

PLEDGE OF ALLEGIANCE

The Honorable TOM DASCHLE led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Today, the Senate will resume debate on the Medicare prescription drug conference report. We had an extended and vigorous debate on this historic legislation yesterday. Again, it is unusual to have a Saturday session and even more unusual to have a Sunday session, but the historic level which this debate has reached demonstrates the importance of doing just that.

There are a number of Senators who will be on the Senate floor to discuss this matter during today's session, and in an effort to accommodate the number of Senators who are seeking floor time today, we would encourage Members to limit their statements to no more than 30 minutes. We hope to work out a schedule so that Members will have a better understanding of at what point in the day or the evening they will be able to speak. If we can lock in 30 minutes per Member, or possibly work out alternating hours, which we will do, hopefully, in a few minutes, we will then have an orderly way to move forward so that everybody will have an opportunity to address this important issue.

Yesterday, it became apparent that we would not be able to lock in a time certain for an up-or-down vote on this important legislation, and at least one Democratic Member said that a filibuster would be the road to pursue. Thus, I filed a cloture motion on the conference report. That vote on the motion to invoke cloture is expected to occur sometime around 12:30 on Monday. All Senators will be notified when that vote is set.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The minority leader is recognized.

Mr. DASCHLE. Mr. President, I share the view expressed by the majority leader about the need for us to accommodate as many Senators as possible. It is my understanding that there is no objection to actually locking in a 30-minute time limit. Senators are free, of course, to ask unanimous consent to extend if they wish. So at this time I propound that request.

I ask unanimous consent that Senators be limited to no more than 30 minutes during the debate today.

The PRESIDENT pro tempore. Is there objection?

The Senator from Oregon.
Mr. WYDEN. Mr. President, reserving the right to object, and I do not intend to object, I just want to clarify one matter. My understanding is, and it is printed in the calendar, that there is already an order of speakers that has been established. I want to make clear that that will be recognized as we go forward today. I certainly will not object to the request of the distinguished minority leader. I just want to be clear that that will be the order of the speakers.

The PRESIDENT pro tempore. Is there objection to the original request? The Senator from Massachusetts.

Mr. KENNEDY. Reserving the right to object on the order, I was referred to by my good friend, the majority leader, last evening at about 6:15 in reference to this legislation. The time-honored tradition of this body is to notify an individual when there is going to be reference made to them. I was not notified, and I heard later last evening that I was referred to. I indicated that to the leader. I would like to be able to do this in a timely way. I was listed yesterday to be either third or fourth in order, but I am not prepared right now—if there is some other previous order that has been arranged, I want to be able to reserve my rights that have been respected in this institution for 220 years, and that is when a Senator is referred to in terms of legislation, a fair opportunity is given for them to respond.

The PRESIDENT pro tempore. Is there objection to the original request? The Senator from Nevada.

Mr. REID. Mr. President, I hope that Senators would not ask to extend beyond half an hour because it is so difficult to object. We have a lot of people. We have 17 on this side. Multiply that by half an hour and one gets the figures. I hope everyone will stick by the half hour that will be entered into, hopefully, momentarily.

I say to my friend from Massachusetts, the way the order is now set on our side, the majority leader would speak first. I would speak second. I would be happy to change places with the Senator from Massachusetts so he can go second, and I will go sixth or seventh.

Mr. KENNEDY. The Senator from Nevada, as always, is more than kind and generous. I appreciate that very much. I have no objection.

The PRESIDENT pro tempore. Is there objection to changing the order as the Senator from Nevada requested? Without objection, it is so ordered. The Senator from Massachusetts will take the place of the Senator from Nevada, and the Senator from Nevada will have the place in the order of the Senator from Massachusetts.

Is there objection to the minority leader's time limit of 30 minutes per speaker?

The Senator from Kentucky.

Mr. BUNNING. Mr. President, the list that is published in the calendar only has Democratic Senators in it. Obviously, there is an alternative list that would allow for Republican Senators to have a 30-minute block in between the Democratic Senators who speak.

The PRESIDENT pro tempore. The Parliamentarian informs me the Senator is correct, that a Republican Senator will go after each Democratic speaker if someone is here to be recognized.

Mr. FRIST. Let me also clarify that on the Republican side we are not locked into any order. The opponents to the bill are locked into an order of speakers. Ours has been just an agreement, so we are not locked into any order, but there will be a 30-minute limit, and we will be alternating back and forth.

Mr. BUNNING. I thank the Chair. The PRESIDENT pro tempore. Is there objection to the minority leader's request? Without objection, it is so ordered.

Who seeks time?

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

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

The PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of the conference report to accompany H.R. 1, which the clerk will report.

The legislative clerk read as follows: Conference report to accompany H.R. 1, an act to amend Title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare Program and to strengthen and improve the Medicare Program, and for other purposes.

The PRESIDING OFFICER. The minority leader is first on the list.

Mr. DASCHLE. Mr. President, I will certainly not exceed 30 minutes. I hope I can speak using less time because we are getting a little bit of a late start.

Let me begin by saying what an important debate this is. This is a debate the consequences of which will last for generations. This debate in many respects will be every bit as important as the debate on Medicare in 1965. One really has to go back to that year, 1965, to fully appreciate what we are debating now.

There was a debate, of course, in that period of our history, in the mid-1960s, about whether it was possible for us to address what was a national embarrassment at the time. About half of all senior citizens in the early 1960s had no health insurance—none. They were left out. There were horror stories about what they had to do in order to accommodate the health problems they were facing. It was a painful chapter. In

some cases, because seniors had no health insurance, they were not living as long, the quality of their lives could not have been worse, and they were the poorest of the poor. They often had no income other than Social Security, and Social Security took them nowhere in regard to paying for the costs of health care.

Thanks to President Kennedy and then-President Johnson, the recommendation was made that we provide a national health insurance plan for seniors. Republicans, at that time, argued that it was not the role of Government, that it ought to be the private sector that provides health insurance. Democrats argued, in response, that given the group of people we were talking about, providing health insurance for senior citizens in the private sector had about as much profit in it as providing insurance for a haircut. You are dealing with the sickest, most elderly in our population. So there is not much of a profit incentive for insurers; there is not an incentive in terms of the demographics and all of the actuarial circumstances. The private sector has virtually been loath to insure seniors because of that. It is like insuring a haircut. There is an inevitability, if you are a senior, to that moment in one's life when illness becomes a serious threat. And obviously, that is when the circumstances involving the end of life become all the more real.

Medicare stepped in. Now, over the last 40 years, it has been one of the most successful programs in all of American history. Forty years of success, 40 years of providing health care with a consistency and a confidence we have never had in all of our time in this country.

My mother has benefits from Medicare. My mother benefits from Social Security. I can only imagine what it would be like today if she did not have Medicare and Social Security upon which to depend.

So Republicans, over the last 40 years, have tried to find ways to go back to that debate of 1965 and say: We still believe in the private sector. We ought to be able to find a way to provide insurance for a haircut and incentivize the private sector.

I will never forget the extraordinary statement made by the Speaker of the House, I believe it was in 1994. He addressed that very issue all over again when he said: It is still our hope and still our design to see Medicare wither on the vine.

For 40 years they have attempted to bring about an end, if not to Medicare itself, certainly to the concept of universal coverage through Medicare for all senior citizens.

That is really the backdrop that today we must recognize as we begin the debate on this bill. How is it that those very colleagues who 40 years ago argued that we really should not have a Government program for universal coverage for health care, who just 10 years ago said we ought to see Medi-

care wither on the vine, now in the name of Medicare are arguing we need to reform it, we need to improve it? We are not improving it with this bill. We are not reforming it with this bill.

Does Medicare need to be changed? Of course. And providing a meaningful prescription drug benefit is probably the single best reform we could enact, because medicine itself has changed. But to those who say we want Medicare to look more like the private sector, I say you don't speak for me with that assertion.

Medicare has had about a 4 percent administrative cost over 40 years; 96 percent of the money that goes into Medicare goes to benefits. Do you know how that compares with the private sector? I am told the average administrative cost in the private sector for insurance plans is not 4 percent. It is not even 10 percent. I am told the administrative cost for a private sector plan today on the average is about 15 percent—almost four times the administrative costs of Medicare.

So if you want to see the Medicare plan become more like a private plan, then count on spending almost four times more for administrative costs. At most, 85 percent of premiums go to benefits in private sector plans.

How ironic that we find our colleagues saying: We want to make Medicare more like the private sector; we want more competition.

We don't mind competition. But the kind of competition they want doesn't make a lot of sense to me. Why would we provide, instead of 96 percent of the benefits to the beneficiary, only 85 percent, and call that progress?

To make Medicare more "competitive," our colleagues want to give more than \$14 billion of incentives to the private sector to get them to insure a haircut. Their notion is that somehow we can find a way to make the private sector more interested in providing meaningful health care to seniors, when Medicare is doing it so well already.

There are a lot of very grave concerns we have about this legislation. I brought some charts to the floor to talk about some of these concerns. I want to address them, if I can, in the time I have allotted to me.

I think one of the biggest concerns I have is that seniors today are very concerned about prices. They are concerned that their drug prices go up each and every year.

I will never forget talking to a woman in Sioux Falls whose name is Florence. She told me that, at 73 years old, she must work and she must use the supplemental pay she gets from her job—at 73—simply to pay for the drugs she needs. Her drug bill is about \$400 a month. It goes up 10 to 15 percent every year.

She drives to Canada once every 3 months in order to save \$100 a month. She figures every 3 months she saves enough to actually buy the drugs for a month with that trip to Canada. So,

without question, I think most seniors are very concerned about what is going to happen to the costs of their drugs.

The answer, with all of the specific analysis done to date about the impact of this bill, the best analysis we can provide so far, is that up to 25 percent of all beneficiaries are actually going to pay more, not less, for the drugs they buy with the passage of this bill—25 percent. It could be more than that.

Many Medicaid beneficiaries are going to pay more than what they are paying right now.

And there are many in the private sector who are going to pay more. You are going to see several million Medicare beneficiaries who now have private coverage actually lose that coverage as a result of the passage of this bill. The estimate is now about 2.7 million senior citizens will lose their retiree coverage when this legislation is enacted into law.

There are a number of other concerns we have with regard to this particular bill, including the coercion of seniors into HMOs and increasing their Medicare premiums with the so-called premium support concept. Within 7 years, many seniors are going to be forced into a pilot project in at least six locations. In those locations at least, and maybe others, we are going to see not only increases in Medicare premiums, but also seniors coerced into HMOs. These are cases where seniors have never even thought about an HMO until now.

In addition, millions of seniors are going to go without drug coverage during part of the year. I will talk more about that later.

We also are going to keep drug prices high as a result of this legislation. There is very little this legislation does to reduce the cost of drugs at all, as I said just a moment ago.

And finally, we squander \$6 billion needed for retiree coverage on tax shelters for the wealthy and the healthy.

For all of these reasons—the cost to beneficiaries, the coercion of seniors into HMOs, millions of seniors who are going to go part of the year without any coverage at all, the fact that drug prices don't come down but they go up, and that we squander \$6 billion on tax shelters for the wealthy in the name of Medicare—it makes a mockery of the whole word "reform."

I said earlier that up to 25 percent of all beneficiaries will see more costs for drugs. There are two categories in particular. Studies have shown that 2.7 million retirees, including about 5,000 South Dakotans, will actually lose the coverage they have with the private sector when this legislation is enacted. And that 2.7 million number, I think, is actually going to be higher. For those millions of Americans and those thousands of South Dakotans, that would be the biggest blow of all. They have confidence now that they can go to the pharmacy, and they can buy their drugs. They do not have to worry about whether or not they are covered. They

had better start worrying because the problems kick in just as soon as this legislation is enacted, if it is.

Up to 6.4 million low-income beneficiaries are going to pay more or lose access to drugs they are now provided. I think the 25 percent number may be a conservative figure.

When you take the number of retirees adversely affected, when you take the number of low-income beneficiaries who may be worse off under this plan, you begin to appreciate the magnitude of the problem this bill is going to create for millions of senior citizens today who are totally unaware of its negative implications.

