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 thumbnail 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,

and that is without adding a new benefit, which most people would estimate to be $6 trillion or $7 trillion. So my colleagues can see we have an enormous challenge before us.

Then just look at Medicare today. There is a lot more money going out than coming in. Medicare is primarily financed by two things. One is payroll taxes; 2.9 percent of all payroll, not capped at the same amount that Social Security is up to the 80,000-something dollars. It is 2.9 percent of all payroll. That is the money going in. It is also financed by general revenue. We subsidize Part B.

If it is added all together and we take out the intergovernmental transfers, Medicare had net deficits last year—in 2002—of almost $70 billion. It gets a lot worse—by 2012 the deficit will be above $150 billion. That is present law. That is without adding a new benefit. So Medicare is in very difficult fiscal waters, a lot more challenging than even Social Security, a lot more challenging than any other program because demographically there are a lot of people who are living longer, health care expenses are exploding, and there are fewer people paying the payroll tax. So it is going to take a greater share of general revenue, money from taxpayers to pay for these obligations.

So I thought, let's provide better benefits. What do I mean by that? Medicare does not provide drug benefits. Everyone knows that. Medicare also has unaffordable deductibles. It has a deductible for the hospital of $840. I compare this to what the private sector offers. If a person buys Blue Cross or Aetna, any of the private plans, they do not have an $840 deductible to pay if they go in the hospital for one day, but Medicare does. All private plans certainly should—I think most do—have catastrophic. Medicare does not have catastrophic.

If a person is really in trouble, if they are in the hospital more than 150 days, it is all on them; they do not get any help from Medicare. I think that is pathetic. That is not a very good benefit. As a matter of fact, if someone is in the hospital more than 60 days, they have to pay $210 a day. If they are in the hospital more than 90 days, they have to pay $420 a day. So if someone is really sick, if they are really in trouble, look out, Medicare does not come through. So it is a program that has, frankly, not been modernized since its creation in 1965.

Medicare does not do enough for preventive care. It does not offer prescription drugs. It does not have catastrophic. Its deductibles are way too high for hospitalization. So I think it needs significant improvement.

I want to pass a Medicare bill that will help solve all of these problems. I want to pass a bill that will provide drug benefits. I think we are way behind the times. We should be doing it. I also want to be cognizant of the fact that Medicare is in real financial trouble, that it is not sustainable in its present form. I do not want to be adding new benefits that will just accelerate the day where it collapses, where it is not sustainable, where our kids are going to be saying: What about this tax?

Some people say: Well, this is not a tax. And that is correct, we are not creating a direct tax to pay for the new benefits, but what we are doing is incurring enormous debt to pay for benefits. Frankly, our kids are either going to be paying for that in the form of taxation tomorrow or they are going to be paying for it in an increased interest rate because debts will increase substantially under this bill.

The budget resolution we passed last year said we should strengthen and enhance Medicare. That means make it more solvent, more sustainable, more affordable. Unfortunately, I am not sure we did that under this bill. In fact, we focused too many resources in this bill to cover the covered and not improve Medicare.

What do I mean by that? If we look at this chart, we find out that 76 percent of seniors now have prescription drug coverage, but we are going to spend billions, almost $100 billion, to provide assistance to those people who already have drug coverage. For employer-sponsored plans, for example, we are going to spend $89 billion to subsidize employers so they can continue providing health care benefits, drug benefits, for their employees. We are going to bribe them to keep covering the people they have already contractually obligated to cover. This is a big bailout, in my opinion, for employer plans, union plans. It is way too high of a subsidy. I know AARP wanted these subsidies and in fact wanted more money.

Now, some people were criticizing Senator BAUCUS. Mr. Hunt in the Wall Street Journal criticized him as a negotiator. I take issue with that. He was a very successful negotiator because in the last several days of negotiating the bill—we spent months negotiating—Senator BAUCUS was a very effective negotiator. He kept winning. I kept losing. We were on opposite sides in many battles. I complimented him. I said: You just keep winning.

He got more money for the employer and union subsidy, another $18 billion in the last few days to cover the covered. It went from $71 billion to $89 billion by making it tax free. He also got an additional $18.5 billion for low-income subsidies and more benefits. That makes the bill more expensive and I think will make utilization go way up. So I compliment Senator BAUCUS for his negotiations, but I also think it makes the bill less sustainable or less affordable for future generations.

So we spend a lot of money to take care of employer sponsored. I also have issues with covering the covered in the Medicaid program. We have low-income subsidies in this bill not just for those who are higher incomes than Medicaid but for the Medicaid population that is dually eligible. We have subsidies in this bill for low-income to the tune of $190-some billion. These are subsidies for seniors which many of whom already had drug coverage. So what is the total package? Everybody says this package is a $395 billion package. In reality it is much more than that. In reality, this bill is closer to $800 billion. It nets out about $400 billion. It is $800 billion because we have $507 billion in drug benefits, but we also have low-income subsidies of $192 billion, and we have employer subsidies of $89 billion. If you add that up, it is almost $800 billion of checks that are going to be written. The Federal Government is going to be writing those checks.

The Federal Government will be receiving money back in the form of premiums from seniors, $131 billion, and a reach-back or call-back from the States. Since we are assuming Medicaid, which in my opinion is a serious mistake, one that was opposed by the administration and certainly opposed by this Senator, but we were not successful. It was not the Senate position to assume federalization of Medicaid. Medicaid is a Federal-State program. It is now an all-Federal program when this bill becomes law. Again, we are covering the covered. We are going to subsidize Medicaid to the tune of $190-some billion in this bill. That is a lot.

We recoup some of the money we were paying. Now it is all Medicare, so the offset will say we will spend less in Medicaid because we are not going to do that. In the future we will make it all Medicare. The net is—we will spend $800 billion, recoup $400 billion—so the net cost to future generations is about $400 billion. Yes, that meets the so-called budget restraint we put in, in this year's budget. But we didn't finance that, we don't pay for it, so we have benefits, frankly, that are certainly overpromised and underfunded. They are not funded. The $400 billion is not funded. That is just additional debt.

I happen to think it will be a lot more than that. I happen to think once you end up paying some benefits you will find that utilization will skyrocket. This is just what CBO has told us. People without drug coverage in this age category spend about $732 on their drugs per year. If they have drug coverage, they spend about double that, $1,337.

