business, I didn't agree with that. When I think about competition, I don't think about paying people to compete. I didn't think that is what capitalism is. I was a stockbroker. That is news to me. To me competition is what it says. You come in, you see you have a chance to make a profit, and you compete.

Well, we were giving them $6 billion. I wasn't happy about it, but I felt that, all in all, because we balanced it and gave $6 billion to Medicare to add prevention and some other very important benefits, it was worth it.

So just sum that up. I want to be clear here. I supported the Medicare prescription drug bill that was before the Senate because it was a decent benefit for seniors. It gave them about a third off their drugs. So it gave you a third off of your drugs. I thought that was a good benefit. You paid two-thirds and you got a third off. Again, I thought it should have been better. It was modest. I wasn't thrilled with it. I tried to have amendments to close the benefit shutdown, to bring the benefit up to 50 percent, but I did not succeed in that effort.

All seniors were guaranteed a Medicare drug benefit, that fallback, if they didn't have two private drug plans competing. Frankly, I wanted a Medicare fallback for everybody. I remember the debate. But they convinced me to compromise. I wasn't thrilled, but I voted for it. Medicare could have bargained for lower prices for drugs. I assumed that would be part of what we would do. We didn't prohibit it. The steps to privatize Medicare, to incentivize HMOs to stay in the Medicare business, were balanced by $6 billion added to Medicare for some important new benefits.

The last thing is, for the lowest income seniors, they got prescription drugs at no cost. That was a wonderful thing in the Senate bill. The poorest of the poor people who worked all their lives and found themselves in a horrible situation today would have gotten drugs at no cost. For all those reasons, I was very pleased in the end that I was able to move that bill forward.

I want to show you something I hope you can appreciate, as I hold this bill up for a minute. The bill itself that has now come back to us is very heavy. Here it is. This is the bill that is before us today. This bill I am holding is 678 pages. How much of this is the prescription drug benefit? It is 181 pages. What does that tell you? It tells you that most of this bill has nothing to do with prescription drugs. Think about it. We sent a prescription drug bill into the conference committee to come back to us, and here it is. This yellow tab shows me where it is. This is the prescription drug benefit. It is 181 pages. The balance of this bill is way more, 5 times more.

Think about it. If the folks who brought you this bill were sincere about giving you a prescription drug benefit, why did they then use that as an excuse to begin changing Medicare—changing Medicare in ways that are perplexing, that are going to be difficult to understand, and the rest?

Now, I am not, generally speaking, someone who is paranoid about things. But I have to tell you, I am when I hear Newt Gingrich, praising all 600 pages of this bill, who said in 1995:

> Now, we don't get rid of it [Medicare] in round one because we don't think that that's politically smart, and we don't think that's the right way to go through a transition. But we believe Medicare is going to wither on the vine, because we think people are voluntarily going to leave it.

Voluntarily. If you mess up Medicare and you make it confusing and start doing the things that they do in this bill, Newt Gingrich will be proven right. Why do you think he went over to the caucus on the other side, in the House, and talked to the Republicans who didn't like the bill? Because they thought it was too good to seniors.

He said: No, it is not. Trust me. Would I lead you astray?

That is Newt Gingrich. The senior citizens in this country, in my view, are the smartest of the folks when it comes to Medicare. They know it. They get it. They understand Social Security and they understand Medicare. They understand when Newt Gingrich said that Medicare should ''wither on the vine,'' and that this isn't something they want to see happen.

Well, folks, please listen. ''We don't have to get rid of it in round one,'' Newt said, ''because we don't think it's politically smart.'' So what did they do? They take a prescription drug benefit that is popular—by the way, it is voluntary, but I will talk about that because it is not voluntary if you are on Medicaid, and it is not voluntary when you find out that your pension plan has dropped your prescription drug coverage because then you will have nothing. You will be forced into it. It is not voluntary for those folks.

But I can tell you that this is just what Newt Gingrich planned. You cannot do it all at once. Not in round 1. We have to go through a ''transition.'' Remember that word because it shows up in this bill—''transition.'' So here is prescription drugs, and here is the withering on the vine.

A lot of the people who fought Medicare in the beginning are embracing this bill. Do you think they had a change of heart? Do you think those of us who built our careers on protecting seniors have somehow gone wacko on you by saying that this bill does more harm than good? Think about the Senators who are standing up here and extolling the virtues of this bill. One of them was here before and he said that people on the other side are saying we are trying to destroy Medicare. How ridiculous, he said. That's crazy. We would never do that. Then he launched into a harsh criticism of Medicare and how it needs to change.

Another, I thought, belied his point of view when he stood up and said—it is on the record from this afternoon—we need to get away from the ''command and control'' of Medicare.

Well, I have news for the Senator from Texas, who said that. In Medicare, do you know who is in command and control? The senior citizens. That senior citizen can go anywhere—to the doctor of choice. That is the beauty of the Medicare system. They are in command and control.

What this bill does is start the unraveling of that command and control and gives it to a whole new system that is so confusing that I would assure you, when you begin to hear the words and the acronyms associated with this new system, if you went up to any Senator and asked him or her a question about it, not one of them would pass the test of understanding every acronym—not even close. So the Senate bill benefited seniors. What we have before us is quite different.

To me, the saddest thing about this bill is that it turned a modest, but decent, benefit for seniors into an enormous benefit for the largest pharmaceutical companies and HMOs in America. Here is what we have now in the bill. This is what we have now. The bill benefits drug companies and HMOs.

First of all, the bill sets up a slush fund of $14 billion for HMOs. I have to say something here. The deficit that we are facing in our country today is nothing short of an abomination. From the minute this President took over until today, we have seen deficits as far as the eye can see and balanced budgets turn into $500 billion-a-year deficits every year. But the folks in the conference committee found $14 billion to give to those profitable corporations in America. Why do you think that is the case?

There is an article today in the Washington Post that tries to explain it. This is the headline on the front page:

> 2 Bills Would Benefit Top Bush Fundraisers. Executives' Companies Could Get Billions.

This is the selling of America. I want to quote from this article.

More than three dozen of President Bush's major fundraisers are affiliated with companies that stand to benefit from the passage of two central pieces of the administration's legislative agenda: the energy and Medicare bills.

We stopped the Energy bill. I don't know how long we will be able to hold that, but the Energy bill is a clear-cut case. We talked about that the other day, and now there is the Medicare bill.

Continuing the quote:

The energy bill provides billions of dollars in benefits to companies run by at least 22 executives and their spouses who have qualified as either ''Pioneers'' or ''Rangers''—

That is what they call the big fat cats, Pioneers or Rangers——

as well as to the clients of at least 15 lobbyists and their spouses who have achieved similar status as fundraisers. At least 24 Rangers and Pioneers could benefit from the Medicare bill—

Twenty-four Rangers and Pioneers, and those are the people who give the most money——

could benefit from the Medicare bill as executives of companies or lobbyists working for them, including eight who have clients affected by both bills.

Talk about hitting the lottery. They benefit from the Energy bill and this bill. We know where the money is going. It is going out of the Federal Treasury to the fat cats. Face it. Unfortunately for the folks around here, we know now. We have it.

How about this?

Hank McKinnell—

He may be a lovely man; this is not a personal attack on him——

chairman and CEO of Pfizer, has pledged to raise at least $200,000 for Bush's reelection, although he is not yet listed as a Pioneer or Ranger. Pioneer Munr Kazmir, who runs a direct-mail drug company called Direct Meds Inc., estimates that he has about 100,000 customers on Medicare who will have more money to buy drugs from his company. ''We know the patients, we know how important this bill is,'' he said.

Follow the money. Dress it up any way you want. Talk about how great this bill is. Follow the money. I hope seniors are watching this tonight. They will make up their own minds. They are calling my office. My phones are overwhelmed. What are they running on this? About 1,000 calls to 200 calls against this bill. For every 100 yeses, there are 1,000 nos. Seniors are smart.

They trust the AARP. Now they are finding out that the head of the AARP wrote the foreword to Newt Gingrich's book. Now they are finding out that the AARP gets 60 percent of their funds from selling insurance. Now they are finding out that the head of the AARP represented big drug companies. Follow the money.

There is a $14 billion slush fund for HMOs at a time when we don't have money to fully fund education. We can't fully fund education, but we can find $14 billion for a slush fund for HMOs. They don't call it a slush fund. They call it a few other names—a stabilization fund. They call it a stabilization fund.

Over 7 years, HMOs get $14 billion. This includes $10 billion in direct subsidies to HMOs handed out at the discretion of the head of the agency overseeing Medicare. How would you like to be that guy? At his whim, this bureaucrat can write checks to HMOs to bribe them to participate in Medicare.

In addition, there are nearly $4 billion of payments to the HMOs that already participate in Medicare just to bribe them to stay in Medicare. What kind of capitalism are we living in this country when we have to pay the private sector extra money when they went in the business in the first place? Things have changed. When I was a stockbroker, it wasn't that way. We didn't give corporations the kind of welfare we are giving them today. This is corporate welfare. Follow the money to the Presidential campaigns and you will get a very interesting story.

This $14 billion slush fund is particularly egregious when you consider that Medicare already pays HMOs more than the per-patient cost of traditional Medicare. Let me repeat that.

HMOs are getting paid more than the traditional Medicare. Do my colleagues know why? The overhead in Medicare is very small. Do we know exactly—is it 2 or 3 percent? Anyway, we do not pay CEOs millions and millions of dollars. They are taking that money right off the top and lining their pockets. Oh, but why not? They are nice people, give them $14 billion.

It is not that they are so great, these HMOs. People get the runaround. They do not get the care they need. People want their traditional Medicare.

Remember what I said. The bill I voted for in the Senate gave $6 billion to HMOs. I was not happy with that at all, but at least it gave $6 billion to traditional Medicare to help us do more prevention. Guess what happened. It is gone. The conference committee took it away. But they have added it on to the $6 billion already there. They added $6 billion that was going to go to Medicare. They put it in the HMOs, and they added $2 billion just in case it was not enough money for their friends.

Secondly, this bill benefits drug companies and HMOs. There is a gag rule on Medicare price negotiation. I talked a little bit about that before. Medicare has all of these clients. Think about the clout Medicare could have when they call a drug company and say that their drug X, Y, Z is a drug for arthritis and our patients like it; we are going to buy a lot of it for our patients; please give us a deal.

Oh, no, the conferees said, Medicare has a gag rule. Watch out. They may do it to the veterans next. The VA can bargain, but Medicare cannot bargain. The drug companies and the HMOs can bargain explicitly. They can bargain, and they can pocket some of the profits that they bargain, but not Medicare. Medicare cannot bargain. There is a gag rule on Medicare.

They will stand up on the other side and say: We are not trying to destroy Medicare; we think it is a great program. Just remember Newt Gingrich: Let it wither on the vine.

Seniors are expected to spend $1.6 trillion in prescription drugs over the next decade. By the way, there are a lot of pharmaceutical companies and a lot of wonderful research companies in my State. I have a great relationship with them. I support them getting an R&D tax credit; in other words, a tax credit for every penny they put into research and development. Why? Because I think that is important. I support their patents—reasonably support their patent rights. I support research through the NIH very strongly, and a lot of that benefits the drug companies as well. So I work very closely with my biotech companies, with my pharmaceutical companies, but, by God, I do not believe in giving them welfare.