The legislation creates a dilemma. The choice seniors will face is higher premiums on one side or an HMO on the other. How is that reform? How does that possibly relate to this widely stated goal we all have that we simply want to provide a meaningful drug benefit to senior citizens? This bill isn't a drug reform plan, this is a Trojan horse for the collapse of Medicare.

We are going to see the loss of Medicare as we know it today if this legislation passes. I think this chart describes it pretty well.

If you want to see increased premiums, support this bill. If you want to see seniors forced into an HMO, support this legislation. It leaves a question mark for a senior citizen right now: What do I do? How do I respond? How can I prepare myself for what is about to come?

What is about to come regarding drug coverage is described on this calendar. This calendar says more than any speech probably can. This calendar describes in essence the drug benefit structure. Of all the concerns I have, the benefit structure is one of the most troubling to me. I want to describe it, but then I want to use this calendar to talk about its implementation.

A senior will start paying \$35 a month. We will come back to that figure in just a minute. A senior pays that \$35 a month 12 months out of the year—January through December. Then the senior must pay 100 percent of all the benefits up to the deductible. That is depicted in red. Then the first dollar of protection under this plan for drug coverage would kick in, following the \$250 deductible. Beneficiaries pay all of the \$250. The drug coverage kicks in from \$250 in spending up to \$2,250. The Government pays 75 percent of the benefit. After the benefit has been paid—75 percent Government, 25 percent senior, up to \$2,250—the Government says: Wait a minute. We paid all we can pay. You are on your own from \$2,250 up to \$5,100. You are going to pay all the costs during that period.

After the beneficiary pays \$35 a month, 100 percent up to \$250, and 25 percent up to \$2,250, they have to pay the entire cost up to \$5,100, even though they are still paying a premium, and then they have a 95 percent benefit that kicks in after that.

Basically, what this calendar depicts is the drug schedule for 2006 for bene-

ficiaries with \$400 per month in drug spending.

By the way, the benefit doesn't kick in until 2006. So there are premiums that kick in, and the benefit lasts for a period of time, during the months of February, March, April, and May. They benefit in June somewhat. But for the entire rest of the year they are on their own.

This convoluted benefit structure is scary, as I think of my own mother, and I think of all of those who are going to try to figure it out: How in the world do I know how much I owe? How much can I count on? How much of these benefits are really going to apply to me?

This period of no benefits is called a coverage gap. Some people call it a donut hole. Whatever you want to call it, it is a mistake.

Think of the myriad of administrative costs involved for every single senior citizen who is going to have to try to decide: Are they in the 25 percent category, the 100 percent category, or are they in the 95 percent category?

By the way, if you are a senior citizen with a lower income, you are entitled to a different schedule. First, they have to know what their income is. They are going to have to turn over their tax records to determine what kind of income they have and whether they are eligible or not. Once those tax records are determined, they then are presented with these different tables that they are going to have to try to figure out. Imagine a 90-year-old woman trying to figure out when she goes to the pharmacy what the coverage gap is: Do I pay the premium? Do I have to pay 100 percent? If I do, how do I pay for it? Am I breaking a law if I expect the pharmacy manager to give me the full benefit? How do I figure this out?

This convoluted, confusing, extraordinarily complex schedule is a disaster.

I will make a prediction. I will predict that within 12 months, we are going to be back fixing this so-called coverage gap. It is chasm, it is not a gap. It is a confusion chasm. It is a disaster. That, if nothing else, ought to warrant reconsideration of this legislation.

But as I say, the coverage gap widens over time. It is not just now. The premium, as I said, starts at \$35. In 2013, the premium goes up to \$58. The deductibles start at \$250. But guess what? In 2013, the actual deductible is going to be almost \$500. The coverage gap then goes from \$2,850 in 2006 all the way up to \$5,066 by 2013.

In other words, senior citizens are going to have to pay \$5,000 even though they are paying \$35, or in this case \$58, a month for the benefit. Can you imagine a senior citizen coughing up these kinds of dollars in just a few short years?

It is absolutely the most reprehensible expectation for senior citizens. They can no more afford \$5,000 in 2013 than they can afford it today. It is

wrong. This, if nothing else, ought to be a reason we should send this legislation back to the conference to figure out a better way of doing it.

The bottom line is, when it comes to the coverage gap, seniors are going to have to pay \$4,000 to be eligible for \$5,000 worth of benefits. Can you imagine that in the name of reform?

First of all, we are coercing seniors into an HMO. We are telling retirees they may lose their own health benefits. Two to three million people are going to lose benefits, and the benefit they are going have instead is a \$5,000 coverage gap and paying \$58 a month in 2013. That, perhaps more than anything else, is disconcerting. As I talk to seniors, the concern they have the most is, of course, the high cost of drugs.

First of all, our conferees wasted no time in eliminating the reimportation of United States-made drugs from Canada. They will point to language in the bill, but the bottom line is we will not see any change in the current law with regard to reimportation of drugs from Canada. There is virtually a prohibition on drugs from Canada. South Dakotans, North Dakotans, Montanans, Minnesotans, Michigan residents have counted on Canadian relief. That has been a big part of what has been their strategy in coping with the high cost of drugs today. That is going to be gone. They will not be able to reimport unless they go to Canada themselves.

They also have a prohibition—and this is amazing to me as one of the things Medicare has been able to show is it can leverage better prices; because of the power of pooling, we can leverage, whether it is hospital prices, doctor prices, prescription drug prices—and there is actually a prohibition for Medicare in the negotiation of lower drug prices on behalf of senior citizens. Drug companies can do it, pharmacy benefit managers can do it, but there is a prohibition on the Federal Government involving itself in negotiating on behalf of senior citizens for lower drug prices today. I have never heard of such a thing. If we cannot bring about a better price, if we cannot leverage drug prices more effectively through Medicare, who in the world can do it more effectively than the Government itself and Medicare specifically?

The reason prices are going to remain high is, No. 1, there is going to be very little competition from those sources where competition is already shown to be very effective; No. 2, Medicare itself, the Government through Medicare, is actually prohibited from negotiating better prices on behalf of seniors. That is an amazing provision of law that is inexplicable.

It goes on. I said earlier one of the concerns I have is this provision that allows \$6 billion to be squandered for those who are healthy, and in many cases wealthy today, money that could actually go for retiree coverage. It creates a new health savings account which is nothing more, of course, than a tax shelter for those who are wealthy

and will draw off people who are healthy. Ordinary Americans cannot afford it and it undermines the employer-based coverage we already have. Six billion dollars is a tremendous pool of resources that could have gone to making this program far more cost effective and far more accessible for a lot of seniors.

Instead, even though we did not have it in the Senate bill, even though we had bipartisan support for this \$6 billion going to those who need it the most, in keeping with the trend, in keeping with the philosophy of many on the other side, creating this tax shelter for the wealthy was a "must pass" piece of legislation.

The bottom line is we lost \$6 billion over the next 10 years that could have gone a long way to reducing the cost of drugs to everyone else.

How is it that with all these warts, with all these problems, with all these deficiencies, with all these concerns, this legislation could be before the Senate today? This chart shows it pretty well.

The Pharmaceutical Manufacturers Association had their agenda as well. I must say, they got virtually every single thing they wanted.

They wanted an administered drug benefit in the private sector that diluted the purchasing power of Medicare. They got it.

They wanted financial incentives for HMOs, another step away from Medicare. They got it.

They wanted a prohibition on Medicare negotiating prices, as I just described a minute ago. Guess what. It is there.

They wanted a meaningless reimportation provision because they did not want the competition. Guess what. That is in the bill as well.

They wanted a watered-down generic access provision. Check that off the list.

They wanted no public scrutiny and secret kickback arrangement potential within the contracts they have with the benefit managers and the insurers. That is in there, too.

They wanted a huge windfall profit. They are going to make more money in the next 10 years than virtually any other sector within our economy. No wonder stock prices are soaring today—because they also see the writing on the wall.

PhRMA had a checklist. PhRMA got their list checked, every single item on the list.

The bottom line is, of course, Medicare beneficiaries lose, PhRMA wins, and the bill comes before the Senate with this realization. PhRMA got what it wanted. But organizations that represent seniors, organizations that represent working families, organizations that represent State governments and city governments, organizations of all kinds—liberal, conservative, name it—organizations of all kinds have come forward to say: Please do not pass this bill. Send it back to the drawing board.

Recognize the damage you are going to do—not just to Medicare; recognize the damage you will do to the confidence and the security of senior citizens.

Now more than 200 organizations have said they oppose this legislation and they want the Senate to oppose it as well.

This legislation would have been killed in the House had they abided by the rules. One of the most flagrant demonstrations of abuse of the institution and rules I have seen: They took almost over 3 hours the other day to bring about the desired vote on the House floor in spite of the opposition of all these organizations.

You have all these organizations on one side. This picture depicts pretty well what is happening on the other. A meeting was called on November 13 to talk about the benefits of this plan, to convince seniors that somehow they are going to be better off. And all these empty chairs pretty well depict exactly what happened. Seniors know what is going on. They were not going to be part of a sham discussion. No one showed up.

No one ought to vote for this either. This legislation does not deserve our support. We can do better. This started out as a debate about providing meaningful help to seniors. It has turned into a debate to save Medicare.

We are going to do all we can to live up to the specific talks, to live up to the needs, the hopes and dreams of senior citizens today. We will do all we can to defeat this bill when those votes are taken.

I yield the floor.

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. FEINSTEIN. Mr. President, I listened to the distinguished Democratic leader and find that I agree with much of what he said. This may not be a perfect bill, but clearly there are positive and negative features to the bill.

I worked a year ago, and through an individual's help, was able to run the numbers with respect to a prescription drug plan and tried to make them come in within \$400 billion and found it to be extraordinarily difficult. In my view, the most positive feature of this bill is that it delivers voluntary prescription drug coverage to this Nation's Medicare beneficiaries. I find the low-income benefits of this bill to be one of its biggest strengths. It is better than anything we ran that came in at \$400 billion or below last year.

These benefits affect about 1.4 million Californians who have limited savings and low incomes and who will qualify for prescription drug benefits under this bill. Some of these are low-income seniors who do not qualify for Medicaid. Because of \$3,000 in savings, they are ineligible to receive prescription drug coverage through the California Medicaid Program. They will now have prescription drug coverage which is much better than I had hoped. So 351,000 low-income Californians who

are not eligible for Medicaid and have no prescription drug benefits now will have them under this bill. This was important to me. It is one of the strengths of the bill.

Analysis shows that this bill will increase the percentage of Medicare beneficiaries with prescription drug coverage from 79 percent to approximately 95 percent.

To begin with, this bill, as I said, expands the drug coverage to the 351,000 Californians who are not eligible for Medicaid. The reason it does that is because it has a much more relaxed assets test. So where the assets tests were so stringent for Medicaid, they are more relaxed here; and, therefore, those 351,000 people who found themselves without Medicaid coverage will now have coverage under this bill.

Secondly, the bill provides a 16-percent increase in Medicaid disproportionate-share hospital payments in fiscal year 2004. This has always been important to me. Every year we have had to fight for it because these are the payments that go to our county hospitals. In California, the county hospitals receive most of the people who have no coverage who are bereft and who are extraordinarily low income. California hospitals who qualified to receive Medicaid DSH money lost \$184 million this year due to cuts enacted in the Balanced Budget Act in 1997.

This bill restores \$600 million to California's hospitals over the next 10 years. I must tell you, with about 25 hospitals that have closed in my State in the last few years, this is a major item for me. The DSH money in this bill will go a long way toward protecting California's fragile health care safety net, which is dependent on a complex combination of local, State, and Federal funding.

Thirdly, the bill improves payments for indirect medical education in fiscal year 2004 and beyond. Teaching hospitals will receive a 6-percent increase in payments in the second half of fiscal year 2004 and will have their payments spelled out in future years so they can begin to plan ahead. Now, they do go down in some years. So there will be advanced knowledge of that so hospitals can begin to plan for that.