I think this figure will skyrocket. I asked my mother: Do you have drug coverage? She said yes. She buys it with AARP. She pays $140 or $160 a month for drug coverage. I said: How much is your drug coverage?

It is 50 percent of whatever she spends up to $1,000. She gets $500 in drug benefits from AARP. She pays almost $1,000 for that $500. Maybe there are some other benefits in there I am not aware of. My point is, a lot of people have drug coverage, but they only have a little drug coverage. The reason I say this bill may not be sustainable or affordable is because 36 percent of

all Medicare seniors are going to get an enormous benefit and they pay almost nothing. They will have only $1 and $3 copays, or $2 and $5 copays; in most cases they will have no premiums, deductibles or gap in coverage.

I have heard some colleagues say we should be doing that for everybody. Let me just give you an example of who is pushing that proposition. I saw that AARP ran an ad today and is asked: Why should you vote for this bill? They had three or four reasons. If you have income less than 100 percent of the federal poverty level—for an individual, that is $9,600; for a couple it would be $13,000, this is the best deal you have ever seen because all you have to pay is $1 if you are buying a generic, or $3 if you are buying a brand-name drug, and you have unlimited drugs—no limit, no deductible, no copay other than that $1 and $3; no premiums, and no donut hole. That is unlimited. All you have to pay is $1 to $3 and all your drugs—whether they are $5,000 or $10,000—are all covered.

It is almost the same if you have an income of less than 135 percent of poverty. That would be for individuals with $13,000 and a couple with $17,600 of income. If they have less, they have the same thing, except their copay is $2 and $5. There is no donut hole, no catastrophic, no limitation. They don't have to pay premiums, no $35 a month in premiums. They have a great benefit. They should be celebrating.

I am surprised to hear some of our colleagues on the other side say they can't support this bill because it is not a very good deal. If they are so-called champions of the poor, this is the most generous federalization of a government benefit in U.S. history. Maybe they are ignoring the low-income subsidies. It is not insignificant—$192 billion according to CBO. I think it is so much more than that. I think when people find out their only copay is $1 or $3 or even $2 and $5, utilization will skyrocket. This chart will be so inaccurate.

We will find out if we have underestimated the impact of providing a federal benefit upwards of a 90 percent subsidy. In a few years we will find out. People who don't have to pay much—in other words, if the Government is paying 90-some-odd percent of it, 95 or 97 percent, which would be the case in many of these income categories, utilization will skyrocket. At least that is my opinion. Maybe I am wrong. We will find out. I am making this statement for the record because I think this benefit is going to cost a lot more than people estimate. I think utilization will skyrocket.

For individuals who have incomes less than $14,500, or as a couple, $19,500, between that 135 percent and 150 percent of poverty, their copay is 15 percent. The Government is going to pay 85 percent. Again—no donut hole. They will have a reduced sliding scale premium and a reduced deductible of $50. This too is an enormous benefit that will skyrocket.

People who have incomes above 150 percent of poverty, they have a copay of 25 percent. Then you are getting into the area where it is not quite as good as what they had in the private sector. So my point is, for low income, for that 36 percent of Medicare seniors, for about 14 million seniors, this is one great package. My guess is, it will explode in cost.

Another reason I think it will explode in cost is because a lot of our colleagues will say whatever we pass, that is just the beginning. I think Senator KENNEDY alluded to that when this passed the Senate: This is a beginning and he wants to expand upon it. I believe that is what AARP says: We will take this and expand upon it.

How do you expand upon it? Well, let's just fill the donut hole. In other words, the basic benefit after you get past the low-income subsidies, the basic again goes up to $2,250. Then above that amount you have to basically self-insure or in other words you pay the next couple of thousand dollars on your own before the Federal Government catastrophic kicks in.

A lot of people would say: Let's just fill that donut hole up. We don't have that donut hole in the private sector, we should not have it in this. If you fill that up, in other words, if Government expands its liability, the cost of this program goes up by the hundreds of billions of dollars—hundreds of billions of dollars. In fact, one does not have to predict that this will happen, it actually already did. The Conference Committee negotiated an initial benefit level of $2,200. This was an agreement. Tuesday night, armed with a CBO score that was under $400 billion the negotiators closed the donut by $50. This cost $4 billion. I have no doubt in my mind that once this passes, future Congresses will be working to fill that donut hole, and my guess is they will be successful. My guess is they will be successful in increasing the number of people eligible for these enormous low-income subsidies. It doesn't have to be 150 percent. As a matter of fact, the Senate bill passed at 160 percent of poverty. So I am sure there will be amendments year by year to increase that level up for the super government benefit. Let's make that eligible up to $30,000 or $40,000 so that will be happening.

I also think areas in which there are significant savings in the bill—and I was involved in this—the reach-back, where we try to recapture a portion of the savings going to States we will see slowly undone. My guess after this becomes law, States will be lobbying us extensively: You are taking too much back. We want that reduced. In fact the reach-back provision was reduced just this past week at a cost to the taxpayers of $4 billion.

I am afraid in many cases States will continue to be successful. So that cost will explode. As a matter of fact, I will make a prediction. Within a few years, the donut hole will be eliminated, the reach-back by States will be reduced dramatically, and the expansion of low-income definition will be enlarged tremendously, so the cost of this bill will more than double, more than double. That is just my guesstimate. I may not be in the Senate when that happens, but my guess is it will happen.

What is my other complaint about the bill? Its explosive nature in cost. I knew it would cost a lot. I knew it would explode. One of the things I really wanted to do was come up with some reforms that would help make this program more sustainable, more affordable for the future.

Presently, we have a system that is bifurcated. We have Medicare hospitalization. That is called Part A. It has Part B for doctors. It will now have a new part D for prescription drugs. The benefits are not integrated.

A lot of people also buy Medigap. Under present law they buy A and B and they buy Medigap. So it is not a very good integrated system, unlike the private sector. The private sector offers the benefits that I said that Medicare lacks. I wanted to have an integrated private-sector alternative to the present Medicare system, one that people could look at and say: Wait a minute, this works better. I think I would rather be in the everyday private sector type system, the same one Federal employees have, the same one private sector employees have.

They have better plans. They have a better package. It is more modern. It is not tied to a government-controlled fee-for-service system that does not work. Do you want the private sector to become a 1965 Medicare fee for service model? This bill is spending billions and billions of dollars to make adjustments for doctors and hospitals and providers because government is underfunding them? That is not the private market and we should not tie them to Medicare's price controls.