Fourteen billion dollars? Is that because we have so much money? Is our deficit not big enough? It is only up to $500 billion in 2½ years or 3 years. Gee, we could do better. Why do we not make it $600 billion? Do I hear $700 billion?

I do not know what has happened, but it is not good. It took us 8 years to balance that budget. The other side said: We want a constitutional amendment to balance the budget. And our side said: Let's just balance it. Why do we need to amend the Constitution? Let's balance it. And President Clinton did that with us over 8 years.

Now it is gone. Now we have $14 billion to add to the deficit, and we are not going to let Medicare negotiate for us because, for whatever reason, they are tying Medicare's hand. I think it is because they want Medicare to wither on the vine. That is what Newt Gingrich said. That is the only thing I can come up with.

We know the cost of drugs could be lowered if Medicare negotiated those drug prices. One might say, well, maybe, Senator BOXER; that would be highly unusual for Medicare to negotiate with the drug companies. I would say, not at all. Medicare negotiates payments to hospitals. They have done that for years. When the bill left the Senate, there was no prohibition, but now there is. Why? Because they do not want the Medicare drug plan to be able to offer lower prices. They have given the right to negotiate to the private sector. They are going to push seniors into those plans.

Just remember where I started from. Just remember, ''wither on the vine,'' and ''follow the money.'' These are some simple concepts. At the end of my statement, just put a little ribbon and tie the bow and everyone will get the picture as to why we are going down a very dangerous path.

In this bill, we are going to be giving to HMOs payments above their stated cost to deliver service. Has anyone ever heard of anything like that in their entire life? A firm bids on a contract.

They say: We can supply you with X number of widgets for a thousand dollars. On the dot, you get it. You deliver the thousand widgets, I give you $1,000.

Here, HMOs are saying: We can deliver health care for patients at a cost of X dollars per patient. In this conference committee, they said: Well, we are going to give them more money than they say they need. It is called a lot of different names, such as premium support. It is payment above and beyond what they said it would cost. So put together the slush fund and the payments above their cost of service and you are scratching your head, saying, maybe I ought to get into this business.

I say to people all over the country, small businesspeople who work hard in their business, be it retail or wholesale, you do not have a deal like this. You open up your doors, you go into business, and suddenly Uncle Sam is knocking on the door: Hey, I got a check for you HMOs, $14 billion over 7 years just to stay in the business; and, by the way, we love you so much, we are going to give you dollars above and beyond what you say it costs. And, by the way, no one will catch on. We are going to call these names different things. We are not going to call it a slush fund.

So the bill left the Senate. It was a good benefit, a decent benefit, but a modest benefit. It was not perfect, but at least it was a bill on prescription drugs. It came back a benefit for drug companies and HMOs. Somebody said to me there was a hostile takeover in the conference committee of the Medicare bill, that the Senate passed, by the HMOs and the prescription drug companies.

If we look at Wall Street, follow the money. Look at the prices of these stocks. They are going out of sight because people know this is a deal of a lifetime, that is for sure.

The last point I want to make is that this bill hurts our seniors. I am going to be specific. First, it hurts all our seniors, and in the end I am going to show you how it hurts my seniors in California, the largest State in the Union.

These are facts. We have gotten them from the staff that worked on this conference bill. Six million seniors will pay more for prescriptions than they do now. Let me tell you who these people are. Six million low-income and disabled beneficiaries currently receive prescription drug benefits from the Medicaid Program, which is a matching Federal-State program administered by the State. These programs are more generous in coverage than the proposed bill that is before us because they serve our very sickest Americans.

For example, a Medicare/Medicaid-eligible person in California can, but does not have to, pay a $1 per prescription copayment. The copayment is voluntary. A dollar may sound like zero, nothing, to people. But if you are an inch away from owning nothing, every dollar counts.

Under the conference bill the same person will now be required to make a copayment, maybe, up to $5. Some will pay premiums of $50 and be subject to a strict asset test. Studies have shown that even small copayments for prescription drugs can make essential medicines unaffordable for low-income seniors, resulting in an 88-percent increase in hospitalizations and deaths, and a 78-percent increase in emergency room visits.

So they say to my State, now you can't help these poorest of the poor. Sorry. They gave that a name, too, which we will get into later. They give it a nice name, but the bottom line is the people, the poorest of the poor, the States that help them can no longer help them once they get into this program.

The copayments to these poorest of the poor are indexed for inflation. So they can and they will go up. Remember, most of these people don't make any money. When you get hit with inflation and you are on a fixed income, that bites. That takes food off the table. So we know there will be an increase in hospitalizations. That was in the background information, that 88-percent increase in hospitalizations and deaths because people will not take their medicine.

States are prohibited from covering the out-of-pocket costs of these dual eligibles, and the bill prohibits States from establishing more expansive drug lists for the mentally ill, disabled, and other groups.

That is important. They may be taking a drug that isn't covered on this formulary.

I want to talk about people with AIDS. We have a high number in our State. People are suffering. Many of them are dual eligibles. They are eligible for Medicare disability and Medicaid. For them this bill is catastrophic. My phones are ringing off the hook with calls from them, their parents, their families. It is likely that they may not have access to or be able to afford all the drugs they need. So this is why this bill is opposed by the AIDS Medicare Project, San Francisco; AIDS Project, Los Angeles; Project Inform, San Francisco; San Francisco AIDS Foundation. But let's face it, it is not just AIDS patients who are going to be harmed. Anyone with a life-threatening illness runs the risk of not having coverage for the drugs they need. If they are denied coverage for these drugs under Medicare, they can appeal the decision, but this doesn't mean they can afford them.

So when it comes to my State, I will show you later the numbers of people who will be worse off. It goes in the hundreds of thousands—the hundreds of thousands.

Now there is a very cruel asset test. When I voted for the bill in the Senate that the Senator from Iowa worked so hard on with the Senator from Montana, that was a good bill. That bill would have allowed low-income seniors to receive assistance without forcing them to sell a car because it was worth over $4,500 or a ring that maybe was their most precious possession from their loved one or a family heirloom.

The conference bill imposes a Draconian asset test of $6,000 per person, $10,000 per couple, for the poorest of the poor. As a result, 3 million low-income seniors nationwide, and 300,000 in California, will be deprived of assistance that would not only help them with their prescription drugs but help them pay the premium so they could receive the coverage in the first place.

In other words, the bill that is before us has some generosity towards the poorest of the poor, but they have added an asset test into it so if you have a family heirloom or you own a car worth more than $4,500 or you have a diamond ring and a gold wedding band that your husband may have given you when you were married, you have to sell it. You have to get rid of it. Otherwise you don't get the benefit of this prescription drug benefit.

I don't get that. I am sad the conferees didn't go with the bill that most of us voted for in the Senate.

Now you come to seniors who are forced into demonstration projects that penalize them for staying in Medicare. That happens in 2010. You say we are just in 2003. We are almost in 2004—that is 6 years away, big deal. One thing I have learned, as long as I have lived, is that time goes fast. Six years will be here. If you are in one of those demonstration projects, what is going to happen is plain and simple: Your premiums are going to go up if you stay in Medicare—bottom line. Even though people say you are not forced into these other plans, the costs may force you into these other plans.

One in six Medicare beneficiaries will be forced to participate in this experiment. In California, 12 of its metropolitan statistical areas will qualify for these demonstration projects. Let's say two of the largest are chosen; one is in L.A. and the other is in San Francisco. So what we will have is my seniors in those areas will have to make a very tough choice. Do they stay in Medicare and pay more money or do they go into an HMO and lose the choice of their doctors?

We have already had some experimentation. We know the healthy people will choose the HMOs because they are cheaper. After all, they are healthy so they are not worried about getting messed up by an HMO. If they are not sick, you know, it is not a problem.

But the sicker seniors would be left in Medicare, and we know that we will see costs spiral out of control because there will be a sick pool of seniors, rather than spreading the risk, which is what insurance is all about.

Now we have a situation where premiums for middle and upper class people are going to go up. My colleagues say they are only going to go up if you earn $80,000 a year. I understand that is

quite a bit. That is not that many people. But this is the problem. This number of $80,000 a year is not indexed for inflation. So it looks like it is a lot now, but in the future it will not look like it is that big.

For example, if this provision, the one that my colleague from Iowa supports, was in place in 1980, the equivalent level of income would be $33,000, and the person at that level would have to pay much more for their Medicare. So the fact is, they have done an interesting thing: They have not indexed this, so in the end you will have people of very moderate incomes paying huge premiums to Medicare.

Now what is going to happen? It will wither on the vine because people will say: I don't want anything to do with this. It is too costly. I don't need it. I will just go out and buy a catastrophic policy elsewhere.

I will tell you, if you take that fact, along with the fact that this bill sets up health savings accounts for the wealthiest people, you are going to have middle-income people and wealthy people walk away from Medicare, and you will lose the class you have when you have a larger pool. That is just a fact of life. That is why we have had a successful program—because insurance needs a very big pool.

I am going to put up a chart that I hope all of you who might be crazy enough to be watching this will remember. I know this isn't exactly prime-time television. But I want to show you a chart of ''Fear and Confusion.'' This is a BARBARA BOXER homemade chart. This is the chaos and confusion that our seniors are going to be facing.

If any of you are watching this tonight, I am telling you to take note. I am telling you to call the AARP. Senator DURBIN gave you the number. I do not know it. I want you to take notes and ask them to explain each of these concepts they have endorsed in this bill. Then I want you to call everyone who votes for this bill, if this bill passes, and call your Senators and ask them to explain what all of this means. I am not going to tell you what it means tonight because we would be here all night. These are the terms that have been thrown around in this bill. You are going to have to understand this if you are going to understand what Congress is about to do to you. You will have to understand this.

Confusion and fear—some of them you know; HMO, you know that one. There is fear there, but it has nothing to do with the fact you don't know what Health Maintenance Organization stands for.

Risk corridors: I want you to learn what risk corridors mean; copayments, plan retention funding, MA-prescription drug plans, or MA–PD plans; donut hole. No, it is not what you buy in the store that is so good. I am on a diet. I haven't had one of them in a while. But a donut hole is something you had better understand because it is going to cost you when you get to it.

Here is another one: MA-Regions; catastrophic, premium support, assets test. I explained that one to you. That is one where you have to sell your wedding band, if you are poor, in order to qualify for getting your drugs free.

Average weighted premium; MSP, Medicare Secondary Payment; coordination requirements; initial coverage limit; CMS, you had better know that because the man who is the head of it is the one who is going to control the slush fund for HMOs.

Here is one which is kind of my favorite because I actually understand it: Claw back. That is a new word for you. That expresses what happens if you are a State and you have helped your poorest people pay for their Medicaid. You no longer can help them, but you can't keep the money. You have to send it to Uncle Sam. That is a claw back.

Transitional assistance, MSA. That stands for Metropolitan Statistical Area. If you are in one of those, you are forced into a demonstration project even if you do not want to be.

Benefit shutdown: This is one I know very well. After you buy a certain amount of drugs—around $2,000—you get a letter in the mail from your company that is giving you this drug benefit, and they say: Sorry, sir, your benefits shut down until you go past $5,100. Benefit shutdown is not a good thing.