This is money that reimburses teaching hospitals. My State has some of the greatest teaching hospitals in the Nation. This money would reimburse those hospitals for costs associated with educating our Nation's next generation of physicians. That is important to me. I think it is essential funding, and it will allow our major hospitals to continue training tomorrow's caregivers.

Fourthly, the hospitals and physicians in California will benefit from this bill. Hospitals will see a full market basket update for fiscal year 2004 and have the opportunity to receive a full market basket update for the 3 years that follow. With more than 58 percent of California's hospitals losing money treating Medicare beneficiaries,

and all hospitals facing Federal and State unfunded mandates, the full market basket update is vital to my hospitals as they struggle to meet staffing, seismic, and privacy compliance requirements.

I have heard overwhelming opposition from doctors in my State to the projected 4.5-percent payment cut that physicians and other health care providers would have faced in fiscal year 2004. In other words, without this bill, doctors in my State—and I do not know about elsewhere—but doctors in my State were going to face a projected 4.5-percent payment cut.

This bill prevents that payment cut from happening, and it includes an increase in payments for fiscal years 2004 and 2005 of 1.5 percent each year. This means that doctors in my State will be paid more for their services. It may not sound like a lot, but we have doctors leaving California and going to other States because they cannot meet the high cost of living in the State of California and practicing medicine. So even a small amount helps them stay in business.

In my State, approximately 33 percent of all Medicare beneficiaries get their health care coverage from Medicare+Choice.

Now, Medicare+Choice has not been a positive experience in every case. I think we all know this. This bill, though, strengthens the Medicare+Choice Program, renames it Medicare Advantage, and it provides payment increases to HMOs. Some find that objectionable. I, frankly, do not, because these increased payments to HMOs and preferred provider organizations should provide some premium stability throughout the State. I intend to watch and see if, in fact, it does happen.

Now, I have many concerns about this bill. The Democratic leader pointed out some of them. This is certainly not a perfect bill. I am not on the committee. I did not write the bill. I struggled to have a little bit of input into the bill, probably much less than I would have liked.

I am deeply concerned about the number of Californians, though, who have lost their retiree health benefits as a result of rising health care costs. This is happening right now without a bill. It is projected that 10 to 12 percent of retirees who have private health care plans are losing their benefits each year. That is happening without this bill. The reality is—and I know people do not like to look at this—if we do not pass this bill, employers in my State will continue to drop coverage for their retirees at this estimated rate of 10 to 12 percent a year. Many of these employers who have chosen to retain coverage for their retirees have required their retirees to pay higher copayments and premiums—not under this bill but today.

Through direct subsidies and tax provisions, this bill actually reduces the number of seniors in California who

will lose their retiree health coverage from approximately 431,420 in the Medicare bill that passed the Senate, that a majority of us voted for, to approximately 198,000 in this bill. These are California numbers, true. I cannot speak to other States. But what I am saying is, because of this bill, the number of retirees in California who would lose their retirement benefits will drop from 431,420 to 198,000.

Now, I wish the number were zero, but the point is, the bill makes it better, not worse. I think that is a good thing.

Now, I find it very difficult that this bill does not restore access to Medicaid and SCHIP for legal immigrant children and pregnant women at the State's option. The Senator from Florida, Mr. GRAHAM, authored legislation which I voted for which did do this. I intend to introduce—and I hope with him—legislation to restore Medicaid and SCHIP benefits to California's legal immigrant children and pregnant women next year.

I find it, frankly, troubling that this bill actually provides \$250 million per year for 4 years to reimburse hospitals for providing emergency care services for undocumented immigrants, and California's hospitals will receive approximately \$72 million a year to reimburse them for their care to undocumented immigrants, but we take away the coverage for legal immigrants.

I expressed my concern to Senator BREAUX, to Senator BAUCUS, to Senator FRIST about this issue. I was told the House would not accept this language. I hope next year the Senate will once again pass a bill to restore these benefits. This is a big item in California, and I deeply believe people who come to this country legally should be entitled to these benefits.

My State spent \$3.7 billion in 2002 in uncompensated care, so the additional money that California gets for the care of illegal immigrants of \$72 million a year at least will go some distance in covering that deficit.

In my role as vice chair of the National Dialogue on Cancer and cochair of the Senate Cancer Coalition, I have a very serious concern about this bill's Medicare reimbursement cuts for cancer care, particularly oncology physicians. It is my strong view that every suffering cancer patient should be able to have a so-called quarterback physician, an oncologist, someone who is with them who can go through all of the terrible choices and decisions that have to be made by a cancer patient and stay with them through it all.

I have talked to both Senators BAUCUS and BREAUX and also to Senator FRIST. They have all said this bill will leave the oncology community better off. I don't see that, candidly. In looking at this complicated Average Sales Price versus Average Wholesale Price issue, I don't see where they will be better off. I want the RECORD to reflect that I have received those assurances. I don't know whether they are true or

not, but I can promise my colleagues, I intend to follow very closely the impact this bill will have on cancer care up and down the State of California. My staff and I will be watching the cancer care situation, and I am certainly prepared to introduce legislation making technical corrections to Medicare reimbursement for cancer care if the bill has the impact the oncology community predicts it will.

It is my understanding that our leadership will appoint an independent commission to be headed by my good friend, former Senator Connie Mack. The commission will monitor the impact of this bill on cancer care throughout the country and will report and make policy recommendations to Congress.

I am also concerned about the impact this bill will have on 50,000 low-income Californians who are living with HIV/AIDS. We have heard a lot from the HIV/AIDS community. My concern is with their access to drug treatment therapy under the Medicare prescription drug benefit.

What happens in AIDS/HIV treatment is that very often a cocktail of drugs, three or four different drugs, proves to be the most beneficial. The type of drugs varies with the individual, just as any drug would with any of us.

I have shared this belief, and the concern is that the formularies would limit an individual to two drugs. I spoke at length with Health and Human Services Secretary Tommy Thompson Friday night about it and asked him to put in writing exactly what would happen. Directly following my remarks, I ask unanimous consent to print in the RECORD his Department's response to my concerns.

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

(See exhibit 1.)

Mrs. FEINSTEIN. I will read just a couple of key points made by the Secretary in response. Let me quote the Secretary:

The Secretary may only approve a plan for participation in the Part D program if the Secretary does not find that the design of the plan and its benefits, including any formulary and any tiered formulary structure, will substantially discourage enrollment in the plan by certain classes of eligible Medicare beneficiaries. Thus, if a plan limits drugs for a group of patients (such as AIDS patients), it would not be permitted to participate in Part D.

I also note that upon completion of this bill, Senators GRASSLEY and BAUCUS and I will enter a colloquy into the RECORD to emphasize this point.

This bill says that if a plan doesn't carry or doesn't treat a drug that is needed by a person with AIDS as a preferred drug, a simple note from a doctor explaining the medical need for that particular drug would get that drug covered at the preferred price. It cannot take more than 72 hours for seniors to get a drug under this expedited appeals process. This is my understanding based on conversations

with the Secretary. I am delighted this understanding is now in the CONGRESSIONAL RECORD so that we can all follow it.

I want to say a word about something that is very controversial in the bill that I happen to support and why I support it. That is income relating the Medicare Part B premium. Let me tell you why I support it. I have a great fear that as I watch entitlement spending grow, and I have watched that happen for a decade in the Senate, our children and our grandchildren will not have access to Social Security or Medicare. Let me tell you why I believe this.

Since 1993, at my constituent breakfasts we have been using charts to illustrate outlays, meaning the money the Federal Government spends every year. I believe they are the truest way to judge Federal spending. When I began this, in 1993, entitlement spending was \$738 million. About 50 percent of the outlays in a given year were entitlement spending. That was welfare, veterans benefits, Social Security, Medicare, et cetera. Interest on the debt was 13 percent. So 63 percent of the outlays in a given year could not be controlled by our budget.

This year, entitlement spending is \$1.174 billion. Entitlements have risen to 54.4 percent, a 4.4 percent increase. Interest has dropped some, to 7.5 percent.

Now, if we look at the projection—and this is with the \$400 billion prescription drug plan—if you look at entitlement spending in 2013, 10 years from now, you see that it is \$2.048 billion. So in 10 years it has gone from \$738 billion to \$2.48 billion. That is the problem. Entitlements will be 58 percent of the outlays, and interest on the debt, 11.6 percent. What does that mean? That means 70 percent of everything that is spent by the Federal Government in fiscal year 2013 cannot be controlled.

The other two pieces, of course, are defense, projected at about 16.9 percent, and discretionary spending, dropping from 20 percent this year down to 13.6 percent. Discretionary spending is everything else we have to do. It is everything in the Justice Department, the Education Department, the Park Service. All the rest of the Federal Government in 10 years will be about 13 percent of what is being spent. That is the enormity of the entitlement picture.

I know it is hard for people to look at this because those people who had the dream of Medicare decades ago looked at it as a program that everyone who paid in got out the same benefit. But what the income relating in this bill talks about is just the Part B Medicare premium, the cost of which today is \$3,196.80. That is the full cost of the Medicare Part B premium in 2004.

Now, what is Part B? Part B is physician care, other medical services; it is outpatient hospital care, ambulatory surgical services, X-rays, durable med-

ical equipment, physical occupational and speech therapy, clinical diagnostics, lab services, home health care, and outpatient mental health service.

The premium is \$3,196.80. The income-relating provisions in this bill are very mild, much milder than what Senator NICKLES and I presented on the Senate floor.

In this bill, beginning in 2007, individuals with incomes of more than \$80,000, or couples with incomes of more than \$160,000, will have, instead of 75 percent of their Medicare Part B premium subsidized, 65 percent of it will be subsidized by the Federal Government.

This goes up four tiers so that individuals with incomes of more than \$200,000 a year, or a couple with an income of more than \$400,000 a year, will have just 20 percent of their Medicare Part B premium subsidized by the Federal Government. Why should hard-working taxpayers pay for a millionaire's health care? That is my view.

I don't see income relating as bringing about the downfall of Medicare. I see it as making the program more solvent.

There is one significant missed opportunity in this bill that concerns me deeply, and that is the whole area of the cost of prescription drugs. I am particularly concerned about the amount of money spent on prescription drug promotion by pharmaceutical companies. Perhaps I have reached the age where I remember when there was no advertising of prescription drugs. We were just as well off then as now, and without huge costs.

Let me give you some examples. Promotional spending by pharmaceutical manufacturers has more than doubled, from \$9.2 billion in 1996 to \$19.1 billion in 2001. That is an annual increase of 16 percent.

Most troubling to me is the rapid spending growth of direct-to-consumer advertising of prescription drugs, which has increased an average of 28 percent.

Bottom line, Mr. President: I intend to support this bill, and not because it is perfect, but because I believe it brings substantial help to people who need that help in my State of California.

I yield the floor.

EXHIBIT 1

ACCESS TO DRUGS FOR AIDS PATIENTS UNDER THE BIPARTISAN AGREEMENT

Question: Will AIDS patients have access to all drugs within a therapeutic class under the Bipartisan Agreement? Can a PDP limit the number of drugs that are covered within a therapeutic class? Are dual eligibles in a Medicare drug plans losing coverage available to them in Medicaid?

Answer: In the Bipartisan Agreement there are significant safeguards in the development of plan formularies that will ensure that a wide range of drugs will be available to Medicare beneficiaries.

Plans have the option to use formularies but they are not required to do so. If a plan uses a formulary, it must include "drugs" in each therapeutic category and class under

section 1860D-4(b)(3)(C)(i). A formulary must include at least two drugs in each therapeutic category or class unless the category or class only has one drug.

The Secretary will request the U.S. Pharmacopoeia, a nationally recognized clinically based independent organization, to develop, in consultation with other interested parties, a model guideline list of therapeutic categories and classes. How categories and classes are designed is essential in determining which drugs are included on a plan's formulary. USP is clinically based and will be cognizant of the needs of patients. We expect they will design the categories and classes in a way that will meet the needs of patients.

In designing formularies, plans must use pharmacy and therapeutic committees that consist of practicing physicians and pharmacists who are independent and free of conflict with respect to the plan, and that have expertise in care of elderly and disabled. The committee has to use scientific evidence and a scientific basis for making its decisions relating to formularies.