Senator GRASSLEY has been a champion for increasing assistance to rural areas, and he is exactly right. The present system hasn't worked very well. I wanted to come up with a more modern system with integrated benefits that integrates Part A, Part B, and Part D—hospitals, doctors, and prescription drugs—and avoid the necessity of a Medigap plan. People had to have Medigap because Medicare alone didn't pay for a lot of benefits, and it had too high of a deductible. People had to buy Medigap. They shouldn't have to do that. I was hoping we could come up with a good, reasonable integrated system. I am afraid that maybe we haven't quite attained that. I am afraid our reforms are really not adequate for the explosiveness of the benefits we are looking at today.

Let me touch on the integrated benefit. I have heard some people say this is a ripoff because we are giving money to insurance companies; that it should be done by the Government. I have already mentioned that Government doesn't do a very good job in providing

the benefits today. Now we are trying to have the private sector come in after Part D, the private sector for a prescription drug package. Nobody in the real market right now offers to Medicare beneficiaries or for that matter anyone a stand-alone drug benefit. We hope and pray they will in the future. But if they do, they will have to basically offer exactly what we told them to offer, and that is the benefit structure of 75–25 up to $2,250. We are limiting the private sector to only offering a government-designed benefit.

There is this big donut hole in the government standard benefit and we have a governmental catastrophic, some call it Government reinsurance—which ties the hands of the private sector and denies seniors the best the private sector has to offer. For example, After you spend $3,600 of your own money, then Government reinsurance will kick in, and individual beneficiary will be liable for 5 percent. The Government is responsible for 80 percent of all costs above the $3,600 ''true out of pocket'', the health plan is covering 15 percent and the individual 5%. The private sector is not able to assume full risk and offer the benefits they want. If the private health plans did offer increased benefits they would lose or delay government subsidies. This is crazy. All they are able to offer is basically the basic benefit up to the $2,250, or the actuarial equivalent, but they are not able to offer both. They are not able to say they will take all of Part D—that they will assume all of Part D and combine it with Part A and Part B and use efficiencies between the system having an integrated benefit and maybe doing something better in hospitalization and doctors, have some savings and offer a more generous drug benefit. They are not able to do that because under this bill, they are required to maintain this true out-of-pocket cost. This bill puts the private plans in straight jacket.

I think that is very unfortunate. It really kind of locks in an inflexible structure. We are telling the private sector, which have extensive experience in offering comprehensive benefits for all types of individuals including public and private sector employee and individuals, that they have to sell a government benefit. They can not offer a plan with prescription drugs for our seniors without having a donut hole. We are mandating that they have that before they can get into catastrophic. I find that to be very unfortunate and very shortsighted and maybe even unworkable. It doesn't really transcend the movement to private sector. It doesn't trust the private sector. By doing that, I am afraid we have put in a rigidity that won't allow it to work as we would like for it to.

We did not get cost containment. We tried. Maybe I should say we have minor cost containment. We did put in a provision that says if general revenue contributions exceed 45 percent, the President shall come up with a plan to fix it, and Congress has some procedures. Nothing mandates Congress do it. We tell the President he should. That is years away. I find that to be a little hollow. I wanted real cost containment. It was opposed by many—particularly on the Democrat side—and we weren't successful in getting that in. That is unfortunate.

There are several provisions in this bill that are good. I want to compliment again Senator GRASSLEY and Chairman THOMAS. We did get health savings accounts. It is not directly related to Medicare, but I think it would help reform health care as we know it. People would actually be spending their own money. I think that is a very positive and a good significant change, and it will change people's behavior. That is about $6 billion or $7 billion. That is very positive. I compliment Senator GRASSLEY and Chairman THOMAS especially for putting that in.

We did put in income-relating Part B premiums. Senator FEINSTEIN and I worked on that amendment on the Senate floor. We included a lot of that in the bill, not exactly as we put it in the bill on the Senate floor, but I think that is a positive change. But to my regret, it puts more money in the bill, and basically we spent that money.

We did get income-related Part B. Basically, that means we are going to have less subsidies for higher income people. Part B has always been paid for. When it was created, it was 50 percent for individuals. Over the years that has been declining. Now the individual only pays 25 percent, and the Federal Government pays 75 percent.

What we said is if you have income above $80,000 up to $100,000, eventually you have to pay 35 percent. If you have individual income above $100,000, eventually you have to go up to 50 percent where it used to be. If you have incomes much higher than that, you will have to pay 65 percent, or you will have to pay 80 percent. Even very wealthy people will still get a 20-percent subsidy under this provision. I think that is good reform.

We also index Part B deductibles. It has been $100 for a long time. Now we index that to the cost of the program. Those are good changes. They will help improve it. Unfortunately, the savings to the taxpayers as a result of these changes have already been spent in this bill. As a matter of fact, in the 2 or 3 days of negotiations, we amended the benefits and the subsidies in the bill by about $40 billion. Most of the good done by the income-relating of the Part B premiums and the indexing of the deductible were undone.

I have no doubt that in future Congresses that the current 75 percent up to that $2,250 subsidy will be changed and the $2,250 is going to be climbing up. I have no doubt that people will say we need the most generous subsidies and low-income subsidies which needs to apply to a lot of other people. It will increase spending dramatically.

My point is, Yes. We made some reforms, but this program may not be affordable or sustainable. Right now, it is estimated to cost $400 billion over the next 10 years. The program doesn't even start for a couple of years; that is, over the next 8 years. The Congressional Budget Office directive said that in the next 10 years they thought this program might cost up to $1.5 trillion to $1.7 trillion. That is with the benefits structure as we have outlined it today. As it expands, it will be much more than $1.7 trillion. When the donut hole is filled—and I predict it will be—when you have the number of eligibles increase dramatically to receive the low-income subsidies, when we reduce the reach-back or claw-back from States, this $1.7 billion in the next decade will probably be much more than that.

That brings me to my final comment. Can we sustain it? I am not sure. It looks to me like we are building a brand new deck on a house with a very unstable foundation. I think we are expanding this program like it is on a solid foundation, and it is not. We are not paying for these new benefits. We are saddling our future generations with enormous liability.

I conclude by saying I have the greatest respect for the chairman of the committee. I have the greatest respect for the majority leader. I want them to be successful. I want the President to be successful, and I want senior citizens to have prescription drugs. I want them to have a modern Medicare system. This bill takes some steps in those directions, but my conclusion is that the benefits greatly exceed the reforms. Without necessary reform, I am not sure this program will be sustainable in the future. So it is my intention not to support this bill.