Risk adjustment premiums—you all know what that means; Part D, income relating, SA-wraparound; national bonus payment. But don't get excited. It doesn't go to you. Comparative Cost Adjustment Program; Stabilization Fund—that sounds as if it is a good thing. If you are an HMO, that is the money you get to keep you in business.

I tell you, if something happens to me and I am not back here after my next election, which could happen to anybody, I am going to consider helping one of these big HMOs. I understand half of this. I may help them.

Medicare advantage competition, wraparound—we did that—MA-regional plans; MA-prescription drugs; annual out-of-pocket threshold. Watch out for that one. Annual out-of-pocket threshold is what you have paid for your drugs out-of-pocket before you can get the benefit. However, if your drug isn't on the formulary, it doesn't count. So don't count on it too soon.

Return disclosure: This has to do with your tax return. You are going to have your tax return sent to the IRS from the Health and Human Services Department if you are an upper income senior. They want to know what you earn. Before, Medicare never asked that because it is an insurance program. Now, do you know in this bill that the people who do not like taxes are making sure the IRS receives from the Health and Human Services Department information about your tax return?

Deductible: Again, very tricky. You have to understand that.

PDP sponsors, Prescription Drug Plan sponsors; monthly benchmarks. I am not sure about that one myself. But monthly benchmarks, we have to be careful about those.

Fallback: The fallback is in the prescription drug plan. In the Senate bill that I voted for, if you didn't have two plans come in to compete, you could always fall back to Medicare. Now it is basically one plan.

I told you about fallback. I went over all of it. MSP; average weighted premium—I think I pretty well went over this; coverage gap; plan retention funding.

The way I have done this chart, it looks kind of chaotic. It is to make a point. I don't even have half of the terms that are in this bill. I am going to work on this so that after the cloture vote when we have a little more debate, I will be able to get a better list.

But there is no secret why seniors are calling up our offices. They are smart. They are the smartest folks around. They have lived a long time. They are smart. They know what Newt Gingrich said: Let it wither on the vine. And then he endorses this. They weren't born yesterday.

The one thing I was interested in with C–SPAN is the people who were calling were Republicans and Democrats, and they all sounded alike. One out of 10 said they liked the deal. So this bill hurts seniors. We know that for sure.

Confusion and fear, large benefit shutdown, which is daunting and penalizes innocent seniors.

I told you before. You get to a certain point, and your benefits stop. A couple of thousand dollars, and then it starts up again at $5,000. Name for me one other drug program that does that. I checked it out. There are hundreds of them. Maybe there was one other that had a small benefit. I have never seen it. We don't have that in our plan. We just go in the pharmacy and give them our Senator's health card. We get a good deal. They never shut us down. Why should we shut you down? It is a bad thing. It is not right. If I was a local pharmacist, I would say to my seniors, I can do better than this plan. Come into my store, buy your drugs here, and I will give you a discount card.

Seniors will have to worry about filling out this form, filling out that form, is this drug on the formulary, and so on—fear and confusion. The bill hurts seniors.

Now we will look at what it does to my State's seniors. This is the direct impact on my State's seniors: 867,000 sick low-income seniors will have worse Medicaid prescription drug coverage. Boom. This starts in 2006 when 867,000 sick low-income seniors will have worse Medicaid prescription drug coverage than now.

Mr. President, 250,000 retirees will lose their more generous prescription drug coverage even after we give payments to the employers. I supported that. That was a good move. But even

with that, they are dropping coverage once they know their retirees have another option. Wait until those people get the clue that is happening.

Years ago we passed a catastrophic medical bill and I remember seniors were attacking Congress people. Wait until they hear they get dropped—retirees who worked all their life, who like their plan and they get dropped. They do not have a choice. If they want prescription drugs they have to come with this plan. Wait until they have to deal with benefit shutdowns.

Mr. President, 296,000 fewer low-income seniors will qualify for low-income protections than under the Senate bill because of the assets test that I talked about and lower-qualifying income levels. The poorest of the poor—when compared to what we did in the Senate, the bill I voted for—are worse off. These numbers are huge because I represent a big State. And 230,000 Medicare beneficiaries will pay higher Part B premiums because they are upper middle income and wealthy. That will happen to them.

Also, because they are in the MSA or metropolitan statistical area, that demonstration project, 1.4 million could be forced into them as we projected because we have the big metropolitan areas, or be penalized for staying in traditional Medicare because the people who are healthy will go into those private plans and the people who are sick will stay in Medicare and the costs will go up.

We have fear and confusion. I don't know how many of these figures are double-counted, so I cannot just add them up. Some of these figures may fit into more than one category, but I can state with certainty a couple of million of my 4 million people on Medicare are going to be worse off with this bill, much worse off. That is a very bad thing to do.

I don't know where the votes are. I think they have the votes to pass this. But if seniors across this country got a couple of days—there are about 48 hours to pick up your phone, call your Senator and say: Senator, maybe you are right. But this thing is confusing. I am fearful. Give me a little more time.

The bill was just printed and we saw it for the first time the day before yesterday. This bill is bigger than I am, and we got it the day before yesterday.

I have shared some of the new bureaucratic ''wordspeak'' in the bill and I have just had a couple of days to look it over. At the least, we should say to our colleagues, put this thing off. We are going to come back in January. This Congress goes 2 years. That is the beauty of it. If it was next year, the legislation would die. But we have 1 more year of this session. What is the rush? Tell your Senator, maybe Senator BOXER is wrong when she says this will hurt me. I am not sure, but she has raised some issues.

Change, if it is positive change, is something we all want. But change could be negative, could be disruptive, could cause us to be confused or fearful. What is the problem in taking a little while longer? To be honest, I would love to have the Christmas holiday recess to read every line of this bill. I started to do that. That is how I came up with all of these words, by reading the bill and trying to understand all of this. I did not even scratch the surface.

This Senate voted down an Energy bill which I felt, frankly, was in many ways a giveaway for a lot of special interests. And the good that was in it—and there were good things in it—was outweighed by the special interest provisions. We should be here for the public interests, for the people we represent.

I remember one of my colleagues saying to me, when someone asked a question about oncology, because there has been some concern about how the oncologists are being treated—someone in the room said, just look, there is a company being traded, a health care company that deals with oncology, and the stock is shooting up. It must be that oncologists are being treated fairly.

I used to be a stockbroker. It is not of any interest to me to do things that make the stock of a company go up. Do you know what I want to go up? The stock of the American people, the lives of the American people, the quality of life of the American people, the quality of life of grandmas and grandpas and their families.

This is truly not a partisan issue. It is an issue of how do we give a prescription drug benefit to our senior citizens and keep Medicare strong and not make this bill a giveaway to the largest HMO and pharmaceutical companies and insurance companies in the country. They are doing very well. This debate has been a good debate so far. We have serious disagreement. I am sure I will be back in the Senate after we have a cloture vote, one way or the other, just to add more terminology to my fear and confusion chart.

I know my colleagues on the other side of the aisle are waiting with bated breath to see my next version of this fear and confusion chart because I know they understand every single one of these terms. It is interesting to look at these terms and to realize how far reaching and how bureaucratic this new bill is.

I will say one last thing and then I will leave the floor, much to the delight of the Senator from Iowa and the Senator from Montana. I say to any senior citizen, any human being who is within the reach of my voice, and there may be a few at this late hour, if you feel we need more time to see whether Senator BOXER is right or Senator GRASSLEY is right or Senator BAUCUS is right or Senator KENNEDY is right or Senator DURBIN is right or Senator HATCH is right, if you think you need more time to take a look at this bill, to get this bill analyzed, this bill that weighs a lot, this bill that is over 600 pages, call your Senator, e-mail your Senators and tell them to take some more time, to put this thing over until after the first of the year and we can come back here and have the whole year to work on this bill, which is really rewriting the Medicare Program.

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

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I think the place for me to start is where the Senator from California left off; that is, the impression that is left that this bill is going to confuse the seniors of America, and almost that the purpose of it might be to confuse seniors.

But let me make very clear to all the seniors who are listening, and everybody else who is listening, one of the keystones of this legislation is to say to the seniors of America: If you do not want to do anything, if you do not want anything to do with this, you do not have to have it. This is strictly voluntary.

For any senior in Iowa or California who comes to their respective Members of Congress and says: Congressman so and so, or Senator so and so, just leave my Medicare alone; I am satisfied, each of us can say to them: If you do not want to worry about all this that we are talking about—prescription drugs or anything new about Medicare—you do not have to because you can keep traditional Medicare as you have known it for the last 35 years. Just keep it as is, if you are satisfied with it.

But for those who might not be satisfied, we give them several options. They have a right to choose. They have a right to keep traditional Medicare with a prescription drug program that they can choose to go into, or they also have the right to choose a new Medicare—preferred provider organizations—that is very close to what baby boomers now have in the workplace. They can choose that with an integrated drug benefit plan.

So we are not trying to confuse anybody. We are trying to give seniors the right to choose. We are trying to give seniors who are totally satisfied with what they have right now an opportunity to just stay where they are right now. It is the right of seniors to choose.

I think I better be very clear because so much of the opposition to this bill today has come from the other side of the aisle, mostly Democratic Members of the Senate.

We are here today with a piece of legislation because over the years 2001 and 2002—after Senator JEFFORDS switched from being a Republican to being an independent and casting his lot with the Democrats, so they were a majority during the remainder of 2001 and all of 2002—there was an effort early on to develop a bipartisan approach to a drug benefit during the last Congress.

When that was developing, there was a fear that there might be a bipartisan

bill reported out of the Senate Finance Committee, a year ago, and the then-majority leader, now the minority leader, Senator DASCHLE, decided that this was an issue that ought to be brought to the Senate floor, not worked out in committee.

Remember, you develop bipartisanship in the Senate in the committee. You do not do it very often here on the floor of the Senate. You build coalitions.

Remember, nothing gets done in the Senate that is not bipartisan—unlike the House of Representatives, where partisan things can be done—because, remember, the Senate of the United States is that only institution in our political system where minority rights are protected.

So a year ago, the then-majority party decided that this ought to be debated on the floor. But they also knew that it would be impossible to get the bipartisan majority that it takes to get things done. They gambled that they needed an issue for the last election rather than a product. They gambled on an issue that we would not do anything last year, and the way they maneuvered this, nothing was done because nothing in a partisan way, even by majority Democrats, can be produced out of this body that is not somewhat bipartisan.

Then there was an election, and they found out that issue did not work for them; that Republicans were put in a majority. This gave, in this new majority, in this new Congress, Senator BAUCUS and I, the top Democrat and the top Republican on the committee, an opportunity to do our magic and put together a bipartisan bill. That bill came to the Senate floor and was passed 76 to 21. It went to conference, and came out of conference in a bipartisan way. And we are here because the majority Republicans and some sensible Democrats want to produce a product and not have an issue for the next election. I happen to think, from the comments I have heard today—all the fault that can be found with this bipartisan product—that there are still too many people on the other side of the aisle who have not learned a lesson: No. 1, how do you get anything done in the Senate? It has to be bipartisan. And, No. 2, they did not learn from the mistakes of the last election when they thought they needed an issue. Do they think if it did not work in 2002, it is going to work in 2004?