Further, the Secretary may only approve a plan for participation in the Part D program if the Secretary does not find that the design of the plan and its benefits, including any formulary and any tiered formulary structure, will substantially discourage enrollment in the plan by certain classes of eligible Medicare beneficiaries. If a plan complies with the USP guidelines it will be considered to be in compliance with this requirement. Thus, if a plan limited drugs for a group of patients (such as AIDS patients) it would not be permitted to participate in Part D.

Under the Bipartisan Agreement, the beneficiary protections in the Medicare drug benefit are extremely comprehensive to ensure access to a wide range of drugs and are more comprehensive than the protections now required of state Medicaid programs.

For example, there are extensive information requirements in Part D so beneficiaries will know what drugs the plan covers before they enroll in the plan.

The plans must set up a process to respond to beneficiary questions on a timely basis.

Beneficiaries can also appeal to obtain coverage for a drug that is not on their plan's formulary if the prescribing physician determines that the formulary drug is not as effective for the individual or has adverse effects. As a result, there should be access to all drugs in a category or class when needed.

Because the Medicare drug benefit will be offered through private plans, plans will have an incentive to offer multiple drugs in a therapeutic class in order to attract Medicare beneficiaries to join their plans.

Because of the optional nature of the Medicaid drug benefit today, states can drop their coverage entirely. According to a recent Office of the Inspector General report, states have identified prescription drugs as the top Medicaid cost driver (FY 2002, Medicaid prescription drug expenditures totaled approximately \$29 billion or 12% of the Medicaid budget). From 1997 to 2001, Medicaid expenditures for prescription drugs grew at more than twice the rate of total Medicaid spending.

Pressures on state budgets have led to Medicaid coverage restrictions for drugs and the use of cost control measures that will not be used in the Part D program.

Eighteen states contain Medicaid drug costs by limiting the number of prescriptions filled in a specified time period, limiting the maximum daily dosage or limiting the frequency of dispensing a drug. Some states also limit the number of refills.

Six states have pharmacy lock-in programs, which require beneficiaries to fill their prescriptions in one designated pharmacy.

States already have the authority to limit the number of drugs that may be provided in a therapeutic class, and nineteen states are using preferred drug lists in their Medicaid programs. Thus, dual eligible beneficiaries will have the same access in Part D that they have in Medicaid, with expanded beneficiary protections and appeal rights.

Concerns have been expressed that the Medicare benefit will result in a loss of coverage for dual eligibles. This is not the case for low-income beneficiaries, the Bipartisan Agreement provides generous coverage.

The Bipartisan Agreement preserves the universality of Medicare for all eligible beneficiaries including those now dually eligible for both Medicare and Medicaid. Unlike Medicaid, the new Medicare Part D benefit will provide a guaranteed benefit to all eligible seniors—a benefit they can count on without fear of loss of benefits when state budgets become tight.

Dual eligibles, who currently have full Medicaid benefits, will automatically be given generous subsidies and pay no premium, no deductible and minimal cost-sharing regardless of their actual income (which can be higher than 135% of poverty based on states' special income rules).

In addition, full dual eligibles with incomes under 100% of the Federal Poverty Level (FPL) will pay no premiums, no deductible and only nominal copayments of \$1 for generic and other multiple source preferred drugs and \$3 for all other drugs. These copayments will increase only at the rate of inflation, the same rate as the Supplemental Security Income (SSI) payments on which many low-income individuals rely.

Dual eligible nursing home patients and other institutionalized persons who only have a small personal needs allowances will be exempt from copayments altogether.

The copayment levels in the Bipartisan Agreement are similar to what dual eligibles now pay in what is an optional Medicaid benefit in their states. In fact, because of the optional nature of the Medicaid drug benefit today, states can drop their coverage entirely. Current regulations permit states to increase coinsurance to 5%, which is more than what will be permitted for dual eligibles under the new Medicare benefit.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, will the Chair please advise me when I have 5 minutes remaining?

The PRESIDING OFFICER. The Chair will do so.

Mr. KENNEDY. Mr. President, during yesterday and early today, we have had characterizations and descriptions of this legislation, which is enormously important. We are doing these debates on Saturday and Sunday, and it is anticipated that we will have a vote tomorrow, Monday, on a bill that will not go into effect until 2006, and other provisions will take effect in 2010. I have right here next to me the bill, the legislation, which was put on everyone's desk. I am still waiting for a Member to come here and indicate that he or she has read it, and describe the details of it.

We are dealing with a matter of enormous importance and consequences, as we are dealing with issues of life and death for our seniors in this country—the men and women who have brought this Nation out of the Great Depression, the ones who fought in World War II, the greatest generation. They came

back and faced challenging times. We went from a 12 million, mostly man military, down to an Army of just a couple of million, with massive unemployment, and they helped to get the country back on a peaceful road. We are talking about a generation that faced down the Soviet Union and communism, and they are now in their golden years.

As the great philosophers point out so well, civilization is measured by how it treats its elderly people, whether they will be able to live in the peace, dignity, and security for their contribution to the country. I believe in that. I believe in that very deeply.

We have to ask ourselves at the end of the day whether this legislation before us, which is being rushed through with effectively 2 or 3 days of debate, is worthy of our senior citizens. I mentioned the issue of time again because my good friend, the majority leader—and he is my good friend—made reference to the fact that I believe that this legislation needed more debate than a Saturday afternoon and evening. I watched the debate going on, and the chairman of the Finance Committee and the Senator from Alaska talked up until almost 10 o'clock last night, and now we are here on Sunday afternoon.

But I wonder whether it needs more than 2 days debate. I believe it does; I do believe so. I believe that particularly after we saw what happened in the House of Representatives.

This legislation makes an enormous difference to the well-being and the security of seniors in this country. And we saw the facade that took place in the House of Representatives where the vote was called at 2 or 3 o'clock in the morning, and the vote was kept open beyond the traditional time of 15 to 20 minutes, for nearly 3 hours, in order to try to effectively coerce Members to support the proposal.

We are doing that on a measure that is supposed to benefit our senior citizens, and a measure that passed the House of Representatives by only one vote in a purely partisan proposal. Then, it passed the House of Representatives by less than a handful the second time, again, on a purely partisan proposal. It seems to me that if the House of Representatives had a full opportunity to have an open discussion and debate, and then have a reasonable vote and call them as they see them, then this process would be worth supporting. We ought to have the same here in the Senate. But, on the one hand, when we have a Republican leadership, which is effectively jamming this legislation through the House of Representatives, and then effectively wants to use the closing off of debate and discussion in order to effectively jam it through here, the Senate of the United States, we ought to take a moment or two to ask why.

I note the references of my friend, the majority leader, about who was really representing the seniors of this

country and whether some were delaying this legislation. Many of us have been fighting for a prescription drug program for years. I will not take the time today to discuss the time when it was bottled up in the Republican Finance Committee, and how it only emerged on the Senate floor when we had Democratic leadership here just over a year ago. It is not worth taking up the time because I don't have it.

But this is a Senator who fought for the Medicare Program, who knows the history of the program, and knows how important the Medicare Program is. I am also mindful—with all respect to those on the other side and in the House of Representatives—that they got 12 votes in support of the Medicare. I know that they are untrustworthy of the Medicare Program, that they have a disdain for the Medicare Program. That is a very important difference. They are obviously entitled to their view.

But what we have seen is the efforts that were made on the floor of the Senate earlier this year, where we had a truly bipartisan effort for a prescription drug program. In 1964, Medicare was defeated in the Senate. It was defeated by 12 or 14 votes. Seven months later, it passed by that number. The only intervening aspect was an election. And the important aspect of that election is that the seniors understood what the stakes were in that election.

I am saying here on the floor of the Senate that the seniors are going to understand, when they know what is in this bill, how much it risks their future and the future of the Medicare system, make no mistake about it.

Make no mistake about it, no matter the outcome of this bill in the Senate, this issue is going to continue to be debated as we go into 2004, the 2004 election, 2006, 2008—all the way down the line. This issue is not going to go away.

I was here when the Senate passed catastrophic coverage. I can remember the catastrophic Medicare changes which allegedly were supposed to be so helpful to the seniors. There was a flood of Senators who left this body and rushed down to the television and radio center to indicate how they supported it. And I remember how they all crept back into this body just a couple of months later to vote to rescind that change because they got it wrong, because they rushed it through the Senate. And that is just what we are in danger of doing with this bill.

The Medicare system is a tried and tested program. It is a beloved program. The reason we have a Medicare system is that the private insurance companies failed our elderly people. They continued to fail them. Finally, in the late 1950s, we began to have a debate about a Medicare system, and when we had the debate in the 1960 campaign and 1962 campaigns, we finally found we were able to pass Medicare legislation in 1965. It took 5 years to pass that program, and we want to risk that program in a 2-day debate in

the Senate when this is a lifeline to so many of our seniors, when we are seeing an effort to undermine the Medicare Program. I will get into that in one moment.

We had a chance to do something we failed to do in 1965. We passed the Medicare Program that dealt with hospitalization. We passed the Medicare Program that dealt with physician fees. But we did not pass a Medicare Program that dealt with prescription drugs. Only 3 percent of the private sector programs had prescription drugs at that time. Can you imagine that we would pass a Medicare Program today without prescription drug coverage? Those prescription drugs are as important as physician services and hospitals today.

We are on the verge of the life science century. The breakthroughs we are going to see in the next months and years are going to be breathtaking, and our seniors ought to be entitled to those programs. That is why a prescription drug program is so necessary.

We passed a good program in a bipartisan way, but that is not the proposal that is before the Senate. The bill before us is not that proposal. The bill that passed the House of Representatives is not the proposal we passed.

We have a major undermining of the Medicare system. There are those who say: You are really overstating this, Senator KENNEDY. Where in the world are you getting this idea?

I understand, as others do, that the position of the President of the United States earlier in March was that no one who was in Medicare would be entitled to a prescription drug program. I want our seniors to listen to that. In the spring of this year, this President indicated he supported the program for prescription drugs only when it was delivered by the HMOs.

He gave up that position. He said: Oh, no, let's try and see if we can figure out something else that may be related to the Medicare system. That was his position. That is the position of the majority of the people who are supporting this program. Make no mistake about it, that is their position. They believe that is what ought to happen: that we ought to dismantle the Medicare system, undermine it, privatize it. That is what they want to do.

You say: Why in the world are you saying that? How can you possibly say that? Read the paper this past week. The Washington Post, Friday, November 21:

Bid to Change Social Security is Back.

They are going to get Medicare first. Social Security is next. Here it is:

President Bush's aide reviving long shelved plan on Social Security. A Presidential adviser said [Bush] is intent on being able to say that reworking Social Security "is part of my mandate."

There it is, my friends, Social Security is next; Medicare now. That is why I think we ought to have some debate because, I daresay, I don't believe the Members of this body understand what is going to be done with the proposals.

There are three major provisions in this proposal that will effectively undermine the Medicare system. The first is the premium support proposal. I have listened day after day, week after week, month after month: We have to give premium support a try. My answer is: Why? Why? We know what it means even before trying it. Committed as they are on the other side of the aisle to start off with hundreds of thousands or a few million and multiply that to millions and millions of people, we understand what the results are going to be before we even try the program. They said: Let's try it; let's understand what the outcome is going to be.

Currently, everyone in the United States pays into the Medicare system. No matter where you live, you get your range of benefits. You get to pay the same premium and you get the same range of benefits all over this country. It is uniform. Not under premium support. You are going to pay in and you are going to pay more. Even the administration has recognized that the minimum you are going to pay is 25 percent more. You are going to pay more. So that every elderly person who understands premium support, this administration understands you are going to pay more at the outset.

Secondly, you are never going to know what your premium is because it is going to depend on where you live. These are not my figures, these are the figures of the Medicare actuary. Here it is: Under the premium support program—this is the Medicare actuary—the national average under current law will be \$1,205 by 2013. It is about \$700 now. Their estimate is \$1,205. A year and a half ago they estimated the premium support would be \$1,771. The Medicare actuary estimated that every senior citizen would be paying \$500 more in premiums than they would be paying under Medicare.