Also, I want to compliment some people who have worked very energetically on this bill. One is my staff, Stacey Hughes, who has just worked unbelievable hours; on Senator GRASSLEY's staff, Linda Fishman and Mark Hayes, and the Senate legislative counsel. There are a lot of people who have put in more hours than you can imagine to put forth this bill. I compliment them for their efforts. They worked in a very positive way. It is a pleasure to work with them and to work with the chairman.

I yield the floor.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. One minute five seconds.

Mr. NICKLES. I yield that time to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I certainly think the cooperation we have had from the chairman of the Budget Committee, Senator NICKLES, helped to move this bill along. Even though he has not liked some parts of the bill, he has been cooperative all the way through the process and, more importantly, through the crucial time of conference.

There is a claim that pharmacies are concerned about beneficiary access to pharmacies, pricing transparency issues, and insurance risk.

I understand the concerns of pharmacists with regard to local access. This bill provides several provisions to ensure that Medicare beneficiaries are provided with adequate choice and easy accessibility to local pharmacies.

First, the conference report provides choice to beneficiaries by containing an ''any willing provider'' provision. This provision requires prescription drug plans to accept any and all pharmacies willing to agree to the terms and conditions of the plan. By adding this provision, we have given all pharmacies, big and small, the chance to participate in the modernization of Medicare.

Second, the conference report provides beneficiaries with convenient access to pharmacies by adopting the TRICARE standard for prescription drug plans. In urban areas, 90 percent of beneficiaries would have a pharmacy within two miles of their residence; 90 percent of beneficiaries in suburban areas would have access to a pharmacy within five miles of their home; In rural areas, plans would be required to provide 70 percent of beneficiaries with a pharmacy 15 miles within their residence.

By adopting this standard, beneficiaries are ensured adequate convenient access to pharmacies of their choice.

The conference report also requires that plans permit beneficiaries the ability to fill their prescriptions at a community pharmacy rather than through the mail. Again, ensuring access to local pharmacies.

In addition to providing convenient, local access to pharmacies, the conference report provides safeguards to ensure fair drug pricing and protects pharmacies from insurance risk.

Under the report, pharmacy benefit manager's, PBMs, would be required to disclose all discounts, rebates, and charge backs given to them by drug manufacturers. This places local pharmacies on a fair playing field with PBMs.

The report also prevents insurance risk to pharmacies by clarifying that pharmacies could not accept insurance risk.

This conference report adequately addresses the concerns of pharmacies and pharmacists alike. It makes sure that beneficiaries have local and convenient access to pharmacies, provides transparency pricing, and protects pharmacies from insurance risk.

REVISIONS TO H. CON. RES. 95

Mr. NICKLES. Mr. President, section 401 of H. Con. Res. 95, the budget resolution, permits the chairman of the Senate Budget Committee to make adjustments to the allocation of budget authority and outlays to the Senate Committee on Finance, provided certain conditions are met pursuant to section 401.

I hereby submit the following revisions to H. Con. Res. 95, and I ask unanimous consent to have it printed in the RECORD.

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

Current Allocation to Senate Finance Committee:	($ in millions)
FY 2004 Budget Authority	771,171
FY 2004 Outlays	773,820
FY 2004–2008 Budget Authority	4,618,622
FY 2004–2008 Outlays	4,627,988
FY 2004–2013 Budget Authority	10,991,722
FY 2004–2013 Outlays	11,007,116
Adjustments:	
FY 2004 Budget Authority	4,800
FY 2004 Outlays	3,800
FY 2004–2008 Budget Authority	11,725
FY 2004–2008 Outlays	11,576
FY 2004–2013 Budget Authority	−5,000
FY 2004–2013 Outlays	−5,200
Revised Allocation to Senate Finance Committee:	
FY 2004 Budget Authority	775,971
FY 2004 Outlays	777,620
FY 2004–2008 Budget Authority	4,630,347
FY 2004–2008 Outlays	4,639,564
FY 2004–2013 Budget Authority	10,986,722
FY 2004–2013 Outlays	11,001,916

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Parliamentary inquiry. This, of course, has nothing to do with the legislation. It is my understanding the action of the distinguished chairman of the Budget Committee would not be in derogation of the consent order before the Senate for debate today.

The PRESIDING OFFICER. The Chair's understanding is that changes in the allocation being submitted by the Senator are just being printed in the RECORD.

The Senator from Massachusetts is recognized.

Mr. KERRY. Mr. President, I believe we ought to reject this Medicare bill. When I look at it carefully—which has been hard because there has not been a lot of time—it is clear it is a cruel hoax for seniors and a cynical giveaway to drug companies and to the insurance industry. Even as we speak, there are lobbyists scurrying around Capitol Hill working feverishly to pass a bill that has already driven up the stock of those corporations I have mentioned, the insurance industry and drug companies across the country. The rise in that stock tells the story about the windfall profits that come with this bill.

With the help of President Bush, they produced a Medicare bill that lines the pockets of the powerful moneyed interests and it leaves America's seniors out in the cold. This bill is less about prescription drug benefits and more about a prescription to benefit large drug companies. America's seniors deserve better.

As I have traveled around the country and heard from countless numbers of seniors about their health care needs, they repeat again and again how they need and they want more affordable prescription drugs. ''More affordable'' are key words when measured against this bill. They need and want a quality Medicare plan—I emphasize Medicare plan—that lets seniors choose their own doctors, their own hospitals, and provides prescription drug coverage.

I have met seniors across the country who have cut their medication, they have cut the dosage in half, because they cannot afford their prescription drugs. I met a woman the other day who could not even afford to start her prescription drugs because the initial bill was $100 and she did not have the cash. I met people in small businesses who have seen their health care premiums more than double because drug prices are rising so fast. And I met seniors in New Hampshire and elsewhere who have no idea how they are going to possibly pay their rent and cover the prescription drugs they need.

When we break past the advertising bought and paid for by the special interests to sell this bill as something it is not, we will notice that America's seniors are outraged by what they have seen already about this legislation. I was at a forum the other day sponsored by AARP, and when it was mentioned what was happening in the bill, seniors booed their own leadership in the AARP. It is no wonder AARP members are tearing up or burning their cards.