So that is why we are where we are because there are Democrats who know that you do not get anything done in the Senate if there is not a bipartisan coalition. There are Republicans who have understood that for a long period of time.

So that is background to what I want to tell the people of America and my colleagues about why this bill should be adopted. During this process, I am going to correct some of the statements made by my colleagues so far today.

I want to correct what my colleague from Iowa said earlier about this bill's impact on rural America and on our State of Iowa in particular.

The rural health provisions of this bill go further and wider than any other legislation that this Congress has ever considered. It enjoys the strong support of the Nation's doctors and hospitals, and it is also strongly endorsed by the Iowa Medical Society and by the Iowa Hospital Association, two of the strongest advocates for rural equity in my State and my colleague's State.

I will read an excerpt from each and then ask unanimous consent that both letters be printed in the RECORD.

This is from the Iowa Medical Society president, Tom Evans, M.D.: ''[P]assage of the bill,'' meaning the bill before us, ''is critical for rural states like Iowa.'' ''He said: ''In addition to providing seniors with prescription drug coverage''—and I want to emphasize this part of his statement—''this legislation fixes many of the reimbursement issues that have unfairly penalized rural States. Congress must pass this legislation before the Thanksgiving [Day] recess.''

Now, I go to the Iowa Hospital Association, which in 2001 circulated statistics, already referred to, showing Iowa in last place in per-beneficiary spending. The Iowa Hospital Association: ''The Iowa Hospital Association strongly endorses passage of this legislation.'' ''In an evaluation of the per-beneficiary increase, this legislation provides Iowa hospitals with the second largest percentage increase per Medicare beneficiary of any state in the Union. This amounts to a per-beneficiary increase of $583, which is the thirteenth highest increase of any state in the Union.

Mr. President, beyond those quotes, I could give a lot of evidence, but I think those quotes speak volumes about our rural package. That package in this legislation speaks for itself. It brings real improvements and equitable payments to hospitals and doctors in Iowa and way beyond.

I ask unanimous consent to have these letters printed in the RECORD.

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

IOWA HOSPITAL ASSOCIATION
Des Moines, IA, Nov. 20, 2003.

Hon. CHARLES GRASSLEY,
U.S. Senator, Hart Senate Office Building Washington, DC.

DEAR SENATOR GRASSLEY: Congratulations in reaching an agreement on a conference report that directly and significantly impacts the issue of equity and fairness for hospitals and physicians in rural America and particularly for Iowa. Just this morning, the entire Iowa Hospital Association Board was briefed on the impact of your Medicare legislation and on a unanimous vote endorsed the pending legislation.

In an evaluation of the per-beneficiary increase, this legislation provides Iowa hospitals with the second largest percentage increase per Medicare beneficiary of any state in the Union. This amounts to a per-beneficiary increase of $583, which is the thirteenth highest increase of any state in the Union.

The Iowa Hospital Association strongly endorses passage of this legislation and will today ask its entire membership to weigh-in on behalf of the legislation with the entire congressional delegation of Iowa in an effort to support your work to achieve passage of this legislation before the Thanksgiving holiday. It is our hope that when Congress completes its work and you return to Iowa for the holidays, that all Iowa providers will have an opportunity to congratulate you for successful passage of this historic legislation.

Sincerely,

KIMBERLY A. RUSSEL,
IHA Board Chair.
KIRK NORRIS,
President/CEO.

IOWA MEDICAL SOCIETY STRONGLY SUPPORTS PASSAGE OF MEDICARE REFORM LEGISLATION

The Iowa Medical Society (IMS) announced today its strong support for the Medicare Prescription Drug and Modernization Act of 2003 conference report.

IMS President Tom Evans, MD, said passage of the bill is critical for rural states like Iowa. ''In addition to providing seniors with prescription drug coverage, this legislation fixes many of the reimbursement issues that have unfairly penalized rural states,'' he said. ''Congress must pass this legislation before the Thanksgiving recess.''

Evans said the bill protects Iowans' access to physicians by replacing a 4.5 percent payment cut scheduled for 2004 with two years of modest payment increases. The bill also fixes a component of the reimbursement formula that deals with geographic practice cost adjustors that causes huge reimbursement swings from state to state.

''If this legislation isn't passed, the American Medical Association estimates that a 4.5 percent cut in reimbursement will take $30 million away from Iowa's health care system in 2004,'' he said. ''Now add to this the fact that Iowa already receives among the lowest payment rates in the country, and you can see how Medicare is threatening our ability to care for our patients.''

Evans also thanked Senator Charles Grassley for his work on this bill as Chair of the Senate Finance Committee, and he urged Iowa Senator Tom Harkin and Iowa's Congressional Representatives to support the Medicare conference report.

The Iowa Medical Society is the professional association representing over 4,600 MDs and DOs. The IMS core purpose is to assure the highest quality health care in Iowa through its role as physician and patient advocate.

Mr. GRASSLEY. Now let me speak to what this bill does for Iowa's seniors. The bipartisan agreement provides all of the 485,042 beneficiaries in Iowa with access to Medicare prescription drug benefits, as I have stated previously, on a voluntary basis. It does it for the first time in the history of the Medicare Program. That begins January 2006. Beginning in 2006, the bipartisan agreement will give 142,297 Medicare beneficiaries in Iowa access to drug coverage they would not otherwise have and will improve coverage for many more.

Within 6 months after this bill is signed—in other words, during the year 2004—Iowa residents will be immediately eligible for Medicare approved prescription drug discount cards which

will provide them with savings between 10 percent and 25 percent off the retail price of most drugs. Beneficiaries with incomes of less than $12,123, or $16,362 for couples, who lack prescription drug coverage, including drug coverage under Medicaid, will get up to $600 in annual assistance to help them afford their medicine along with a discount card. That is a total of $100,840,345 in additional help for 84,034 Iowa residents during these years of 2004 and 2005, as this interim program is in place, helping Medicare recipients with drugs until we get the permanent program put in place. Then beginning in the year 2006, all 485,042 Medicare beneficiaries living in Iowa will be eligible to get prescription drug coverage through a Medicare approved plan.

In exchange for a monthly premium of about $35, seniors who are now paying the full retail price for prescription drugs will be able to cut their drug costs roughly in half. In many cases, they will save more than 50 percent on what they pay for their prescription medicines. One hundred thirty-three thousand beneficiaries in Iowa who have limited savings and low incomes—and this would generally be those below $12,000 for individuals and $16,000 for couples—will qualify for even more generous coverage. They will pay no premiums for their prescription drug coverage, and they will be responsible for a nominal copayment. That copayment would be no more than $2 for generic drugs and $5 for brand name drugs.

We have 41,300 additional low-income beneficiaries in Iowa with limited savings, and incomes below $13,500 for individuals and $18,000 for couples, qualifying for reduced premiums and a reduced deductible of $50 and a Medicare that will cover 85 percent of their prescription drug costs with no gap in coverage.

Additionally, Medicare, instead of Medicaid, will now assume the prescription drug cost of 50,000 Iowa beneficiaries who are eligible for both Medicare and Medicaid. These seniors generally will pay $1 and $3 per prescription and those in nursing homes will pay zero dollars for their prescriptions. This will save Iowa $175 million over 8 years on prescription drug coverage for its Medicaid populations.

I have tried to address for my colleagues, but particularly for my residents and constituents in Iowa, how this program will impact them as individual beneficiaries of the prescription drug part of our bill. And I have tried to inform my colleagues and my residents of Iowa how the rural equity package will help provide quality care for Iowans because we are increasing the reimbursement for our hospitals and for our doctors in rural America.

Now I will address several of the most egregious misconceptions about the bill that have been spoken on the floor of the Senate today. First, I will address the issue of protecting retiree drug coverage. This would be those people who have, for the most part, coverage from places where they used to work that also continue to cover people with health benefits and prescription drugs after they leave employment.

During the debate on S. 1, when this bill passed the Senate the first time in June of this year, it passed by a 76-to-21 bipartisan vote. At that time, even though we had that high bipartisan majority, my colleagues raised concerns about what they referred to as the high level of employers that would drop their retiree prescription drug coverage should we enact the prescription drug benefit into the Medicare Program.

At that time, the Congressional Budget Office told us that 37 percent of the seniors who have drug coverage—that is roughly one-third of the seniors under Medicare—would lose that coverage if we passed the bill. I think I ought to say that there was another group, the Employer Benefit Association, that studied the same issue and said it would be 3 percent to 9 percent who would lose coverage. So we probably have an intellectually honest difference of opinion by the Congressional Budget Office on the one hand and the Employer Benefit Association on the other hand. But we in the Congress are stuck, as we determine the cost of programs, with what the Congressional Budget Office says. We would rather—and it would be easier—if we could just go by what the Employer Benefit Association says, but we go by CBO because they are God when it comes to saying what something costs. So we had to live with that 37 percent.

Well, as we all know, however, employers have been dropping or reducing prescription drug coverage for many years. So this is really nothing new. If we were not even talking about this bill today, some board of directors of some corporation in America could come to the conclusion that they couldn't afford to cover their retirees anymore and drop them. What could Congress do about that? Nothing. But it is nice to have a program when that happens for people to fall back on. That is one of the reasons for this legislation.

Of course, we want to take care that we can do everything possible to make sure that corporation X doesn't do that. In just the past 2 years, retiree health care coverage has dropped by 22 percent. That was with this Congress not doing anything, not considering this legislation.

We know these days employers are finding it harder and harder to continue to voluntarily provide health insurance coverage. That is due to a lot of factors, including rising health care costs overall. Now, as we were in conference between the House and the Senate, we took this marketplace dynamic of company XYZ, ABC, or whatever corporation—that they could do this. This is a dynamic we had to take very seriously. So we went to great lengths to improve employer participation in drug benefits to keep employers in the game; to keep their retirees covered, as retirees would expect to be covered, but sometimes they are surprised when they are not.

Our conference report reflects this. It includes remarkably better policies for employers than those that were in either the bill that passed in the Senate 76 to 21 or that passed the House in June as well. So I am saying to you we brought back a conference report that was better in regard to employee-retiree coverage than either passed the Senate or the House in the first place.

So what happens when we do that good work? The policies in this conference report have led to major corporate plans endorsing our conference report. So the people on the other side of the aisle, with their charts, who are saying bad damage is being done by this legislation, what would they have us do? Pass nothing? If corporation X decides to drop, and there is nothing there for their employees, do you think those same people are better off if Congress does zilch? Where were they when they voted in the first place, complaining about S. 1 or H. 1, the House bill, when we passed them in June?

Here we are bringing back a conference report that is being endorsed by these corporate plans. Doesn't that mean anything to any of you? Under this conference report, employers will be given an enormous amount of flexibility and options—employers that already provide retiree benefits beyond Medicare coverage. This legislation will help make it more affordable for these employers to continue providing these benefits. We do that by a direct subsidy worth 28 percent of their drug spending between deductibles and the coverage gap.

I should add, too, this conference report makes this 28 percent completely excludable from taxation, so that instead of doing 65 percent good because of a 35 percent tax bracket that corporations are in, it does 100 percent good, bringing down the number of people who might lose coverage.