This year they have gone down to \$1,501. They have gone down nationwide as starters, and we have to learn something more. That is not good enough.

The difference with premium support is there is no security. It depends on where you live. Do you understand that? Your premiums are going to be based not on the national standard that we have at the present time but on where you live.

In my State of Massachusetts, under premium support, it will be \$1,450 in Barnstable, MA, and \$1,050 in Hamden, MA; \$400 more. The difference is 100 miles. In Dade County, FL, it is \$2,000 and, in Osceola, FL, it is \$1,000; \$1,000 more.

Explain that to some senior who lived there all their life, has a house and is proud to live there, and they find that their premiums are going to be \$2,000 and their neighbors in another part of Florida are paying \$1,000.

It is very interesting what my friends on the other side say: Senator KENNEDY, you don't understand what we are going to do in this bill. We are only

going to let it go up 5 percent a year this year. That is what they say this year. Next year in the Budget Committee, or the year after, it won't be 5 percent. We will have to recalculate. It will be 10 percent or 15 percent, or let's have a free enterprise system and let it sail off. That is what is going to happen.

That is what has happened in the Metropolitan Statistical Areas (MSAs), and the list goes on: \$1,700 in Los Angeles, \$775 in Yolo, CA. Medicare actuaries—every senior citizen ought to understand that premium support is written in this legislation. One can say, well, it is written in such a way that we are not going to face it for several years. Several years? But it is still there. The only way to repeal it is to come back here to the Congress.

In Yamhill, OR, premiums would be \$1,325, but only \$675 in Columbia, OR. It is double the amount if one lives in a different part of the State.

Why do we have to experiment with premium support? We already know what the results are going to be. That is a key element in this legislation. It was not in the Senate bill. I did not hear our majority leader make much of a case for it. To be honest about it, I do not hear the President of the United States make much of a case for it.

Nonetheless, when one is talking about the House of Representatives, they understood what this was all about. They committed to it, alright.

Now one might say: Well, Senator, what about the health delivery system? We are going to have the health delivery system delivered through the HMOs. Let us have real competition.

How many times have I heard this from our Republican friends over there: Let us have competition? We are glad to have competition, but do not suggest that this bill is competition. It is not. I see the chairman of the Finance Committee. He can correct me if I am wrong about any of these figures.

We start off with every HMO getting a 109 percent increase in the cost of living over Medicare. Is that competition? Competition? Come on. Beyond that, CMS—the governmental agency that administers the Medicare program—pays an additional 16 percent in excess of Medicare's own costs to private insurance companies because seniors who join Medicare HMOs are healthier than seniors in the traditional Medicare system.

So, under this bill, Medicare is going to pay a 25 percent advantage or bonus for every senior citizen that goes into an HMO. Our Republican friends are talking about competition, the free enterprise system. Is there a business man or woman in this country who would not want a deal such as this? The tragic part is, who is paying for it? It is our seniors who are paying for it.

And you think Medicare is going to be able to hold on when they are effectively getting a \$1,936 overpayment per senior? That is what they are getting now. This is not competition with

Medicare. This is a rip-off. This is a scandal. This is a payout. And that is what is happening now under our overpayment to the HMOs.

As a matter of fact, you are overpaying them almost the amount that the average person does for the prescription drugs. You could almost make a deal and say, do not even bother with the prescription drug program. The HMOs are almost paying the whole amount. That is what the seniors pay, \$2,300. We are paying close to a \$2,000 overpayment.

On the one hand, you have the premium support that is going to undermine it. Secondly, you have this program on the overpayment of the HMOs. Given the dramatic overpayment on this, we can see what is going to happen with the HMOs.

Look at what is going to happen with the HMOs, according to the actuaries. This year, there is \$31 billion that went through the HMOs in this country. The best estimate, given the arrangement that has been made now, will be \$181 billion going through the HMOs. You call this private competition? Competition with Medicare? This is outrageous. Do my colleagues think we are having that debate here on the floor of the Senate? Do my colleagues think we have time to change that 109 percent down to 102 percent or 104 percent? Absolutely not. We do not have time to do that.

Do my colleagues think we have time to change this with regard to the 16 percent advantage? Do my colleagues think we have any time to do that? Oh, no, let's stamp it. Let's close the books. Let's say to those who would like to have that kind of debate and offer amendments, this is being delayed for our senior citizens.

This is absolutely outrageous. We know what is going on. These are the payoffs to the HMOs.

Beyond that, if that is not enough, listen to this: Not only do they have the additional 25 percent, which is almost \$2,000, there is also a \$12 billion slush fund. What did the Senator from Massachusetts say? A \$12 billion slush fund.

Well, what can they do with the \$12 billion? They can give it to the HMOs as well. This is running-around money, walking-around money, \$12 billion more. Who pays for that? The seniors pay for that under the Medicare system.

Do we have an opportunity to offer an amendment to strike that? Oh, no. Do my colleagues think we have an opportunity to go back to the Senate position that said let's take half of that and use it for good preventive kinds of medicine for our seniors, such case management programs? No, no. That was what we passed in the Senate. Do my colleagues think we can go back? No, no. We have to rush this proposal in.

In the meantime, we are telling our seniors all across this country that \$12 billion is needed to help the HMOs. Tell

that to the 10 million seniors who need Celebrex to deal with arthritis, or the 12 million to deal with osteoporosis, or the 11 million with treatments for diabetes, high cholesterol, thyroid deficiency, and depression. These are millions of our fellow citizens who could benefit from that \$12 billion. Oh, no. We have to give that as a supplement to the HMOs.

I have listened to those who say: Well, at least our senior citizens are going to be better off. Let us just look what is going to happen to our senior citizens. We have the 2 to 3 million retirees who are going to be dropped. They are certainly not going to be better off. There are 6 million people worse off. Who are these 6 million? These are the Medicaid beneficiaries who, the day this bill goes into effect, are going to be worse off. These are the people who are paying the \$1 to \$3 copays. The States are paying for it with the Medicaid. Know what? They will not be paying anymore. Why? Because this bill prohibits it.

So one might ask whether they are better off. We start right off with 9 million beneficiaries who are going to be worse off. People say: Well, Senator, what about all of those low-income people we are all concerned about in this program? I am going to come back to that.

Let's take these 6 million people, who are the poorest of the poor, who are going to be worse off. Is that really going to make much difference, because it is only a couple of bucks a week, \$3 to \$5 a week, maybe \$20, \$25 a month? But when one is talking about the average income for seniors at about \$12,000, it adds up. There are studies to show what happens to the poor when they do not pay the copays in terms of adverse health outcomes.

The PRESIDING OFFICER (Mr. AL-LARD). The Senator from Massachusetts has 5 minutes remaining.

Mr. KENNEDY. Will the Chair tell me when I have 1 minute remaining, please.

This is what happens to those poorest of the poor when they do not have the copays—serious adverse events effectively double. The emergency rooms effectively double. These findings are demonstrated by research studies published in JAMA.

Of course, the sad fact is it ends up costing hundreds of millions and billions of dollars more to pay for in these circumstances. It is bad health policy and it is bad economics.

Finally, we had a good program that passed the Senate. We found our friends in the conference knocked out 3 million of the neediest elderly people in this country. We provided for up to 160 percent of poverty, they made it up to 150 percent of poverty. That is a million people. And they reimposed the asset test for those under 150 percent of poverty. As a result of reimposing it, that is a total of 2.8 million who were included for help and assistance under the Senate bill who were wiped out in

this conference report. We had a good bill, but that is not the one that is before us.

Finally, the third part of the inclusions in this legislation, what they used to call Medical Savings Account, now referred to as Health Savings Accounts (HSAs), which have very high deductibles and low premiums. Who takes advantage of those programs? The most healthy people take advantage of those and the most wealthy people take advantage of those.

What is the problem with that? The problem with that is that if you are the working poor, working middle class, if you have some children, you can't afford to constantly pay the deductibles. So what happens to your premiums? Two studies—one study by the American Academy of Actuaries "Medical Savings Accounts: Cost Implications and Design Issues," May 1995, and another by the Urban Institute, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," April 1996—indicate that premiums will rise at least 60 percent. That is not just talking about the elderly people, that is across the country. That is undermining the employer-based system.

We have enough problems in this country with the uninsured. Now we have an additional proposal that is going to raise the cost of premiums for working families in this country? That has been included. Was that in the Senate bill? Absolutely not. But it has been in the House. It has been a matter of faith in the House. There you have it: Premium support, not a level playing field, a new form of health insurance that is going to raise the premiums for workers. What in the world does that have to do with the prescription drug program? It has a lot to do with ideology. That is what this bill is about, to undermine, to privatize Medicare. After they do that, coming right behind it is the Social Security Program, make no mistake about it.

We can do better. We should do better. We ought to take the time to do better. There are enough Republicans and Democrats alike in this body who have demonstrated over the period of the last year and a half that we can get a good bill. There is no reason to be stampeded with a bad bill. Why are we being stampeded with a bad bill? We ought to take our time, get a good bill, make a difference for our seniors, make a difference for our country. That is what I believe.

I hope we will have the opportunity to take the time so all of our Members understand it, and not just these Members but so our seniors, whose lives are going to be affected, who are suffering every single day and making choices between putting food on the table and paying for their prescription drugs, so they understand it. Don't we have enough respect for our seniors so we can provide some opportunity for those individuals to understand it? Or are we

going to be rushed into the situation with short debates on Saturday and Sunday and then have the gauntlet come down. We saw what happened over in the House of Representatives. It took them 3 hours in order to galvanize this. I think we should demonstrate in this institution too much respect for our seniors to be stampeded into a bad bill.

The PRESIDING OFFICER. The time of the Senator has expired. The Senator from Kentucky is recognized for 30 minutes.

Mr. REID. If I could offer a unanimous consent request?

The PRESIDING OFFICER. Does the Senator from Kentucky yield for a unanimous consent request?

Mr. BUNNING. I have a unanimous consent request first to propose. Then I will.

Mr. REID. That is fine.

Mr. BUNNING. I ask unanimous consent that with the previous order standing in place, the 30-minute time limit on each Senator be considered controlled time, so that any remaining time may be yielded to another Senator, and if not yielded, the time be automatically yielded back.

The PRESIDING OFFICER. Is there objection?

Mr. REID. In layman's terms, what this means is, if there are Senators on our side or the other side who want to use the 30 minutes in any way they want—10-10-10, 15-15—that is certainly permissible. The going back and forth would be unfair otherwise because someone here would use 30 minutes and only 10 there.

So what we are going to do—I think this is totally appropriate. I ask the distinguished Senator from Kentucky to allow a modification, simply a housekeeping matter over here. The Senator from Michigan, Mr. LEVIN, and the Senator from Florida, Mr. NELSON, are going to switch places, and also that Senator EDWARDS would be listed at the end of our list as the final Democratic speaker.

The PRESIDING OFFICER. Is there objection?

Mr. BUNNING. I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Kentucky is recognized for 30 minutes.

Mr. BUNNING. Mr. President, today I rise to talk about the Medicare prescription drug bill. First, let me commend the members of the conference committee who worked day and night for many months to reach this agreement. I know it was not easy, but they have done a good job that will finally bring Medicare into the 21st century.

Second, let me say how disappointed I am that it appears some Members may try to filibuster this bill. In fact, it seems as though there are Members in this body who want to filibuster just about everything we try to do, whether it is stopping judicial nominations, the Energy bill, or this Medicare bill. Just a few weeks ago we spent several days

in continuous debate on judicial nominations. On Friday, the Energy bill was blocked. Now it looks as though some are going to try to kill this bill. I call that obstructionism.

I want to show a chart because from the beginning there have been charts shown on both sides. These are 358 different groups—358 different groups that support this bill in its present form. It is headed by the American Association of Retired People—the AARP, which represents over 35 million seniors.