For Senators who are planning to vote for this bill, I ask a very straightforward question: How are you going to explain to seniors that Congress stuck them with a Medicare plan that forces those seniors into HMOs? How are you going to explain to seniors that this plan will stick them with a raw deal that raises premiums for those who do not want to go into an HMO by $56 to $200 a month? What do you say to the 2 or 3 million seniors who are actually going to lose quality retiree prescription drug coverage under this bill and they are going to get something much worse?

We have to, in future years, add a real prescription drug benefit to Medicare in order to make seniors' lives better. By now accepting a phony drug benefit, Congress literally risks making it worse for those seniors.

How do you explain to seniors that Congress was not willing to let them buy cheaper prescription drugs from Canada, but Congress was willing to hand the pharmaceutical companies new windfall profits of more than $139 billion?

How are you going to explain this bill could only be passed in the House under the cloak of darkness in the early morning hours, and only then by

stretching the rules of the House beyond almost anything in history? And that the Senate then jammed through a 700-page bill with only 3 days of debate, giving seniors very little chance to understand what is involved in the biggest and most dangerous change ever made to Medicare?

I ask those Senators who are planning to support this bill why they think it is worthy to hold a prescription drug benefit hostage to a backdoor deal to privatize Medicare, a deal that will help lobbyists, help powerful Washington interests and other interests around the country and help pharmaceutical companies but will literally make the lives of a lot of our seniors worse off than they are today?

Seniors need relief from inflated prescription drug prices, and they need it now. Nearly 40 percent of Medicare beneficiaries report having no prescription drug coverage. Yet the average amount they have to pay out of their own pocket for prescription drugs is going to more than double between the years 2000 and 2006. It is on track to be $1,400 the year this bill is scheduled to go into effect. If you deduct the amount of money given by this bill from the amount seniors will be paying on average out of pocket, the benefit to most seniors in this country for being pushed into an HMO will not be worth the cost.

Congress ought to be demanding more. We ought to be demanding a real deal for seniors, a Medicare bill that does what it says instead of this phony bait-and-switch legislation. We ought to go back to the drawing board and pass a real Medicare prescription drug benefit. This bill does more harm than it does good. Seniors are not guaranteed that the price of their plan is not going to skyrocket. This bill prohibits the Government from even negotiating discounts for Medicare prescription drugs. It prohibits the Government from doing that. It denies the opportunity for seniors to import reasonable drugs from Canada and other industrialized countries. How extraordinary that the acolytes of free trade are closing down the ability of Americans to exercise free trade and import a product from another country at a lower price.

This bill is really about President Bush passing the buck on prescription drug coverage and passing the bucks from seniors to the pharmaceutical industry. And this bill is being pushed through Congress without adequate debate and exposure to the public light, with too many backroom deals, and with blatant contempt for the public interest.

The Republicans could not win a legitimate victory in the House, so they held the vote open for an unprecedented 3 hours of special interest lobbying, of almost $900 million of giveaways in exchange for votes, so they could get enough people to switch over to their side.

President Bush twisted arms, twisted facts, until he finally managed to get the vote. Time and again, the President chooses to get cozy with the lobbyists. We saw it on the Energy bill. We have read it in the newspapers in the last weeks about who gained and who lost on any particular debate each day in the debate over this bill. This administration's motto ought to be: Leave no special interest behind. This Medicare bill lays that record bare for all Americans to see.

The President goes around the country at a furious pace, fundraising at record levels. He has a group of insiders who provide his campaign with a minimum of $100,000 of campaign cash. They have a name. They are called ''rangers'' and ''pioneers.'' Well, it should come as no surprise to Americans, and particularly to seniors, that 24 ''rangers'' and ''pioneers'' are executives or lobbyists for the very companies that will benefit from this Medicare bill, and they are getting a good return on their money.

This bill makes it easier for the big drug companies to gouge seniors and jack up health care costs so that top executives can walk away with millions. I am all for people who work hard to make a living, and I want people to be able to get rich in America. But when the drug companies' CEOs are making $40 million a year while the seniors they sell to are choosing between their medicine and their mortgage, I do not consider that just plain old free enterprise; I consider that plain old greed.

This bill smooths the way for even higher drug company profits. In the past 6 months, drug companies, HMOs, and other powerful industries have spent $139 million in lobbying Congress to give them what they want. Now they have gotten a bill that will give them an estimated $139 billion over the next 8 years. A thousandfold return on an investment is not bad. You can say what you want about President Bush, but it is clear that his powerful campaign contributors got what they paid for. And it is easy to see why they make so much profit, given this bill, which does nothing to control the rising prices of prescription drugs, nothing to control the rising prices.

Without an effective means to restrain double-digit price increases, this bill does nothing to protect seniors from ever-growing out-of-pocket costs. Someone needs to explain why we are in such a rush to do this. Is someone concerned that the more this cynical bill is exposed, the less likely seniors will be to accept it? What harm would be done if the Nation took some time to look carefully at what is in this bill?

This plan does not kick in until 2006 anyway. So it is not as if seniors are going to get the relief they deserve at the stroke of a Presidential signing ceremony—no indeed. For the next 2 years, seniors are going to get a discount drug card to give them a 15-percent discount. Well, it does not take an act of Congress to do that. Ask any senior today, and he or she will show you about three or five cards they already carry in their wallets to get a discount on drugs.

Seniors deserve and expect more than a discount card with $400 billion on the table. If we were really crafting a drug benefit and allowing the Government to institute cost-saving measures in order to tame out-of-control prices, we could deliver a benefit sooner than 2006. The Government ought to be ready to do this within a matter of months.

The entire Medicare plan was set up in 11 months. Now that it is already set up, in the age of computers, are we saying we could not deliver a prescription drug benefit in a matter of months?

Why are we waiting until 2006? I will tell you why. It is for the private, for-profit companies that need to lure people into the market. And it is going to take them time to warm up to the plan. We are waiting for 2006 for those companies.

This bill sets aside a $12 billion slush fund for the Secretary of Health and Human Services to entice private HMO-style plans to come into the market in order to offer prescription drug plans to seniors. Larded up financial inducements are needed to attract these plans to the market because the risk is so high.

Insuring seniors for drugs usually makes about as much sense as trying to sell a homeowner's policy to someone whose house is burning down. In other words, you are going to lose money. But in the name of ''private competition,'' and to prevent the Federal Government from running this program, this is what they came up with: a great big cookie jar from which to dole out public dollars to private companies to get them to do what we could do less expensively and at less cost to seniors.