Now, some people would say, what is this corporate welfare all about—Congress giving money to corporations to do something they have been doing forever. Some people might say, well, when you buy a Chevrolet, you pay for these retirement plans. How many times do you have to pay for them? You pay for them when you buy a car and when you pay a 28 percent subsidy. We are cautious about the fact that some do that.

So I tell my colleagues over there—each of them who are complaining about this—this 28 percent subsidy is something you ought to be glad to have. Sometimes when we give corporations something, you condemn us for giving corporations something; but you cry when we do it and you cry when we don't do it because they might dump their retirees. In the final analysis, we are also doing it to protect the

taxpayers and the Medicare Program because it is better to encourage these employers to keep their retirees in these plans at a 28 percent subsidy, which is about $750 per person, instead of having those corporations dump those plans on the Medicare Program, and it is going to cost about $1,250. So that is why we do that.

Now, besides this 28 percent help, we also say that employers can use the flexibility this legislation provides to structure plans that complement Medicare's new drug benefits and provide them even enhanced benefits for their retirees. They can even do better than they are presently doing because of this flexibility we have in the legislation.

These new choices and options will do much more to help and, consequently, not threaten employer-sponsored health care coverage for those who currently receive it.

In fact, the Congressional Budget Office now estimates that the so-called drop rate—in other words, the rate by which corporations will drop their retirees—is now 17 percent because of the changes that were made in conference. In other words, we listened to our colleagues over there complain about a 37 percent potential drop rate because of the way S. 1 was written. But it goes to conference and it comes back from conference with, instead of 37 percent, 17 percent, and you folks are still complaining. I don't understand it. And these 2.7 million retirees will still be better off with Medicare coverage, likely paid for by their former employees. In other words, the 2.7 million people who would have been dropped, according to CBO, because of what we did in the conference—that is better than either bill when first passed in June; 2.7 million people are still going to be in their corporate retiree plan.

So I say to my colleagues—I hope you hear this—we have come a long way since June, when 76 people, in a bipartisan way, voted for this. Half of you over there voted for it. I believe company plans have a lot to be happy about under this conference agreement.

All seniors deserve health care benefits. All seniors deserve access to prescription drug programs. This compromise between the House and Senate provides that, and it makes certain that good sources of existing coverage remain intact. I urge my colleagues to embrace the strong employer provisions we have agreed to and vote for this conference report.

We have also heard from a lot of them over there that somehow we are trying to privatize Medicare. How many times do I have to say it? This program is voluntary. Nobody has to go into anything in this bill if they don't want to. If they want to keep traditional Medicare, keep it. But this issue has been brought up. Do you know why? Because these folks over there, my colleagues over there—every one of them—like to scare seniors. You know, it is called Medicare, but you like to make Medicare into ''medi-scare.''

You know, it is easy to scare seniors. I have my town meetings around Iowa. I hold town meetings in each of the 99 counties every year so I can keep in touch with my constituents. There are people—the older, the more so—but seniors come up to me and they actually believe what is said on that side of the aisle when people say somebody is going to take their Medicare away from them. They believe that ''medi-scare.''

They are really nervous. Some of them even have tears in their eyes. I tell them, if you just knew as seniors how you have a hook on Congress, that Congress is scared to death of you, you would be laughing at me instead of being scared of something we might do. That is how the concerns of the seniors of America are taken into consideration by people in the Congress of the United States.

Maybe we ought to have a little more of an independent view than be so concerned about the electoral power of the seniors, but they have tremendous influence on Congress. Maybe some people say too much influence. Regardless, it is wrong for people over here to ''medi-scare'' our seniors.

I wish to address this issue of privatization, but the easiest answer is that if you are satisfied with what you have—traditional Medicare—don't worry. Also, if you like other provisions in this bill, they are voluntary. You don't have to do them.

This bill before us today brings Medicare into the 21st century practice of medicine. It does not privatize traditional fee-for-service Medicare. Overall, this conference agreement relies on the best of the private sector to deliver drug coverage, supported by the best of the public sector to secure consumer protections and important patients' rights. This combination of public and private resources is what stabilizes the benefits and helps keep costs down.

Seniors will be able to purchase prescription drug coverage on a voluntary basis as part of Medicare's traditional fee-for-service program or be part of a new Medicare-approved private plan where the drug benefit is integrated into broader medical coverage. These Medicare-approved plans have the advantage of offering the same benefits of traditional Medicare, including prescription drugs, but on an integrated, coordinated basis. This creates new opportunities for chronic disease management and access to innovative new therapies.

Let me comment on chronic disease management. That is very important if we are going to keep costs down in the future. We won't have to squeeze seniors at all. In fact, seniors will have a better quality of life under chronic disease management because 5 percent of the seniors are responsible for 50 percent of the cost of Medicare. The reason for that is that we only pay doctors to make people well after they get sick. We never pay enough to keep them well in the first place.

We can concentrate on this 5 percent in chronic disease management, and by so doing, we are going to provide a better quality of life because they will not be in and out of the hospital as much, and we save money there. But also their quality of life is going to be better, and it protects the taxpayers in the process and preserves the longevity of Medicare.

Unlike Medicare+Choice, we set up a regional system where plans will bid in a way that doesn't allow them to choose the most profitable cities and towns. Cherry-picking cannot take place. Systems like this work well for Federal employees, such as the postmaster in New Hartford, IA, my hometown. He has a choice of several plans. We want to give that same choice to his parents who today only have traditional Medicare. They have no right to choose.

We provide an alternative plan for people who want to try something new, something that is probably close to what baby boomers have for health plans where they work. We have set up preferred-provider organizations. Are they right for everyone? We give seniors the right to choose. Our bill sets up a playing field for preferred-provider organizations to compete for beneficiaries. We believe preferred-provider organizations can be competitive and offer a stronger, more enhanced benefit than traditional Medicare, assuming seniors want to choose that. They have that choice.

Let me be clear, no senior has to go into a preferred-provider organization. My policy has always been to let seniors keep what they have if they like it with no changes. All seniors, regardless of whether they choose a PPO or not, can still choose prescription drug coverage if they want to, to go along with their traditional Medicare, but it is their right to choose.

I can't mention preferred-provider organizations without correcting the record regarding the preferred-provider organization stabilization fund that the other side has called a slush fund. It is no slush fund. It is something that those of us who live in rural America know we have to have. We learned a lesson from Medicare+Choice because in 1997, I worked hard to bring greater reimbursement to rural America through Medicare+Choice so that people in Iowa would have the same options that 40 percent of the people in Miami have chosen: to go into an HMO. It is a voluntary choice. If they don't like it, they can get out tomorrow. Get in today; get out tomorrow. In rural America, we enhanced greatly the reimbursement for them, but they have not come because of cherry-picking.

We want the preferred provider organizations to serve all of America, rural as well as urban. The stabilization fund is so those of us in rural America have an opportunity to get the same benefits as people in New York City or Los Angeles or Miami.

The bipartisan agreement on a final Medicare bill establishes this stabilization fund. It was not in the Senate bill. Some people say the Kyl provisions were similar to that, but Senator KYL will tell you he had a whole different idea in mind. His idea is not even in this bill, but we did take a stabilization fund to accomplish something he wants to accomplish. He wants his entire State of Arizona to be served by PPOs, not just Phoenix. We did this in an effort to expand access to private health plans in all areas of the country and, additionally, to maintain existing health care choices in areas where health plans face particularly difficult challenges.

My colleagues on the other side who find fault with this conference report are always talking about this slush fund as benefiting some organization's profit motive.

Every one of them has rural areas. My colleagues ought to want the people in the rural parts of their State to be served the same way as people in the urban parts of the State.

The reality is that this is not a slush fund, but it is to help beneficiaries have equal services, whether they live in rural America or urban America, and that will be helped by this stabilization fund. It is targeted and its plans are held accountable. Resources will be distributed from the stabilization fund only when specific conditions are met. Moreover, in instances where these conditions are met, then health plans will be accountable for using these funds only to promote affordable health coverage to beneficiaries, not for profit. Under no circumstances will plans then be permitted to use these funds to pad their bottom line.

It expands choices and ensures access in rural areas. The fund is designed to expand and preserve beneficiary choices and benefits in areas where it is most difficult to provide private health plans and to get them to participate in this program.

The stabilization fund will ensure that millions of additional beneficiaries, including many in rural areas, will have access to health plans offering high quality, comprehensive benefits, and low out-of-pocket costs. If the stabilization fund is not successful, the worst case scenario is that the funds will be returned to the U.S. Treasury.

Now I will speak about the accurate explanation of how this bill helps low-income seniors. We did something in the conference report that the House did so the Senate receded to the House on this point, and that is where we in the Senate decided to leave dual eligibles who were covered by Medicaid. That is the way it passed the Senate. The House wanted to have one program for seniors, a totally Federal program, so dual eligibles in the House bill were taken away from Medicaid and put in Medicare. We accepted what the House wanted to do, as a matter of equality I suppose. We had other motivations for doing it in the Senate.

In fact, most of the support for doing that—that was one of the shortcomings that Democrats said about the Senate bill in June. Now we are hearing complaints from them about aspects of this dual eligible, how it impacts seniors, particularly on asset tests. That is one of the reasons we tried to avoid putting dual eligibles under Medicare in the Senate bill, because we wanted asset tests to be the same for this group. Now they are complaining, I think inaccurately, which I will prove in a minute, about it negatively impacting people with less coverage than they presently have.

We have heard from the other side how 6 million low-income eligible seniors will be worse off under this conference report. That is inaccurate. It is a lot of talk, and I want to tell the American public the truth about this issue. Beneficiaries are not hurt by this bill. They are helped. This bill provides generous predictable coverage to 6.4 million dual eligibles, but it does not stop there. It provides coverage to an additional 7.7 million low-income seniors. Madam President, 14.1 million seniors are eligible for low-income subsidy, nearly 36 percent of Medicare beneficiaries.

So who are these dual eligibles? They are the 6.4 million who are enrolled in both Medicare and Medicaid.

This conference report for the first time provides drugs to dual eligibles through Medicare rather than Medicaid. This is a great help for the States that have budget problems, and Medicaid is a growing, biggest part of State budgets.

As I said, the Senate bill left dual eligibles in Medicaid. That policy allowed the Senate to provide generous coverage for low-income seniors. S. 1 focused on providing drug coverage to seniors who did not have any coverage whatsoever, and duals did have that coverage. So in the spirit of compromise, the Senate conferees changed the policy in the Senate bill.

The conference report provides prescription drugs for dual eligibles through Medicare. It is not exactly the same, but in general policy it is the same way they were treated in the House bill. Providing drugs for dual eligibles through Medicare was a cornerstone issue for House conferees.

The conference report covers duals in the Medicare Program. The coverage is designed to benefit as many low-income seniors, including duly eligibles, as possible, given the budget constraints of $400 billion in our budget.

This bill comes out at about $395 billion. Blanket statements about the reduction of benefits for the dual eligibles in the conference report are not accurate. We have heard some of those inaccurate statements this Saturday as we have debated this bill. This bill is generous and does not leave 6.4 million seniors worse off. I will bet tomorrow those over on the other side will be putting those signs up again that say that. Well, don't do it.