Seniors have been pleading for Congress to expand Medicare to include drug coverage, and this bill will do just that. It might not be all things to all people, and I am sure every Member in here would have written a different bill if it was completely up to him or her, but that is not the way we work around here and this bill is a very large compromise. Even the AARP, as I said before, has endorsed this bill and said that, although the bill is imperfect, it is an historic breakthrough. I want to repeat that—an historic breakthrough; and that we should not let this opportunity pass us by.

Today, Medicare provides health insurance to about 40 million seniors and disabled individuals each year. The number is only expected to grow as the baby boomers begin retiring. Medicare provides important medical and health and hospital benefits for seniors. However, it is a program that is still trying to provide health care as if it were in 1965 instead of the year 2003.

When Medicare was created, prescription drugs played a small role, a very small role in medical care. Today, as we all know, that is much different. In fact, for many seniors and many Americans, prescription drugs have replaced expensive surgeries and extended their lives significantly. By tying a drug benefit to Medicare, this bill makes these lifesaving and life-enhancing drugs more available to millions of Americans.

This has been a very long process, and I kind of chuckle when I hear people say we are rushing into this. I can tell you as a member of the Finance Committee that we have been working on this bill for almost the entire year, working and crafting legislation to make the best drug bill possible for all Americans.

I was supportive of our bill as it moved through the Finance Committee and through the full Senate. Today I am supportive of the bill before us. It is time to add this benefit to Medicare. Seniors have waited too long for their benefit, and I urge my fellow colleagues in the Senate to support this bill. Talk is cheap, and it is time to act and it is time to act now.

We have \$400 billion allocated for this benefit. It would be a shame if we let this opportunity pass us by. It might not come again.

This legislation provides a much needed prescription drug benefit to Medicare beneficiaries. It provides more options to seniors than just tradi-

tional fee-for-service Medicare, and it provides incentives to companies to continue offering medical benefits to their retirees.

Seniors will be able to receive prescription drug coverage under two options: Through the traditional fee-for-service Medicare and also through a new Medicare Advantage Program made up of private companies offering Medicare benefits.

Under the fee-for-service Medicare, beneficiaries will be able to enroll in Medicare drug plans. The standard drug benefit will require a \$35 monthly premium and a \$250-a-year deductible. Once seniors have met the deductible, they will pay 25 percent of the prescription drug cost up to \$2,250. Once a beneficiary has received an out-of-pocket spending limit of \$3,600, they will pay 5 percent for their prescription drugs.

I emphasize this because this is the key to the whole Medicare prescription drug benefit.

Low-income seniors will be provided with assistance paying for their drug costs depending on the level of their income. This means that seniors with the lowest income—those below 100 percent of poverty—will not pay a deductible or monthly premium and will pay either \$1 or \$3 per prescription drug up to the catastrophic limit. Once they reach the catastrophic limit, these seniors will have 100 percent of their drugs paid for.

These are the seniors who truly struggle to pay for their prescriptions. At 100 percent of poverty, a senior's income is \$8,900 per year. Other low-income seniors below 150 percent of poverty will receive additional assistance depending upon their level of income. Personally, I believe our biggest responsibility is to low-income seniors. These are the ones who struggle the most to buy their prescriptions, and they deserve a very generous benefit.

Seniors will also be able to choose to receive their health care through a private company. I hope everybody heard that. They will be able to choose. This is a voluntary program. You can choose to stay in Medicare Part B and have no prescription drugs if you choose to do that. You can choose to take Medicare Part B and add a prescription drug benefit or you can choose to go into a private company's health care program.

Under Medicare Advantage, seniors will be able to choose whether they would like medical coverage from a preferred provider organization, known as a PPO, or a health maintenance organization, or HMO, operating in their regions.

These plans will provide beneficiaries with an integrated benefit, which means seniors will receive both medical and drug coverage under the plan. They would have a single deductible for medical benefits currently provided under Medicare Part A and B. They would also be able to receive preventive care, disease management, and chronic care under these programs.

These private plans will have much more flexibility in the type and scope

of benefits they provide than traditional Medicare, and will provide many seniors with a valuable health care option.

Please notice—"option, voluntary." These are very key to this whole program.

I know some of my colleagues do not like these PPOs and HMOs because they say seniors will not be able to go to any doctor they choose. Hogwash. No one is going to force the seniors into these private plans, and they will be able to pick a plan in which their doctor participates.

Please understand that. We are not going to force any senior away from their given doctor. They will be able to choose their own doctor and stay with that doctor.

That is one of the key elements of the bill—giving seniors more choices instead of forcing them to use a health care plan created in 1965, which has changed very little since then. If these care advantage plans sound familiar, they should.

Finally, Medicare will provide seniors with a modern benefit similar to what is offered to most employees, including what the Federal Government offers to employees.

One of the biggest concerns with the legislation as it moved through the Finance Committee and the full Senate was what would happen to retirees who currently have drug coverage from their former employer. No one wants this new program to be an excuse for employers to drop their retirees' health coverage. That would be counterproductive and unfair to those seniors. To encourage companies to continue providing these benefits, this agreement sets aside almost \$70 billion of our \$400 billion for subsidies to help companies cover their prescription drug costs for their medical-eligible retirees. This is a substantial commitment by Congress to make sure companies do not have an excuse to drop their coverage.

The members of the conference committee have worked long and hard for many hours and in many meetings over the last year on this compromise. We have a real chance to pass this bill, and we shouldn't pass up this opportunity.

If we don't pass this bill now, it will be several years before we get another chance, and seniors have waited much too long already.

Again, I urge my fellow Senators to pass this bill and finally fulfill the promise that each and every one of us in the Senate has made either on the campaign trail or anywhere that we have spoken to senior groups. We have promised this benefit and we can deliver it.

I urge my fellow Senators, once again, to pass this bill providing prescription drug coverage to our seniors. We can talk about it for 2 or 4 more years or we can do it now.

I yield whatever time I have to the Senator from Iowa.

Mr. GRASSLEY. How much time remains?

The PRESIDING OFFICER (Mr. BUNNING). There are 14 minutes 50 seconds remaining.

Mr. GRASSLEY. Mr. President, we have heard in the Senate today and last night that the comparative cost adjustment demonstration project, which some of the Members refer to as premium support, would end Medicare as we know it. I want to be very clear, nothing could be further from the truth. I have 10 facts about this demonstration to explain why this is not the case. We are talking about the comparative cost adjustment.

Fact No. 1: It sunsets in 6 years. The demonstration will only be in existence for 6 years. It will not begin until the year 2010. During that time, there will be a 4-year phase-in period. Explicit authorization from Congress at the end of 6 years is necessary to extend the demonstration and/or expand it to other areas of the country. This proposal is significantly modified from the House of Representatives' original position. Congress weighs in before this becomes something other than a demonstration project and becomes policy for the entire country.

Fact No. 2: Very limited areas of the country will be affected in the demonstration. Under the agreement, the Health and Human Services Secretary may select no more than six metropolitan statistical areas to participate in the demonstration. It is not easy to be put in that list of six because in order to be selected, a metropolitan statistical area must have at least two local coordinated care plans offering services in the area and at least 25 percent of the Medicare beneficiaries must be enrolled in these plans. That means the private PPOs we are setting up beginning in 2006 must succeed. I hope they succeed. But we do not know if they will succeed, and if they do not succeed, at least to the tune of 25 percent in two local areas, there will not be one. If that does happen, according to the Congressional Budget Office, somewhere between 670,000 and 1 million beneficiaries will be included in this limited demonstration. It is a demonstration. It is not something that could ever, without an act of Congress, encompass all 40 million seniors.

Fact No. 3: Low-income beneficiaries are not affected at all. So if they are low-income, below 150 percent of poverty, none of them will see their Part B premiums increase.

Fact No. 4: Premium increases for beneficiaries above 150 percent of poverty will be limited to 5 percent. For everyone else, if premiums go up, there is a cap of 5 percent. As an example, if the national Part B premium was, say, \$100 in 2010, the fee-for-service premiums in the demonstration areas could not exceed \$105 a month. The increase, by the way, is not compounded over that 6-year period of time.

Fact No. 5: Other than the limited impact on the Part B premium calculation, the fee-for-service program is unchanged choice. Fee-for-service bene-

fits, beneficiary cost sharings, payments to hospitals, and other health care providers are unaffected by the demonstration. The Medicare entitlement to benefits and payments to health care providers are unchanged in these same areas.

Fact No. 6: Beneficiaries are not required to enroll in these private plans. The right for a Medicare beneficiary to remain in fee-for-service programs is maintained in the demonstration areas. The fee-for-service program will remain affordable for all beneficiaries.

Fact No. 7: The prescription drug benefit is unaffected. The prescription drug benefit and the drug premiums are not changed. The demonstration only minimally affects the Part B premium, and that is the maximum of 5 percent increase.

Fact No. 8: Over the demonstration period, enhanced payments to private plans are phased out to ensure that their payments to private plans are on a level playing field with the fee-for-service program.

Fact No. 9: The preferred provider organization stabilization fund, referred to on the other side by my colleague as a "slush fund," has no relationship to this demonstration. So one cannot talk about the demonstration and talk about a stabilization fund in the same breath. If you do that, you do not know what the bill does; you have not read the bill.

Under the conference agreement, the stabilization fund may only be used to provide assistance to the newly regional PPO options. However, any enrollment in regional PPOs is not counted toward the 25 percent enrollment requirement in the metropolitan statistical areas. The extent to which beneficiaries enroll in the new regional PPO opposite will have no bearing on whether a metropolitan statistical area becomes a candidate for demonstration.

Last fact, No. 10: Strict quality monitoring is required. The Health and Human Services Secretary is required to closely monitor access to care and quality and submit a report to Congress upon completion of the demonstration to determine if the demonstration has reduced Medicare spending and/or increased cost to beneficiaries; second, access to physicians and other health care providers has declined; and lastly, whether beneficiaries remain satisfied with the program. The evaluation would be on the basis of any congressional decision to extend that demonstration.

Premium support, as has been described in the Senate numerous times in the last few days by the Senator from Massachusetts and by other Senators, is not in this bill. It is not included. This bill strengthens and improves fee-for-service Medicare.

How much time remains?

The PRESIDING OFFICER. Seven minutes.

Mr. GRASSLEY. It would be good at the start of the third day of debate on

this bill to remind people of the political situation that has gotten us where we are today. That is a very positive political situation.

Last year, we were beginning to develop a bill in the Senate Finance Committee that would have had bipartisan support to get it out of the committee. Bipartisan support in the committee is a way to have a chance of success in the Senate where there can always be an extraordinary minority who can keep a bill from being passed because we protect minority interests in this body as no place else in our political system. So we must be bipartisan.

About the time that was going to happen, the majority leader—the Senator from South Dakota, last year—decided we needed to talk about this in the Senate. But the bill never came out of committee. It was brought right to the floor. When bills are brought to the floor, there is no chance of developing bipartisanship. We discussed it for 2 or 3 weeks and no one could get the bipartisan majority it takes to get pieces of legislation passed.

At that time, I surmised, and I think the outcome of the debate last year proves it, that the other side wanted more of an issue for the election rather than a product. They gambled and they lost because Republicans gained control of the Senate in that election and then we were right back to square 1 where we went to the Senate Finance Committee where there could be, even with a Republican majority, still a bipartisan working relationship that was able to report out a bill on 16-to-5 bipartisan vote. Then we brought that bill to the floor during the month of June. And it got through here 76 to 21.

We are as successful as we are because the people made a change in the Senate.

In the Senate, then, we adopted a bipartisan bill, and we were able to get through, for the first time on this issue in the history of the Senate, prescription drugs for seniors. We were able to match the House, where it had passed three times previously. We went to conference. We operated in the conference, at least from the Senate point of view, on a bipartisan basis, and we were able to produce a product where here we are doing the best improvement and the most sweeping improvement in Medicare in 38 years. We are able to do that because of bipartisanship.

Now, all of a sudden, people on the other side of the aisle, at this last minute, are filibustering. I hope they do not get away with that filibuster. But, again, they are trying to be very partisan, as they were a year ago. I hope they learned a lesson from a year ago and will not try to be partisan on this very important social issue for the seniors and the disabled of America, and that they will not repeat the mistakes of last year when they wanted an issue instead of a product.