On top of giving them extra payments to participate, the bill does nothing to require that private plans actually operate efficiently. The Medicare Program, in its entirety, now spends only 2 percent of total expenditures on administration. By contrast, many health plans in the private market often commit as much as 15 to 20 percent of their expenditures to administration. So every dollar that goes to administrative costs is a dollar not available to improve benefits for Medicare beneficiaries.

I think smart stewards of taxpayer dollars ought to demand that private plans be more efficient if they want to participate. Instead, they are being rewarded from the slush fund and given advantages that only their lobbying influence could get written into law.

In addition, this bill squanders another $6 billion on tax breaks for wealthy Americans that is going to harm Medicare. The legislation would create a tax-free, high-deductible catastrophic health policy known as health savings accounts. That account will undermine the traditional Medicare Program because it will result in cherry-picking. The healthiest and the

wealthiest seniors will come out of the risk pool where they share the risk of coverage, and that will result in raising the premiums for everyone else—for the poorer and the sicker—and it will raise those premiums by as much as 60 percent.

The so-called cost containment provisions in the bill add insult to injury by essentially placing a cap on Medicare spending. This bill would attempt to force future Congresses to reconcile Medicare spending growth by cutting benefits, raising premiums, or increasing the payroll tax. I believe that is unacceptable.

So what do America's seniors get from this bill?

More than 2 million seniors who have good drug coverage now, through retiree health plans, are going to lose it. About 6½ million low-income seniors—the very people we need to help the most—could get less drug coverage than they have now. That is a raw deal for seniors.

Under this bill, 7 million seniors will be given this choice: Pay more for Medicare and get forced into an HMO, give up on choosing your own doctor and hospital, or watch your bills skyrocket. That is the choice for seniors.

The name of this provision in the bill is called premium support, but like Clear Skies, which means dirtier air, or Healthy Forests, which means cutting down the trees, it is an innocent-sounding name for a plan that could raise Medicare premiums from about $60 to thousands of dollars. It breaks the compact of Medicare.

In fact, what it really means is the beginning of the end of Medicare as we know it. Those are not my words, those are the proud boasts of the author of this bill, House Ways and Means chairman, BILL THOMAS. He said:

> To those who say that it would end Medicare as we know it, our answer is, we certainly hope so.

It is not surprising that Newt Gingrich is supporting this deal because he long wanted Medicare to ''wither on the vine.'' Most Americans and most Democrats have a different hope, that Medicare remain secure and strong. I intend to fight with everything I have to make that happen.

We need a real-world, affordable Medicare prescription drug benefit for seniors, a plan that won't force seniors into an HMO, that won't undermine the coverage for seniors who are already getting help today, that will be run by Medicare instead of an insurance company in search of a buck, and that will send a real benefit to every senior, no matter whether the costs are average or high. That is a real deal for America's seniors. But as I said before, right now this bill is a bad deal for seniors and they know it.

They know that this bill provides the skimpiest of benefits, with holes in coverage and complex rules. The coverage gaps remain too high, and seniors are still charged premiums even after their benefits shut down in the so-called donut hole. I think we ought to go back to the drawing board. They know this bill does not adequately protect them with a guaranteed government fallback with a national premium. Until this bill stops slanting all the advantages toward the HMOs and private companies, I believe we have to vote it down.

I believe seniors deserve a guaranteed Government fallback plan. Seniors know that this bill will jack up the out-of-pocket costs in order to visit doctors and hospitals. This is supposed to be a bill to add a prescription drug benefit, but along the way beneficiaries got stuck holding the bill for an additional $25 billion in increased out-of-pocket costs from means testing the Part B premium and increasing the deductible and indexing it to inflation.

This revenue raiser isn't done in order to improve Medicare but to give sweet deals, slush funds, and tax accounts to corporations and to the rich. It is wrong. We should vote it down.

I believe the proponents know that this bill fails to fix protections for low-income seniors—certainly low-income seniors know that across the country—and people with disabilities that currently rely on both Medicare and Medicaid for their coverage and should be defeated. They know it and you know it. This is not a good deal for seniors.

This week in November of 1945, Harry Truman sent to Congress a proposal for health care for Americans. He said:

> Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. And the time has now arrived for action to help them attain that opportunity and to help them get that protection.

But powerful interests mobilized 1945 on Capitol Hill and defeated health care for Americans, Harry Truman's proposal, and especially for our seniors.

It was almost 20 years later that a young American President took up Harry Truman's cause and called for health care for America's seniors. This week in November of 1963, the House of Representatives was considering John Kennedy's Medicare proposal. The same powerful interests were swarming through this building, but there was a spirit of hope and possibility. Now those who support this bill are breaking the promise of Truman and Kennedy that was fulfilled under President Lyndon Johnson.

This has been tried before. This week in November of 1995, 30 years after Medicare became law, Speaker Newt Gingrich and his ideological allies shut our Government down for the first time ever in order to achieve their radical objective of tearing down Medicare. Millions of seniors would have been harmed by those cuts, but we stood up and we stopped Newt Gingrich because President Bill Clinton and others stood their ground and defended Medicare.

I believe we need to stand our ground today and stand on principle again. This bill will hurt seniors more than it will help them. We should pass a bill that offers a real prescription drug benefit under Medicare. We need to rebuild Medicare, not sell it out to the highest bidders. Medicare is one of the best Federal programs we have. I don't believe it is time to shred it. It is time to strengthen it. This Congress and President Bush will be held accountable by America's seniors and American history for the decision we make now. I believe we ought to give seniors a real deal, a prescription drug benefit under Medicare that works for them, and not a phony prescription drug benefit that provides benefits only for the most powerful special interests that stand in their way.

I yield the floor.

The PRESIDING OFFICER (Mr. GRASSLEY). The Chair recognizes the Senator from Missouri.

Mr. TALENT. Mr. President, I appreciate the opportunity to speak about this landmark piece of legislation that is so necessary and has been so necessary for too long and of which we have deprived America's seniors for too long. If I may say with great respect, I had a chance to listen to the last two speakers, my friend from Oklahoma and my friend from Massachusetts. Listening to those speakers just summed up for me why we have not passed this bill in the years and years it has been necessary and that seniors have been demanding it. The last two speakers represented pretty well and eloquently, with their usual vigor, the opposite ends of the political spectrum on this bill.