For instance, unlike the Senate bill or the current Medicaid Program, the conference agreement does not have cost sharing above the catastrophic limits for the dual eligibles. That is right. There is no cost sharing. I hope my colleagues on the other side get that.

I will put this in perspective, then, from the State level. According to the Kaiser Family Foundation, the Commonwealth of Massachusetts currently charges $2 for every prescription filled by dual eligibles. There is no catastrophic limit for duals in that Medicaid Program in that State, just a requirement for beneficiaries to pay $2 for every single prescription.

Like many Medicaid Programs, this bill establishes copayments for a majority of the dual eligibles who are either equal to or less than those required by most State Medicaid Programs. So let's get that straight. These copayments are no more than, and in some cases less than, those required in most State Medicaid Programs.

More specifically, today 25 States have copayment levels for generic and brand-name drugs set at $1 or higher for dual eligibles enrolled in their Medicaid Programs. In this conference agreement, dual eligibles with incomes below 100 percent of poverty will be responsible only for a copayment between $1 and $3 for their Medicare drug benefit. Taking a step back, it seems to me that this level of cost sharing is very similar to what the duals pay for in Medicaid coverage.

In fact, in South Dakota, duals pay $2 per prescription. That policy is on par with the coverage offered through this bill. This conference report contains a generous drug benefit, then, for dual eligibles. There is no donut, or no loss of coverage, no gap in coverage, for low-income Medicare beneficiaries. But my colleagues on the other side would lead us to believe otherwise.

The bill guarantees all 6 million dual eligibles access to prescription drugs. Under the conference report, dual eligibles will have better access through Medicare than they do today, specially since State Medicaid Programs are increasingly imposing restrictions on patients' access to drugs because of budget problems that 45 of our 50 States have.

Further, States have the flexibility to provide coverage for classes of drugs, including over-the-counter medicines that might not even be covered by the Medicare Program.

This bill ensures appeal rights for dual eligibles. Under the agreement, duals will maintain appeal rights, such as those that they presently have in the Medicaid Program. The dual eligibles are a fragile population and are well taken care of in this bill. The conference report recognizes and provides generous coverage to these 6 million beneficiaries and in fact goes further by providing full drug coverage to 7.7 million more low-income seniors.

So I turn now to highlighting what this bill does to protect Medicare in

the long run. I have heard some Members trying to assert that this $400 billion expansion of one of the most successful social programs in our country's history is going to destroy traditional Medicare; you have said it, ''Medicare as we know it.'' That is another one of your ''medi-scare'' tactics.

I know Members are tired. I know we are nearing the closing of our first session of the 108th Congress. Many Members are using these wornout lines because they would rather not take a serious look at the bipartisan Medicare agreement we put together and really assess whether or not those scare tactics are true. I am here to tell all my colleagues and the people of this country that the allegations that this Medicare bill destroys traditional Medicare are falsehoods.

This Medicare bill strengthens and improves traditional Medicare in a number of ways. We are not talking about just Medicare as it has been for the last 38 years. We are talking about some improvements we made in traditional Medicare that seniors will have the choice, the right to choose to stay in if they want to. I will discuss just three.

First, we add new preventive program benefits. For the first time ever, every new Medicare enrollee will receive a ''Welcome To Medicare'' physical; they go to the doctor when they go into Medicare, get a benchmark physical. Hopefully, nothing is wrong. But if something is wrong, we know about it right away and it is part of our effort to see that we zero in on keeping people well, as opposed to waiting until they get sick and it costs a heck of a lot more. It is part of our program, of a quality of life for our seniors. It is part of our program of zeroing in on the 5 percent of the people who, because of not having chronic care management, are costing us 50 percent of the total costs.

Seniors are going to have physicals that will help them—maybe their lifestyle, like getting their weight checked, but more seriously, the heart; receive cancer, diabetes, and bone mass screenings. It is very important to have an initial physical because, as we say in Iowa, an ounce of prevention is worth a pound of cure.

Consider these statistics. In 2000, 6.2 percent of the U.S. population had diabetes. Heart disease and stroke are the first and third leading causes of death in the United States. In 2003, 1.1 million Americans will have a heart attack. Diabetes, heart disease, and other chronic conditions exact an awful toll on our seniors. By getting an initial physical, seniors can get valuable information on their health status. They can enroll in weight loss programs, start a blood pressure medicine, or know whom to call if something goes wrong.

We have also eliminated the deductibles and the copays on screening tests for heart disease and diabetes, so beneficiaries do not incur any costs. There is an extent to which that cost today may inhibit them or divert them from having needed tests, so this is an additional incentive, particularly for those with limited resources who might not otherwise access these benefits. Adding preventive benefits is just one way we have improved traditional Medicare.

A second way we have improved the fee-for-service program is by providing access to disease management. It is a common option available to younger people in health insurance. If you have a chronic health condition such as heart disease, diabetes, asthma, you can get extra help managing your condition. You may be taking a lot of medications and seeing several doctors. Disease management programs help patients take responsibility for their health care and better control of their lives, but they also involve health professionals in that process, to aid you.

When this Medicare bill becomes law, seniors with access will have access to these services. It will be a voluntary program and one that will improve the quality of life for millions of Medicare beneficiaries.

Another improvement is this bill provides an additional $25 billion for rural health care providers. That is new money to strengthen our Nation's hospitals, physicians, ambulance riders, and dialysis clinics, just to name a few. This is the biggest funding boost Congress has ever passed for our rural health care system. This is going to help fee-for-service, traditional Medicare because in some places in this country there is not an adequate number of health care providers. Providers in rural States such as mine, Iowa, practice some of the lowest cost medicine in the country. Yet health care providers in rural areas lose money on every Medicare patient they see. This Medicare bill takes historic steps toward correcting geographic disparities that penalize rural health care providers.

So when I hear people in Washington say this bill is going to destroy traditional Medicare, I suggest that each of them take a closer look at this legislation. Providing new preventive benefits, allowing seniors to access state-of-the-art disease management programs, and mending the rural health care safety net will help millions of seniors with these three important ways we are strengthening Medicare.

I would like to turn now to a subject that is important to me, to the taxpayers, and to the seniors, and that is the issue of curbing waste, fraud, and abuse. You just read in your news releases from HHS, $11.5 billion of waste, fraud, and abuse within health care. If we can save that money, we are going to make Medicare strong for a long time in the future.

When it comes to reimbursements for many of the items and services that Medicare covers, the price, historically speaking, has not been right. That goes, for instance, for doctors and hospitals in rural areas who are paid too little, and some drugmakers and equipment suppliers, to name a few, who are paid too much.

This conference agreement makes great strides toward correcting both the underpayment and the overpayment that plague the Medicare Program. I have already talked about the underpayments to rural States such as Iowa and how this bill corrects that through the $25 billion of new money we are injecting into making Medicare reimbursements equitable.

But I want to talk now about just the opposite. There are overpayments in Medicare. Overpayments eat away at Medicare's reserves, eating away at its solvency slowly, like a cancer. Overpayments are bad for taxpayers, they are bad for beneficiaries, both of whom deserve to pay a fair price. In certain areas of Medicare, in many payment systems there are few fair prices.

Fee schedules pay too much, providers play games with complex rules and regulations, and beneficiaries pay a higher copay as a result. The sad fact is that Medicare's price is often far higher than the marketplace price. This conference agreement begins to change that in significant ways.

My colleagues should read title III of the conference report, and that is entitled, ''Combating Waste, Fraud, and Abuse.''

Our bipartisan initiative in this bill will end overpayments, reduce fraud, and cut down on opportunities for abuse to the tune of $31.3 billion as scored by the Congressional Budget Office. That is significant.

These measures in this bill directly reduce Medicare's spending on overpriced, wasteful, fraudulent items, and services to the tune of $31.3 billion over 10 years.

Throughout my time in Congress, I have worked hard to combat fraud and waste in Federal programs. In 1986, I successfully passed False Claims Act improvements that give whistleblowers new rights and protections under Federal law. In just the last year alone, civil fraud recoveries have tallied a record $2.1 billion, the Justice Department announced just last week. This is a 75-percent increase over the prior years' recoveries of $1.1 billion, and brings total recoveries to over $12 billion since I got that bill passed. Of the $2.1 billion, $1.4 billion is associated with suits initiated by whistleblowers.

While the False Claims Act is one of our best weapons in the war on fraud and abuse, our policies in this new language of the title III conference agreement adds still more weapons to our arsenal.

First, we make important technical clarifications to existing law that strengthen and improve what is known as the secondary payer statute. The purpose of the statute is to ensure that Medicare pays first for seniors' medical needs when other sources should be, in fact, paying instead of the taxpayer paying.

These other sources include, for instance, employer coverage. In addition, when a Medicare beneficiary is injured by wrongful conduct of another entity, that entity's liability insurance or the entity itself, if it has no insurance, or it might be self-insured, is always required to pay first instead of having the taxpayers pay. The provisions in title III do not change existing law in this area but, in fact, clarify the intent of Congress in protecting Medicare's resources.

According to the Congressional Budget Office, these clarifications alone promise to restore Medicare over $9 billion out of that $31 billion.

Second, we change the way Medicare pays for durable medical equipment, first by slowing the spending growth in these areas for 3 years, and then by instituting a competitive mechanism that will deliver a fair market price for seniors.

While I have concerns about the impact of such a new system on very many small businesses across America, the supply of high-quality equipment especially in rural areas, I am confident that good protections are in this conference agreement for small business and for our seniors as well.

The Congressional Budget Office estimates that these changes will save Medicare $6.8 billion out of that $31 billion.

Next, title III institutes what we call market pricing mechanisms for drugs administered in the doctors' offices that both the Office of Inspector General and the GAO have concluded are priced far higher than their actual costs.

In addition to the financial toll these overpayments take on the taxpayers, they also affect Medicare's beneficiaries who are often required to pay dramatically higher copayments for the drugs they rely on. In some instances, these copayments can even exceed the actual prices the doctors paid for the drug.

In recommendations to Congress, the GAO urged Medicare to take steps to begin paying doctors for Part B-covered drugs and related services at levels that reflect the doctor's actual acquisition costs—not some inflated cost. And they use information about actual market transactions prices to bring that about.

I am pleased that our conference agreement accomplishes this first by reducing the so-called average wholesale price by 10 percentage points, and then instituting a new payment system based on manufacturers' reported average sale price—or ASP reporting—which will be closely scrutinized by the inspector general on an ongoing basis ensuring its accuracy.

Errors or abuse of the system will be corrected swiftly so that Medicare will never again pay an unfair price.

These changes result in Medicare savings of approximately $11 billion out of that $31 billion total.

Finally, title III takes similar steps to correct overpayments for respiratory medicine which the Office of Inspector General has said are priced far in excess of their actual costs. These drugs will be reduced by 10 percentage points in 2004, and then priced on a similar average sale price system, as others I just mentioned, and that will begin in the year 2005.

The Congressional Budget Office says that this policy alone will save Medicare $4.2 billion of that $31 billion total.

I have listed three or four examples of how you save that $31 billion.

I believe all of these changes have been carried out in a compassionate fashion with twin goals of protecting both the Medicare Program's resources and our senior citizens' access to those services. We have done both.

Our market-based improvement Part B drug payments are accompanied by sweeping changes in payments for clinical services associated with delivering them.