We have a bipartisan product. I listed last night, in my closing remarks, all

of the organizations that are supporting this bill. Other Senators have put charts up saying how many organizations are supporting this bill.

We have this opportunity. Let's hope partisanship—that is demonstrated by the filibuster that was announced yesterday—does not keep this bill from passing. Democrats who want to filibuster ought to consider that is not the way to go. They should learn from the lesson of the past. That lesson is that last year when they wanted an issue instead of a product, they got a defeat at the polls.

I yield the floor.

The PRESIDING OFFICER (Ms. MURKOWSKI). The Senator from Florida.

Mr. GRAHAM of Florida. Madam President, since its creation in 1965, the Medicare Program has helped millions of our Nation's elderly and disabled when they desperately needed it, after they became ill.

It has been an extremely successful and popular program, and has improved the health of countless seniors.

Now that we are in the 21st century, it is time to reap the full benefits of the advances made over the years, and shift the focus of the Medicare Program from assistance after illness to one that promotes wellness.

To achieve that, a prescription drug benefit is mandatory. Ninety percent of seniors have at least one chronic condition; drugs are often the best way to manage those conditions.

The bill we are considering is frequently divided into two parts—one part is the prescription drug benefit, and the other part is Medicare reform.

Let me state what we all ought to know by now: A prescription drug benefit is the most fundamental reform that we can make to the Medicare Program.

If we want to truly reform Medicare, we must change the approach of the program from one of sickness to one focused on wellness. This prevention approach will require access to prescription drugs.

Modern medicine has been altered fundamentally by prescription drugs, notably by improving the quality of people's lives, ending the need for surgeries and long recovery periods.

A side benefit of this change would be that the cost to the Medicare Program could be lower by reducing these procedures.

I have introduced several prescription drug bills over the past few years because I believe a reorientation toward wellness is in the best interest of our seniors, as well as the Medicare Program.

However—and this is critical—not just any prescription drug bill will do. The bills I have authored have been constructed to provide an affordable, comprehensive, reliable prescription drug benefit to our seniors and Medicare beneficiaries with disabilities.

The bill I introduced in 2001, cosponsored by Senators ZELL MILLER and EDWARD KENNEDY, was voted on in July of that year. It received 52 votes.

That bill would have made a significant, and positive, difference in the lives of the nearly 41 million older Americans and disabled citizens who are covered by Medicare—more than 2,770,000 of whom live in Florida.

The conference agreement that we are now considering would also make a significant difference in the lives of our seniors. However, that difference will not be a positive one.

I have many grave concerns about this legislation. The drug portion of the bill is deeply flawed. It includes an enormous coverage gap. When a senior has reached \$2,250 in total drug expenses, all drug coverage stops. The drug benefit doesn't begin again until total drug spending reaches \$5,100. That is a gap of \$2,850.

And during all of the months the senior is in that "gap", the senior is required to keep paying premiums.

The bill is projected to cause 2.6 million retirees nationwide, and over 160,000 in Florida, to lose their retiree prescription drug coverage.

It will cause 6 million low-income seniors nationwide, and over 360,000 in Florida, to pay more for their drugs, and to face more restrictions on the drugs they can get.

It relies on an untested delivery system which would either herd seniors into what we know they don't like, a managed care organization, or would turn them into guinea pigs for a never previously utilized drug-only insurance plan.

Millions and millions of seniors who will not have access to drugs through the traditional Medicare Program will suffer the fate I have just described.

In addition, the legislation that was supposed to be about adding a prescription drug benefit now includes provisions that will privatize the Medicare Program beginning in the first year of implementation fragmenting the health insurance group by subsidizing health savings and increase the costs of comprehensive health insurance for our non-Medicare citizens.

I am not alone in my concern about this legislation. In a recent survey conducted by Hart Research, of voters aged 55 and older, only 19 percent said we should pass this bill. Sixty-four percent said we should go back to the drawing board. This isn't the Medicare prescription drug benefit that they need.

And although the AARP has taken the inexplicable position of supporting this legislation, the national organization may want to listen to its members. Only 18 percent of AARP members want Congress to pass the bill. Sixty-five percent have instructed us to go back to the drawing board.

The percent of seniors in favor in my State is even lower. I have received over 1,000 calls from seniors opposed to this agreement, representing about 80 percent of all calls.

Listen to what some of my constituents are saying about the bill:

Earl Dangler of Beverly Hills, FL said:

This prescription drug benefit is going to cost my wife and I an additional \$750 to \$1,000 per year whether we use it or not.

Many of my constituents have expressed outrage at AARP for endorsing this conference agreement.

One constituent said:

I'm really mad at the AARP and I am going to cancel my subscription that I've had for 20 years.

Another constituent remarked:

I've been a member of AARP for many, many years, and I can't believe that they have sold out to the pharmaceutical industry and the insurance companies.

The real test of the reaction to this legislation is a bit down the road—but it will come. The impact of the bill won't be felt until at least 18 months after enactment.

I would predict the vote we cast on this legislation will be politically inconsequential for those running in the year 2004. The stunning impact will be felt first in the fall of 2005, when Medicare beneficiaries get the notice that it is time to enroll in the drug benefit.

What choices would the senior face in 2005 when considering whether to enroll in the new, highly touted program?

Many Medicare beneficiaries will have to consider the following:

No. 1, sign up for a prescription drug plan, PDP—a private drug-only insurance plan with no limits on the premium that may be charged, or No. 2, enroll in a managed care plan.

Given that more than 85 percent of seniors today have rejected managed care, I anticipate a "1980s" catastrophic outrage. But, that is not the end of the outrage. In fact, it may be just the beginning.

As the senior considers his choices, he will soon realize that the private plans hold all the cards. They have all the flexibility, all the options, and none of the commitments.

The plan defines the classes, or categories of drugs, then decides what drug is in the class or category, and how much the senior will be charged for the drug.

The plan doesn't even have to tell the senior prior to enrolling what the charge for the drug will be, and can change which drugs are in each category at any point in the year.

But the senior? The senior has to make an enrollment decision prior to the beginning of each calendar year, based on limited and subject-to-change information, and cannot change plans at any time during the year.

The private insurance plan can make changes during the year, but the senior cannot.

Once enrolled, in the first part of the year 2006, seniors will begin to feel the impact of the deck being stacked in favor of the private plans. They will discover that the plan can make changes to the drugs covered and the price of the drugs at any time.

They will discover that the drug prices aren't all that low, and they will discover that they have to pay the full cost for part or all of January as they struggle to meet the \$250 deductible.

At this point, you may be thinking that things are bound to improve for the senior. But, hold on, because the summer of 2006 is coming. What happens then? That is when, for the first time, seniors—voters—will experience the infamous "gap." Beginning sometime after Memorial Day 2006, many seniors will reach, and fall into, the gap.

At this point the senior has been going to the drugstore for about 6 months, each month filling prescriptions for treatment of any number of chronic illnesses.

The senior has met his or her deductible, has never missed a monthly premium payment, and dutifully has been paying 25 percent of the cost of each prescription.

But when the drugstore counter is reached in July, the senior finds he is now responsible for paying 100 percent of the cost of the prescription, and yet still is responsible for paying the monthly premium.

I predict that by Labor Day of 2006, seniors will have made loud and clear their opinions about this prescription drug benefit.

And yet, there is still more ahead. In the year 2010, a vast experiment called "premium support" will be imposed on millions of seniors in several parts of the country, including Florida.

Seniors in my State, as in others, will be forced to choose between enrolling in a health maintenance organization or paying a much higher premium to stay in the traditional fee-for-service Medicare Program.

Although we are beginning to hear the outrage now, it will be nothing compared to what we will hear in the summer of 2006.

The voters have been polled and my constituents have been calling, and they all cite many concerns with the bill—many of the same issues I mentioned a few moments ago. Each of these issues should be discussed in great detail, and I hope we have the time to do so.

Today, I am going to concentrate on one of the aspects of the bill that I find to be the most troubling, and one that is shared by 64 percent of those polled: the legislation does little to contain drug costs. The legislation actually forbids Medicare from negotiating with the drug companies to reduce costs.

It doesn't seem to make much sense. A Medicare prescription drug benefit should allow the Medicare Program to do whatever it can to get the best possible prices from the drug companies. Why? Because both seniors and taxpayers would benefit.

Under this legislation, the majority of seniors would have to pay either 100 percent or 25 percent of the price of the drug—100 percent before the deductible is met, and during the time the senior is in the enormous "gap" in coverage, and 25 percent after the deductible and before reaching the "gap."

In 2001, the median income of a Medicare beneficiary was \$19,688. After cov-

ering the cost of housing, food, and transportation, there isn't a lot left.

We need to make sure the prices are as low as possible so that our seniors are able to actually purchase the drugs they need to keep them well.

Of course, the taxpayers would also benefit from Medicare serving as a tough negotiator. The taxpayer is going to pay the portion not paid by the senior.

Both parties—the seniors and the taxpayers—have an interest in keeping drug prices as low as possible. The party that does not share that interest is the pharmaceutical industry.

The interests of that industry can be the only reason for a provision included at the top of page 54 of the conference report. The provision is designed to appear helpful by being called a "noninterference" clause.

What is a "noninterference" clause? According to the authors of this legislation, it is the following:

NONINTERFERENCE.—In order to promote competition under this part and in carrying out this part, the Secretary—

(1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and

(2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

Let me get this straight. A provision that prohibits the Secretary of HHS from negotiating with drug manufacturers to lower the price of drugs—a provision that prohibits the Secretary from using the purchasing power of 41 million Medicare beneficiaries to lower the price of drugs—and thus lower costs to seniors and taxpayers alike—is "noninterference"?

I put my money on this being a form of "interference" that senior wouldn't mind. Saying this provision is about not interfering, and about promoting competition, is akin to the fox putting on the San Diego chicken costume and heading into the chicken coop to "protect" the chickens.

This may sound like dry stuff. But it has very real life implications. Take the case of Patricia Kittredge, a 71-year-old woman who lives in Tamarac, FL.

She takes 6 different prescription drugs to stay healthy, which add up to \$409 a month, or approximately \$4,908 annually. Fortunately, her former employer picks up the majority of these costs so that she pays \$65 a month, or \$781 annually.

A former credit analysis for a major employer in South Florida, Mrs. Kittredge has good retiree health coverage. Yet she is far from wealthy. She makes about \$18,000 a year when you combine her pension and Social Security income.

Because the conference bill does not allow the Medicare Program to negotiate on her behalf—should Ms. Kittredge find herself among the 4 million Americans who will lose their retiree coverage—her out-of-pocket costs, including her premium, will explode to \$3,830.

That is nearly 5 times what she currently spends, nearly 5 times what she now pays, and nearly \$4,000 in out-of-pocket drug costs on an income of \$18,000 a year. What kind of benefit is that?

But don't take my word for it, this is what Patricia Kittredge has to say:

That would really hurt me. The handwriting is on the wall. The companies that have retiree coverage will be walking away from it to save money and won't feel bad about it at all.

Were Medicare able to use its bargaining power to negotiate with the drug manufacturers, our seniors would likely see drug prices more in line with the VA drug prices. Mrs. Kittredge's drug costs under the proposed plan would decrease dramatically.

Yet the conference bill strictly forbids Medicare from using its bargaining power to negotiate lower drug prices for seniors.

How good are these VA prices? Let's compare the VA prices of Mrs. Kittredge's drugs to their retail prices.

Diazepam, which Mrs. Kittredge takes to help her sleep, costs the VA \$0.84 for one hundred 5 milligram tablets, while the same pills cost \$16.70 at the drug store.

In addition, a month's supply of pravachol which she takes to regulate her cholesterol, costs the VA \$19.80 at 40 mg per pill for the clinical equivalent, while the drug store charges \$116.75 for the same amount.

Mrs. Kittredge would face similarly high prices for her other prescriptions: a 20 mg dosage of accupril, a drug to treat her high blood pressure, costs the VA \$7.69 for 30 pills goes for \$32.00 at the drug store.