For the first speaker, the bill represented too much government, too much money. For the second speaker, it represented too little government, too little money. Both speakers are terribly disappointed with President Bush. Both want more time to consider this bill and, if necessary, go back to the drawing board; if necessary, wait years more before we provide a prescription drug benefit that millions of seniors around the country need and have needed for many years.

I rise to speak in favor of the bipartisan Medicare conference agreement. I think it is necessary. Medicare is a great program. My dad passed away last October. He was 91 years old. My mom had passed away about 15 years before then in her early seventies. They both used Medicare and stayed alive as long as they did and as healthy and as happy as long as they did in part because of Medicare. It has covered tens and tens of millions of seniors, not only with good medical care but with the security of knowing that they had medical care if they got sick.

Medicare was a great program and is a great program in 1965 terms. That is when it was developed. It covers the kinds of things that good health care covered in 1965, and it doesn't cover the kinds of things that were not covered in 1965. It doesn't have very many preventive health care benefits, catastrophic coverage for long-term acute

illnesses. And it does not have coverage for outpatient prescription drugs because in 1965 you didn't use prescription drugs very often, unless you had an infection or some kind of pain killer. Now they are a part of almost every ongoing medical care treatment plan. Everybody who has health insurance—and not enough do—just about everybody who does has some kind of prescription drug coverage because it helps keep you healthy.

In providing insurance to somebody, you want them to stay healthy because if they get sick, it ends up costing more money for everybody. That is the reason we haven't had this coverage in Medicare, and it has hurt people.

There was a parade I used to be in every year when I was in the House. I like parades. You get a lot of exercise, and they are fun. It is in Hazelwood, MO. I would go down the same street. I always walk parades. I remember running up this driveway and these two seniors would be sitting at the top of their driveway watching the parade every year. Every year I would stop there for 60 seconds, and they would ask me when we were going to cover prescription drugs in Medicare.

I would say: Well, we haven't done it yet.

And they would say: We know that.

Then the issue finally moved on the front burner here at the end of late 1990s and the House began passing bills, 3 or 4 years in a row. We never passed one until this year here. The sentiments we have heard today—I respect so much the Senators who uttered them—are the reasons why.

I just do not want to wait until we get a bill that satisfies every extreme in politics and the political exigencies for everybody because we will wait forever. We will never get a bill then. I would rather go ahead with this bill, which is a good bill, and take what is good about it and then see what is working and what isn't working and then go back and fix it.

That is the reason the AARP supports this. They are tired of waiting, too. I had a hearing on this. I have the honor of sitting on the Special Committee on Aging, a great committee, with a great chairman, Senator LARRY CRAIG. The hearing was in St. Louis. One of the witnesses was Audrey Vallely, a delightful lady, who attended the Route 66 Senior Center in Eureka, MO, regularly. I have been out there for lunch a couple of times. She testified about her experiences over the last 12 years. Audrey suffers from osteoarthritis, a degenerative bone disease, and she also has a sinus disease. She ought to be taking two different types of prescription drugs for these conditions, but it costs $100 a month for 15 pills. So she often cannot take the drugs. She gets some pain relief over-the-counter pills; sometimes it makes her feel better and sometimes it doesn't. She does the best she can. She has to choose between paying for those drugs or paying her rent. Having an air conditioner working in the summer is hard for her. All of these statements about the problems in this bill mean nothing to Audrey, who struggles month after month because of this gap in Medicare.

What would the bipartisan agreement mean for Missouri? We have over 888,000 beneficiaries in Missouri. They all have the opportunity to get a discount card—a 15- to 25-percent discount immediately. Better than that, low-income seniors get, in addition to that, $600 a month in annual assistance to help them afford their medicines, along with discount cards. That is a total of over $200 million in assistance for over 170,000 Missouri residents over the next 2 years, if we pass this bill—not otherwise.

Beginning in 2006, every Missouri senior in Missouri would be eligible for coverage in this bill for approximately $35 a month. They get at least 50 percent off—or approximately 50 percent off their prescription drug costs. Of the approximately 270,000 beneficiaries in Missouri who have limited savings and low income, they will qualify for even more generous coverage. Additionally, the Government will help the State pick up the cost of the Medicaid-eligible seniors. That will help Missouri, which is in a cash-strapped situation with regard to its budget.

This bill meets the conditions that I thought was important for a Medicare prescription drug bill. It has an immediate benefit, reasonable monthly premiums, strong catastrophic coverage, targeted help for low-income seniors, quality benefits for rural areas, protections for local pharmacies, choice and access to all medicine, and participation in it is voluntary. If you like what you have, you don't have to participate.

That is the reason I am supporting this. I will be pleased to vote for it on final passage. I hope a majority of the Senate does. I hope we are allowed to vote. You never know these days. This is the most important Medicare bill in a generation and maybe we will be able to vote on it and maybe we will not. I know most of the people want to have an opportunity to vote on this bill. I think most will vote for it if they get that opportunity.

I am going to close by saying what I have said on the fairly rare occasions when I have spoken on this issue on the Senate floor. In this body, everything always gets said but not everybody says it. Once in a while, I feel maybe I should deprive the Senate of my comments on something in the service of expedition. But I have said, look, if the bill is reasonable, I am going to move ahead with it. I am tired of waiting. I would like to help these people, such as the folks I saw in that parade, and like Audrey Vallely, and others, get access to prescription drugs. I think most of the people who have worked on this on both sides have done their best. As far as I can tell, they are not motivated by all the lobbyists or the special interests. I have been in a lot of meetings on this, and that hasn't come up once. They are trying to do the best they can for seniors, in a way that will work and be affordable for everybody. That is what this bill does. I am going to vote for it on that basis. I hope it passes.

I congratulate the chairman, who is presiding now, for his fine work.

How much time remains?

The PRESIDING OFFICER. There are 21 minutes remaining.

Mr. TALENT. I am pleased to yield that time to my friend from Colorado.

The PRESIDING OFFICER. The Senator from Colorado is recognized for 21 minutes.

Mr. ALLARD. Mr. President, I thank the Senator for yielding the balance of his time.

Mr. President, first I want to compliment Majority Leader BILL FRIST, from Tennessee; Chairman of the Finance Committee, CHUCK GRASSLEY; and the Conference Committee on working diligently and in good faith toward a workable prescription drug program for elderly citizens. Some have come to this floor and proclaimed it is about politics. I couldn't disagree more. President George Bush, Majority Leader BILL FRIST, and Chairman GRASSLEY have not only talked about the need for a prescription drug program but have worked hard for several years toward a workable program.