We worked closely with oncologists to ensure that access to cancer care was not harmed.

Similarly, we went to great lengths to ensure that seniors who rely on medical equipment supplies will be able to rely on them as they do today.

Finally, to my colleagues who talk about cost containment and the need for Medicare to curtail its spending, I say this: It starts right here. Cost containment begins by ensuring that the costs to Medicare and to the taxpayers who finance it are, in fact, fair.

The conference agreement starts us down the road. The sum total of $31.3 billion of savings, and the market prices we are imposing on future spending in this area, are in my view, the most significant cost containment policies in this conference agreement.

In the months and years ahead as Medicare spending increases with the expansion of benefits that we are going to pass here shortly, our focus on cost containment will obviously increase. The best thing that Congress can do is to be vigilant. We all need to watch Medicare's outlays closely, and to listen to whistleblowers who are patriotic citizens telling us when there is fraud and crying for government to do something about it.

We also need to pay attention to other private individuals who have inside information on wrong doing. We need to heed the warnings of the Office of Inspector General, and, most of all, insist that Medicare never pay more than market price. Taxpayers, on the one hand, and the seniors' Medicare services, on the other hand, deserve nothing less.

I want to conclude by talking about the views of very many organizations that support the conference report.

Mr. GRASSLEY. Madam President, I want to quote from some.

As you know, I have a chart up here talking about the AARP. All of you colleagues on that side of the aisle have been saying to me all day how dastardly it is that the AARP is backing this legislation. Some Members have even spoken of them becoming a political organization. They cannot become a political organization or they will lose their tax-exempt status. But you accuse them of being a tax-exempt organization.

It is funny, last year when they did not come out for the bipartisan bill that several Members brought out, that the Democrat majority did not want to let pass because they wanted an issue in the last election instead of a product, the AARP was not backing what I, Senator SNOWE, Senator JEFFORDS, Senator BREAUX, and Senator HATCH wanted to do. Ours was a bipartisan effort, or a tripartisan effort, with Senator JEFFORDS being an Independent, to get a bill through because you cannot get through anything in this body if it is not bipartisan. The AARP did not like what we were doing. They did not discourage us but they did not help us. They actually sent letters out to support what Senator KENNEDY was trying to do a year ago.

I did not accuse the AARP of being a tool of the Democrat Party like Members on the other side are accusing the AARP of being in bed with the Republicans. They are not in bed with the Republicans. They are in bed with a bipartisan group of this body who want to do something for seniors of America. It is funny how the AARP is OK when they are helping Senator KENNEDY but they are not OK if they are helping a bipartisan group led by Senator GRASSLEY and Senator BAUCUS.

I would say they are discretionary in what they do. They may not be consistent, but thank God they are not consistent because they would not be representing the diverse group they represent.

Here is what the AARP says in their endorsement:

> AARP believes that millions of older Americans and their families will be helped by this legislation.

They continue:

> This bill provides prescription drug coverage at little cost to those who need it most: People with low-incomes, including those who depend on Social Security for all or most of their income. It will provide substantial relief for those with very high drug costs and will provide modest relief for millions more.

The last sentences I will read:

> An unprecedented $88 billion will encourage employers to maintain existing health retiree benefits. The legislation will help speed generic drugs to market and add important new preventive and chronic care management services. This legislation protects poor seniors from future soaring prescription drug costs.

All the Members complaining about the AARP, put that in your pipe and smoke it.

Then we have the National Council on the Aging:

> . . . we find it too difficult to again say to millions of vulnerable seniors in need: Sorry, come back in a few years and maybe there will be some help for you then.

Another sentence:

We urge Congress to pass the Medicare bill so that millions of seniors with greater needs will receive long-awaited and badly-needed prescription drug coverage.

Are Members trying to tell me the National Council on the Aging does not know what is good for seniors when they see it? Put that in your pipe and smoke it.

The Alzheimer's Association says:

This is a historic accomplishment that may potentially provide meaningful relief to the 4.5 million Americans dealing with Alzheimer's disease—many of whom also suffer other health issues.

That is from Sheldon Goldberg, president and CEO of the Chicago-based national organization for the Alzheimer's Association.

Are Members telling me the Alzheimer's Association cannot make a judgment if this bill is good for their members? Go put that in your pipe and smoke it.

From the American Diabetes Association:

. . . contains important improvements to the Medicare Program that will benefit many people living with or at risk for diabetes.

. . . the prescription drug package assists seniors living with diabetes by providing coverage for insulin and syringes, a critical component for seniors that take insulin to manage their diabetes.

. . . the American Diabetes Association supports passage of—and strongly urges Congress to enact—the Medicare package as a way to improve the lives of millions of seniors living with diagnosed and undiagnosed diabetes.

Are Members trying to tell me the American Diabetes Association does not know a good piece of legislation when they see it? Put that in your pipe and smoke it.

We have a statement by Advancing Health in America, AHA, saying:

It provides prescription drug benefits to the elderly and provides needed Federal relief to hospitals, particularly rural hospitals.

The legislation includes important provisions that help patients by providing hospitals the resources necessary to continue caring for America's seniors.

Tell me an organization called Advancing Health in America does not know what is good for their Members.

From the American Medical Association:

Congress listens to America's patients and physicians who serve it.

The status quo is unacceptable to patients and their physicians. The Medicare conference agreement includes numerous provisions that will improve seniors' access to medical services.

Tell me the American Medical Association does not know what is good for their members or what is good for their members' patients.

The Arthritis Foundation says:

The Arthritis Foundation supports a Medicare Prescription Drug, Improvement, and Modernization Act for 2003 that for the first time would provide coverage for prescription drugs and biologicals for persons with arthritis.

Can Members tell me the Arthritis Foundation does not know what is good for their members, know a good piece of legislation when they see it?

We have the American Pharmacists Association:

. . . APhA supports this as an important, long-overdue step toward providing Medicare beneficiaries greater access to medications and critical pharmacist services.

The proposal creates a comprehensive benefit that provides coverage for drug products and pharmacist services, and provides seniors their choice of pharmacists and ensures any willing pharmacist can participate in a plan and incorporates important administrative efficiencies.

Those Members who oppose this bill, are you trying to tell the people of America that the American Pharmacists Association does not know a good piece of legislation when they see it and that they cannot speak for not only their membership but also their patients and clients they serve?

From the College of American Pathologists:

This legislation will improve Medicare coverage for seniors and protect access to the physicians and services upon which they rely for quality of care.

The conference agreement also preserves critical health care services provided by independent laboratories in to hospital patients, especially in smaller and rural communities.

Are Members telling me, as they criticize this legislation, that the College of American Pathologists would support legislation that is not good for their patients and the people they serve?

The Federation of American Hospitals:

This agreement does more to improve Medicare coverage for seniors than any legislation since its program inception.

That is 38 years.

The Federation of American Hospitals commends President Bush, the Congressional leadership, and members of the Medicare Conference Committee for their great efforts in bringing these vital improvements to the Medicare to fruition.

H.R. 1 would greatly enhance the ability of hospitals to provide necessary care medical care to Medicare beneficiaries. It would make important strides in ensuring that all hospitals have sufficient funding to meet the medical needs of this nation's seniors and would particularly aids though hospitals that serve seniors in rural areas.

Every Member has rural areas in their State. And we have a major hospital association supporting this legislation because it is particularly going to serve seniors in rural America.

Now, tell me that they do not know a good bill when they see it.

Here is something that answers complaints that were heard late this morning or early this afternoon. One of the first speakers on the other side of the aisle, the Senator from Illinois, was complaining about this not doing enough for generics. But here we have the Generic Pharmaceutical Association:

The Generic Pharmaceutical Association today called the Medicare Conference compromise on generic drugs a tremendous victory for all consumers that will ensure timely access to affordable pharmaceuticals. . . .

The House and Senate conferees have met the challenge of eliminating some of the most serious barriers to generic competition by closing loopholes that have unnecessarily delayed the timely introduction of affordable pharmaceuticals—and American consumers, young and old alike, will be the winners.

Now, how many of you speaking today have complained about this legislation not doing anything about the cost of drugs? And we know that putting generics on the market sooner is one of the ways to bring down tremendous drug costs.

Now, the Generic Pharmaceutical Association supports this legislation, and yet you do not recognize that they understand a good piece of legislation when they see it.

We have the United Seniors Association:

We commend the Senate and House Conferees on their historic step to benefit every senior in America. Partisan politics and rhetoric-without-results on prescription drugs are simply unacceptable. Years of hard work by many in Congress and years of heartache for America's seniors have led us to this point. The whole senior world is watching and Congress must not collapse so near the finish line.

Are you trying to tell me that the United Seniors Association looks at this legislation and sees it is good for their members, and yet you cannot see that?

We have The 60 Plus Association:

The bill makes available much needed assistance to millions of seniors who lack any prescription drug coverage. Significantly, those who can least afford to pay will get the most help [from this legislation].

From the Rural Hospital Coalition:

We support your efforts to modernize Medicare and give senior citizens a prescription drug benefit that they deserve. . . . [T]his bill strengthens health care in rural America.

From the National Rural Health Association:

This bill is a big boost for the rural healthcare system. . . . A stronger healthcare system will help revitalize rural economies which will positively impact rural Americans throughout the country.

We have the National Hospice and Palliative Care Organization:

NHPCO strongly supports these provisions and believes these changes will improve the quality and timeliness of hospice and palliative care for seniors and their families.

From the Mayo Clinic, 150 miles from my home in Iowa:

Mayo Clinic supports the compromise Medicare reform legislation that has emerged from a congressional conference committee.

We have NAMI, The Nation's Voice on Mental Illness:

This conference agreement does represent an improvement for Medicare beneficiaries living with mental illness. . . . NAMI feels strongly that it is time for Congress to end partisan stalemate over this issue and take advantage of the $400 billion available this year to spend on a new drug benefit.

This is kind of a partisan statement I am going to read to you, but it does represent a group of people who are impacted by what we do here with dual

eligibles. It is from the Republican Governors Association:

Medicare will provide first-time access to prescription drug coverage to many of our seniors. The agreement also assists states with the costs related to the dual eligible population. Assistance to low income persons as well as critical protection against high out-of-pocket drug costs are essential components of this legislation. . . . [T]he preventive benefits found in this measure will keep our constituents healthier.

From the Alliance For Aging Research:

With this act the millions of Medicare beneficiaries will no longer have to wait from 15 months to 5 years for access to new state-of-the-art medicines and life-saving and life-enhancing technologies. In addition, and most importantly, it targets those with the greatest need by providing significant low-income subsidies for prescription drugs that will assist millions of Medicare beneficiaries living longer and healthier lives. . . . This will be a giant step toward expanding and modernizing Medicare, while preserving the power of science and technology to improve and enhance the lives of our people in the future.

Lastly, we have the American Benefits Council, a news release. The headline: ''Medicare, prescription drug reform bill represents historic, positive achievement.''

We urge swift enactment of the legislation. . . .

I have quoted these statements from these outstanding organizations for the RECORD because they speak louder than any Member of this Senate can about what is good about this legislation.

I would hope that you folks on the other side of the aisle would take these statements into consideration, particularly tomorrow, when I am told 15 of you are going to speak, probably most of you against this legislation. I would appreciate you taking into consideration what these major groups have said.