Diltiazem, which Mrs. Kittredge also takes for her blood pressure, costs \$69.20 at the drug store but only \$32 through the VA.

Metrocream, which she takes for a skin disorder, costs \$69.99 at the drug store compared to \$25.13 through the VA.

If the Medicare bill we are now considering actively negotiated on Mrs. Kittredge's behalf, she would likely pay prices more in line with the prices available to veterans. Her total bill would be \$2,188 rather than the \$3,830 as she will pay under the conference agreement.

Mrs. Kittredge's example is not unusual. Look at the price differentials between the VA price and the average retail price of some common drugs.

How is the VA able to secure such good prices for veterans?

In 1992, concerned about the prices veterans were paying for drugs, Congress passed the "Veterans Health Care Act"—a Rockefeller, Simpson, Murkowski, Cranston amendment—by voice vote.

It is interesting that an issue that was and is so controversial could be passed by voice vote. We are only asking that Medicare not be prohibited from negotiating prices for seniors.

This legislation gave the VA the authority it needed to secure better drug

prices for our veterans. What was the result of that legislation? In the first 5 years alone, the VA saved more than \$1 billion.

VA's savings have continued to grow exponentially, as both the cost of pharmaceuticals and the number of veterans seeking prescription drugs have grown. The savings represent valuable Federal dollars that have been used to provide quality health care to our Nation's veterans.

In addition, the savings on pharmaceuticals have allowed VA to provide a long-term care benefit, including nursing home care, adult day care.

What are the implications of allowing Medicare to negotiate prices? In 1998, the Inspector General, IG, of HHS, studied 34 drugs currently covered by the Medicare program.

The IG found that Medicare and its beneficiaries could save more than \$1 billion a year if the allowed amounts for just these 34 drugs were equal to the prices obtained by VA.

If the Medicare program were able to achieve similar savings on the outpatient drugs covered in this legislation, Congress would be able to provide a much richer prescription drug benefit for the same \$400 billion we are proposing to spend now, reduce the costs to taxpayers, or both.

In terms of the drug benefit: we could give seniors a lower deductible and fill in the gap; we could remove the gimmicky definition of what counts toward reaching the catastrophic limit so that employers wouldn't drop their retiree drug coverage; we could remove the assets test; We could allow the Medicare Program to pay to the cost-sharing of our low-income seniors.

What would allowing Medicare to use its purchasing power do to the pharmaceutical industry?

Some would have us believe that only the proposal we are discussing today would allow the industry to thrive and continue to develop life-savings drugs.

But in June 1999, reaching to the prospect of a Medicare prescription drug benefit, Merrill Lynch advised investors that

volume increases could overwhelm negative pricing impact. It is important to remember that a reduction in prescription drug prices, both with or without associated prescription benefit coverage, is likely to be associated with price elasticity and increased utilization.

The proposal before us fractures the Medicare market. One of the great strengths of the Medicare Program has been its universality. Seniors from Anchorage to Key West knew they would get the same benefits for the same premium.

The proposal before us also uses scarce Federal dollars in an attempt to force private insurers into a line of business they have repeatedly said they do not want to enter.

Instead, we should be using the purchasing power of the nearly 41 million Medicare beneficiaries waiting for a drug benefit to drive down prices—for

their benefit, and for the taxpayers benefit.

I ask unanimous consent to print an editorial at the conclusion of my remarks.

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

(See exhibit 1.)

Mr. GRAHAM. I'd like to quote from the November 21st Miami Herald, which editorialized as follows:

The problem: Instead of using the free market to drive down the costs of prescription drugs, the bill would protect pharmaceutical companies from competition and pay more than \$100 billion in incentives to employers and insurers in an attempt to make its flawed logic work. The bill also threatens to cap future Medicare spending.

True, the measure promises prescription-drug coverage for low-income seniors not already covered by Medicaid and would benefit seniors with extremely high prescription costs. But its coverage for middle-class seniors is modest at best.

That's just not enough benefit for a 10-year price tag of \$400 billion that will add to the skyrocketing Federal deficit, especially when it doesn't even contain the cost of prescription drugs.

A better, more logical approach would be to harness the buying power of the 40 million Medicare seniors to drive down drug costs. But this bill actually would prohibit the government from doing so. Instead it would dissect the country into 10 regions and pay incentives to companies—\$12 billion to private insurers and \$1.6 billion to HMOs—so they'll offer prescription-drug coverage.

For the Record, I'd like to make one correction in the otherwise excellent editorial. Under the latest version of the bill, between 10 and 50 regions would be allowed—further dissecting the country.

The last drug benefit endorsed by the AARP was the Medicare Catastrophic Coverage Act. We all know how seniors felt about that drug benefit, and it was quickly repealed.

If we adopt the proposal before us, we will be turning a deaf ear to history, and to the seniors across the country today who are already telling us—through AARP card burnings, through the messages they are writing on the AARP "message board", and through the hundreds and hundreds of calls from seniors we've been receiving over the last week—that we need to get back to work.

This drug "benefit" is actually no such thing. It leaves millions of seniors worse off.

Along with many others, I have worked to provide an affordable, comprehensive, reliable prescription drug benefit for our seniors and citizens with disabilities for the last several years.

It is therefore with great regret that I have no choice but to vote against a conference report that does not provide the benefit seniors need, and have been promised.

If the proposal is adopted—and I sincerely hope it is not—it will not be the last chapter. Seniors won't stand for it.

I predict voters will put Congress on the hook in 2006, and we will spend many, many years attempting to fix

this deeply flawed legislation—or will repeal it outright as we did with the catastrophic legislation.

Or we could have the worst of both worlds.

We could repeal the prescription drug benefit because the benefits are too meager, its subsidies of health maintenance organizations are too great, and its delivery system too confusing and disrespectful.

And what would be the price of repealing the drug benefit?

We would leave the privatization of Medicare in place and destroy one of the Federal Governments most effective, efficient and popular programs: traditional fee-for-service Medicare.

In the event the legislation before us does become law, I plan to use my last year in Congress working to fix it. Our seniors need better from us.

EXHIBIT 1

[From the Miami Herald, Nov. 21, 2003]

WHEN HALF A LOAF ISN'T NEARLY ENOUGH
OUR OPINION: REJECT THE FLAWED MEDICARE
PRESCRIPTION BILL

With its \$7 million ad campaign to win support for the Medicare prescription-drug bill, AARP says that the legislation "isn't perfect. But millions of Americans can't afford to wait for perfect." We agree with AARP's assessment of the bill but not its conclusion.

The proposed bill is badly flawed. It delivers too few benefits to seniors at too big a cost. Americans don't need perfect, but for \$400 billion they deserve a bill that helps more people and drives down the high costs of prescription drugs. The proposed bill does little of either. Congress should reject it and try again.

The problem: Instead of using the free market to drive down the costs of prescription drugs, the bill would protect pharmaceutical companies from competition and pay more than \$100 billion in incentives to employers and insurers in an attempt to make its flawed logic work. The bill also threatens to cap future Medicare spending.

True, the measure promises prescription-drug coverage for low-income seniors not already covered by Medicaid and would benefit seniors with extremely high prescription costs. But its coverage for middle-class seniors is modest at best. That's just not enough for a 10-year price tag of \$400 billion that will add to the skyrocketing federal deficit, especially when it doesn't even contain the cost of prescription drugs.

Don't repeat the past

A better, more logical approach would be to harness the buying power of the 40 million Medicare seniors to drive down drug costs. But this bill actually would prohibit the government from doing so. Instead it would dissect the country into 10 regions and pay incentives to companies—\$12 billion to private insurers and \$1.6 billion to HMOs—so they'll offer prescription-drug coverage.

We've tried such incentives before with HMOs, and experience shows that they didn't work. Half of the Medicare Plus Choice plans provided by HMOs have folded, even though taxpayers still pay more to subsidize a senior in a Medicare HMO than a senior in traditional Medicare.

The compromise measure also guts provisions that would have allowed seniors to legally buy prescription-drugs from Canada, another concession to pharmaceutical companies, some of which now are retaliating against Canadian wholesalers who sell to Americans.

The doughnut hole

The standard coverage that the bill offers would only benefit a senior who spends more than \$835 a year, or some \$70 a month, on drugs. Then there's the "hole in the doughnut" coverage gap in which the government's 75-percent subsidy stops after \$2,200 in out-of-pocket cash has been spent. If out-of-pocket spending reaches \$3,600, the subsidy kicks in again, this time at 95 percent of drug cost. Deductibles and co-payments are complicated enough without trying to explain the "hole in the doughnut" to elderly recipients.

AARP and other supporters say that even a flawed benefit is better than nothing. They reason that once passed, bad provisions could be changed before they go into effect. But why fix later what should be fixed now?

Seniors deserve affordable prescription-drug coverage. Congress should scrap this flawed approach and come up with a plan that delivers that coverage while driving costs down.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. JOHNSON. Madam President, I ask unanimous consent to speak for 5 minutes as in morning business.

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

HAPPY 90TH BIRTHDAY, DAD

Mr. JOHNSON. Madam President, today my father, Van Johnson, is celebrating his 90th birthday. He is joined by my mother Ruth, my brother and sister and their spouses, dad's sister Ardis, and a great many wonderful friends. I had long planned to be there to join in this celebration, but the Senate failed to adjourn on time, and now is staying in session through the weekend and into next week in an effort to conclude legislative business which should have been completed months ago.

The good people of South Dakota honored me by electing me to represent their interests and values in the Senate, and I simply cannot neglect those duties by leaving Washington today.

While I cannot be with dad on this very special day in his life, I rise to express my long appreciation for a father who has always been there for me. Dad taught me about the importance of family, of fatherhood, of faith, and of personal integrity. He taught me about the importance of public service—that life is more than about the collection of things, and that helping make the world a better place is, indeed, a central purpose to our lives.

Dad was there for me, whether it involved the countless family camping trips, athletic events, school work, or church activities—all at a time when he was intensely busy with his own career as a highly regarded teacher, coach, professor, and university administrator. He and mom were and are a great team, and my brother Tom and my sister Julie and I have benefited all our lives from their loving guidance and care.

As a father of three children, and now a new grandfather myself, I continue to draw from the values imparted

to me from my father and find with each passing year how profoundly important they are.

But dad, although an educator all his adult life, did not teach exclusively in a pedagogical manner. Many of the greatest things I learned from dad came from observing his example—his commitment to our family, his love for mom, his dedication to professional excellence, and his willingness to assume leadership roles in the church and in our community.

Dad, it deeply disappoints me that I cannot be with you today, but know that I am with you in thought and spirit. Happy 90th birthday, dad.

I yield the floor.

Mr. REID. Madam President, Senator NICKLES is in the building. I do not know if he is going to speak.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. NICKLES. Madam President, I rise to speak on the Medicare bill that is before us. First, I compliment a couple colleagues with whom I have had the pleasure of working on this bill, particularly in the conference committee. First would certainly be Senator GRASSLEY who, in leading the Senate conferees, I think did an outstanding job. I also would echo that for the majority leader. The majority leader seldom gets involved in a conference. This majority leader, Dr. BILL FRIST, has an interest in Medicare and he was a very influential member of the conference. In addition, Senator KYL, Senator HATCH, Senator BAUCUS, and Senator BREAUX and, I would also include, Chairman THOMAS.

This was a very challenging conference between the House and the Senate. The bill that was reported out of the Senate—I did not vote for it. I thought it was very heavy on expense and very light on reforms. I did not really think it was a sustainable bill, one that we or our children could afford. So I worked very diligently, I guess, or very aggressively, trying to come up with a conference report that would meet the test, that would provide better benefits at a sustainable level.

I think the present Medicare system has crummy benefits. It does not cover a lot of things that should be covered. It is so far behind the times, I really did want to modernize it. I also wanted to add the new benefits in a way that would be affordable and sustainable.

Under the present situation in Medicare, just to give people a little thumb-nail sketch—and this is without providing any new benefits—the total debt held by the public is \$3.6 trillion. Social Security unfunded liabilities is about \$4.6 trillion. Medicare is almost three times as much. It is \$13.3 trillion,