Madam President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. GRASSLEY). Without objection, it is so ordered.

Ms. MURKOWSKI. Mr. President, I realize the hour is late. This body has been discussing the issue of Medicare legislation for close to 12 hours now on this Saturday.

I want to speak briefly this evening about the legislation that is under consideration in the Senate and its impact on senior citizens in my home State of Alaska as well as around the Nation.

We have heard a great deal today on the floor about the need for reform, about what we need to provide for our senior citizens.

We must keep in perspective what we owe our seniors. This is the generation of Americans who paid most dearly to protect the freedoms we enjoy. Many of our older Americans today went through the Depression and have very personal, truly gut-wrenching memories of the hunger that they perhaps went through at the time. They were the generation who settled the frontier areas of America, including my State of Alaska. They remember the horror and the stories from Pearl Harbor. We owe this generation of Americans many things, not the least of which is honesty.

Since Medicare was enacted in 1965, it has provided health security to millions of America's seniors and people with disabilities. Medicare is that promise of health security we must always keep.

Many of my colleagues on the other side of the aisle would like Americans to believe that the bill in front of us today is designed to kill those promises made in 1965. I remind my colleagues that Americans deserve more than the rhetoric and the scare tactics we have heard saturating the airwaves from here. Earlier this evening in listening to the debate, one of my colleagues made reference to the fact that seniors are going to have to sell their wedding rings in order to meet certain levels for low-income subsidies for Medicare beneficiaries.

I thought, wait a minute, that can't be true. That is not a part of this legislation. Seniors will not have to do that. So I said: Show me. Let me know for sure that, in fact, this is not the case.

We pulled it out and looked at the application of the asset test. It very clearly states those resources that are not counted for an asset test, excluded resources, include, and No. 3 on the list is memorabilia such as a wedding ring. For us to stand here on the Senate floor and suggest to a senior citizen that in order to meet certain requirements to keep your Medicare benefits you might have to give up your wedding ring, I sure hope my 84-year-old next-door neighbor was not hearing that because I know she wouldn't sleep well knowing that that could be true.

We have to be real. We have to be honest with our statements, and we have to talk the truth about what is and is not contained in the legislation before us.

Americans deserve to know that this bill, while not perfect—I don't think any of us would suggest it is perfect—will provide good drug coverage for any senior citizen who wants to enroll. Americans deserve to know that this bill doesn't force seniors to join HMOs to get prescription drugs.

This legislation is designed to provide choice, not coercion. If seniors want to add prescription drug coverage to the Medicare plan that they have right now, they would have that option. Their benefits would not be reduced, would not be taken away. If they don't want the drug coverage or if they are happy with the coverage they have now through their retirement plan, they don't have to accept the voluntary Medicare benefit.

The incentives for employers to keep offering their own prescription drug benefits: The Employer Benefit Research Institute indicates that they expect between 97 percent and 99 percent of beneficiaries won't have any change in benefits. We need to clearly repeat these provisions.

The bottom line is this: If you like Medicare the way it is today, you can keep it that way because it is designed to be a voluntary benefit.

The problem is for many Americans, including those in Alaska, Medicare has not been living up to its promises. It will only pay for your drugs if you have been hospitalized. And for many, it does not pay for the health care professionals. Essentially, this program is still stuck in the 1960s mindset of reactive care rather than the kinds of proactive care we expect today.

Several months back I had an individual up in the State who was meeting with me and going out to senior centers. We were talking about the Medicare legislation in front of us at that time. She made the analogy that Medicare is like the telephone. In 1965, the telephones that we had in our homes were the black rotary dial. They came in one color and one style, and that was it. And that was how we talked.

Now in the year 2003, we talk on cell phones, by fax, e-mail, on colored phones. The technology has changed incredibly, but we are still doing the talking.

Medicare is essentially the rotary dial system of health care that just hasn't been ramped up.

Americans need to know that Medicare still doesn't provide full coverage for preventive care, including cancer, diabetes screenings. It doesn't offer protection against catastrophic medical costs, these things that can rob our seniors of their hard-earned savings. There has been a lot of rhetoric about the drug benefit. But if you cut all through it, if you do the number crunching, you get to the indisputable fact that the average senior citizen, after paying their premium, is going to see a savings in the cost of their drugs—we estimate about a 63-percent savings in the cost of drugs.

For those seniors with limited income and limited savings, which is about half of Alaska's senior citizens, half of Alaska's senior citizens are in this lower income bracket, they will have closer to 90 percent of their drug costs covered, and this is not a skimpy benefit.

The bill also adds important preventive benefits that are many years overdue. In order to combat our Nation's No. 1 and No. 3 killers, which are heart disease and stroke, Medicare would be required to cover screening blood tests with no cost to the senior. This bill helps the millions of Americans who struggle daily with the chronic diseases such as asthma and diabetes. The bill adds principles of disease management to Medicare which will help the seniors navigate the oftentimes confusing health care system and get them

the access to vital specialty care and educational resources.

While we all seem to agree that it is important to add preventive benefits to Medicare, there has been a lot of discussion about whether to allow government-regulated private plans to offer these Medicare benefits. I have to step back a little and wonder if perhaps I am the only one who finds it ironic that we would use taxpayer-funded subsidies to give each one of us in Congress a choice of health plans, but yet we would deny our senior citizens that same choice.

The bill before us rejects this philosophy of ''big Government knows best,'' and tells our seniors: You have the right to select a benefit that meets your needs. If you don't need drug coverage, you don't have to enroll. You can keep Medicare the way it is today. If you don't want to join a private plan, you don't have to. If you don't want to change anything about Medicare, you don't have to.

I also want to address a comment that a number of Members—primarily on the other side of the aisle—have made characterizing Medicare as good the way it is now. I have even heard a number claiming that the Medicare Program today gives seniors such things as a choice of doctors. While I agree with them that Medicare is a good program, and I believe we need to make sure it still exists for our children's children, I need to let my colleagues know that the way the current Medicare Program does business, it hurts those in my State who have been promised care.

Every week, Senator STEVENS, Congressman YOUNG, those in the Alaska delegation, and I come to work and we are faced with a huge stack of mail, e-mail, phone calls, and the like from Alaskans about the problems they are having with Medicare. I mentioned earlier that this summer, back in my State, I held a senior citizen forum in the community of Chugiak. What I learned may actually surprise some of my colleagues who seem particularly enamored with the way Medicare is today. Seniors in Alaska are not only being denied a choice of doctors, but in many cases they don't have the ability to see a doctor at all. This is because doctors, or health care providers, in Alaska are paid just about 37 cents on the dollar for the care they provide to seniors on Medicare. Medicare is a price-fixer. So what we have is somebody in Baltimore sitting in a cubical, and they are deciding how much to pay for medical care in the community of Delta Junction, in Alaska; or take the community of Bethel, not on the road system, completely cut off from the rest of the world. If the payment the folks in Baltimore have said we are going to be charging is less than the cost of actually providing the care, Medicare basically tells our doctors: Tough, you are out of luck. This price-fixing causes problems not only in the rural areas of the State—as I mentioned, in a place such as Bethel or Delta, where you would expect these problems—but the sad truth is that even seniors in the urban centers of Alaska, in Anchorage and Fairbanks, cannot find a doctor who will accept new Medicare patients.

Perhaps I need to go a little further in explaining to my colleagues how much of a problem this is in my State. When a senior in the lower 48 cannot find a doctor in their community to help them, they can hop into their car and drive to the next town and find a doctor—just go to the city. But when seniors cannot find a doctor in Fairbanks—and the whole State knows seniors in Anchorage are having the same problem—there are two options for them. The first one is that there are few things you can do. Second, there are bad things you can do.

The simple fact is that for many of my constituents, their choice for a doctor is limited to those who are practicing in the emergency room. Who is the doctor on call that night? That is their choice of doctors.

The only other choice is—and this is probably a choice only for a few—to fork over the $1,400, or whatever the price of the airplane ticket is, to make the 8-hour roundtrip flight to Seattle and try their luck with doctors there.

Just 2 weeks ago, I had a constituent in my office who told me she flies to Virginia every year to see her doctor. She lives in Alaska. She flies to Virginia to see her doctor. She does this because she cannot find one in Anchorage who will accept new Medicare patients. The cost for the ticket alone, not counting her lodging and meals while she is there, is about $1,500. Unfortunately, these situations in Alaska right now are not the exception; they are the rule.

We have somewhere between 1,000 and 2,000 senior citizens in Anchorage alone who cannot find a doctor who is willing to treat them. The situation in Fairbanks is not much better. We recently called up the State to one of the larger clinics there that accepts Medicare patients. We asked them: Are you accepting new Medicare patients, and when would the first available appointment be? We were told mid-July. This is not choice when it comes to your doctor.

How is this situation keeping the promise we made to our senior citizens in 1965 when we established Medicare? What kind of treatment are you advocating for when you keep Medicare the way it is? We can come up with grand plans here in Washington and we can talk about Medicare reform, but if we don't have doctors who can write the prescriptions, if we don't have access to physicians, we have not done anything to fix the problem with Medicare.

Keeping Medicare as we know it in Alaska means Alaskans will go to the emergency room for primary care. It means making Alaskans pay to fly across the country by themselves to go find a doctor, and it means making Alaskans go without preventive screening.

Medicare as we know it doesn't give patients a choice of providers or access to the care of their choice, as some of my colleagues have stated. Medicare isn't working perfectly and desperately needs reform. I believe the legislation we have in front of us is a good compromise. It includes provisions that will ensure that senior citizens around the Nation and in Alaska will be able to find a doctor somewhere other than in the emergency room.

We owe our seniors a little more honesty in this debate. They deserve to know clearly that the prescription drug is voluntary. They deserve to know they will not be forced to join a program they don't want to join. They deserve to know the average senior citizen who joins will save somewhere around 63 percent on the cost of their prescription drugs. They deserve to know low-income seniors will pay no deductible, no monthly premium, and have no gap in coverage; and Medicare will pay about 90 percent of their drug costs. They deserve to know the group purchasing power we are giving to seniors is going to make the drug companies work for their business.

Mr. President, those who stood defending our freedom deserve more than the partisan rancor that has been sailing around this Chamber. They deserve to know more than some of the half-truths that have been told. Medicare, as we know it, should provide seniors with access to vital health care services and the physician of their choice. I believe this bill does those things, and I believe it will meet the needs of my constituents.

We have come a long way toward making good on our promise to our senior citizens, and that is to the credit of the administration and to the leadership of this Congress, certainly to the leadership of the Senator who is presiding this evening. We do need to strengthen Medicare, and seniors do need access to vital prescription drugs.

Many who are now on Medicare fought for the freedom that we enjoy today, and Monday we will, hopefully, have the opportunity to keep our promise to seniors and to fight on their behalf by providing them with a voluntary prescription drug benefit.

I urge my colleagues to support this legislation.

ORDERS FOR SUNDAY, NOVEMBER 23, 2003

Ms. MURKOWSKI. Mr. President, on behalf of the majority leader, I ask unanimous consent that when the Senate completes its business today, it adjourn until 1 p.m., Sunday, November 23. I further ask unanimous consent that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day,