It is the Democrats who have demagoged this issue. We just have to look at last year when the prescription bill was brought to the floor by the Democrat majority leader, without having it debated and reported out of committee. I believe that it was their hope that they could embarrass Republicans in an election year. Instead, it only helped point to the failures of a Democrat-led Senate that couldn't even pass a budget because they did not want to deal with the tough votes they would have to face on this floor.

I believe this Republican-led Senate is wrapping up one of the most successful sessions since 1994. There have been long hours and a lot of hard work that has paid off, despite filibusters on judges and attempts to slow down and kill many provisions, such as the budget. But Republicans passed a budget. Republicans are still working hard to pass an energy bill that was blocked through the efforts of key Democrats, and the Republicans are now working hard to pass a description drug benefit that is facing a possible filibuster on the Senate floor by the Democrats.

Mr. President, I am very disappointed that we have had to face all this obstruction on the floor, despite the concerted effort to work responsibly and respectively through the Senate committee system, then bringing the prescription drug bill to the floor and passing it. Now, here we are again, facing a threatened filibuster by the Democrats. Mr. President, we need to have an up or down vote on this conference report. Again, I know that the conferees worked hard in a bipartisan way.

I plan on voting for cloture because I want to see the conference report on Medicare voted on the floor of the Senate. I have stated that I am undecided on final passage. That is because, as a general rule, in the process of negotiations, legislation doesn't get less expensive, it gets more expensive through spending to attract more support and votes. I hope to act as a counterbalance with the clear message that, if spending gets out of hand, I will not vote for the bill.

I am not happy with creating a new program that could lead to a monstrous program in the future. That is why I opposed the bill as it left the Senate, because it was not limited to just the most needy and I felt it broke the budget. It was later proved that I was right in the assessment that it would break the budget, and with more accurate budget figures the conference committee set to work to reduce the scope of the program to keep it below $400 billion for 10 years and within the parameters of the budget. This, in effect, forced the conference committee to means test the program and keep certain provisions that would hold the user accountable by forcing that patient to participate with a deductible and the so called ''donut hole.''

In my view, it is very difficult to have a third party pay system and yet maintain accountability. Users feel that they have already paid for the system and are going to utilize it to its maximum to get their just return, and providers feel that it has already been paid for and creates no particular hardship on the individual so they charge with little restraint the third party. So utilization is regulated. And we end up with regulations like we have now in the current Medicare system, which prevents a patient from paying for their own medical care if they want, and it prevents the physician from receiving cash outside the system that could reduce the burden on taxpayers. It ends up creating a system where the close patient-doctor relationship is disrupted to where the patient can't use whomever they desire to care for their medical needs. So what we have today is a Medicare system that is not actuarially sound and, if not reformed, will lead to much higher payroll taxes and huge demands on the general budget. That is why I was pleased to see some reform proposals on medicare emerge from the conference committee, such as health saving accounts.

When I served in the Colorado State Senate, I sponsored, with State Representative Phil Pankey, a bill to put in place an individual medical saving account; and Colorado became the first State to have such a program.

Unfortunately, in an effort to pass the bill, we allowed the program to become so limited that the risk pool became too small to function as insurance against future liabilities. Consequently, when Colorado moved to a modified flat tax, this program became a victim of tax reform.

This Congress puts forth a health savings account that will work. Individuals can put in $5,000 a year or a family can put up to $10,000 per year and save on their taxes. The income builds up within the health savings fund without tax liability and, finally, can be pulled out to pay for the family medical needs without paying additional taxes.

This is wonderful reform because it reestablishes the doctor-patient relationship and makes individuals responsible for their own health care with much fewer regulations, and it brings common sense to the decisionmaking process. It builds upon previously enacted medical savings accounts that have been limited to small business and the self-employed by Congress.

One other attractive feature in this bill is that the elderly are not forced to participate. It is voluntary. It also tries to prevent large businesses and local governments from dumping their current prescription programs into the Federal system to save themselves future liabilities and further burden the Federal prescription drug program.

The other side has repeatedly made the claim that this bill is full of giveaways to Republican contributors. This is simply not true. That is simply more absurd ''medi-scare'' tactics by the opponents of a bipartisan drug benefit for our Nation's seniors and the disabled.

The argument I find most amusing is the claim that this bill will lead to increased drug company profits. The reason this bill is so desperately needed is because our Nation's seniors and the disabled, particularly those with low incomes, are unable to afford their prescriptions today. Let me stress that again. The reason this bill is so desperately needed is that our Nation's seniors and the disabled, particularly those with lower income, are unable—unable—to afford their prescriptions today. Today they are forced to choose between food and rent and taking their medicine. We have all heard the stories of seniors cutting their pills in half to get by and in so doing taking a lower dose than their doctor prescribed.

When this Medicare prescription drug benefit goes into effect, they will be able to get their prescriptions filled. Of course, this is going to lead to increased drug sales. Surely, this is no surprise to anyone. With new technologies and new medications, invasive procedures become less likely. Any prescription drug bill that works is going to lead to increased drug sales. That is just common sense.

Where are the medicines supposed to come from except the manufacturers of those medicines? Every single medical prescription drug bill introduced by these naysayers would also increase drug sales and the bipartisan conference report has the same basic drug benefit structure that passed the Senate by a vote of 76 to 21.

The Congressional Budget Office has concluded that the competitive approach in this bipartisan drug benefit will do better at controlling drug costs than other proposals. To suggest that no one should support a Medicare drug benefit because it will lead to increased drug sales turns logic on its head. If this were our basic principle, then we should not have food stamps because this will lead to increased profits by grocery stores and farmers. How about housing subsidies? This might lead to profits by construction companies and utility companies and increased sales of lumber, bricks, and nails. This is just an absurd issue, and it is easy to see why.

I am here to tell you that this bill will strengthen and improve the Medicare Program. The spending on this bipartisan prescription drug bill goes to better benefits for America's seniors and the disabled.

As I draw to a conclusion, unfortunately, those who want universal health care and the big Government solution to drugs, making people more vulnerable to Government control, are vehemently opposed to this conference report.

The conference report lays out a plan for Medicare reform and a way to help the most needy. It is a balance that does not come easily and not without a lot of discussion on both sides of the aisle. We should at least have a vote on the bill. It is time to put partisan obstruction aside and think about what is good for America.

I ask my colleagues to join me in voting yes on cloture to stop the filibuster and to help hold down costs to within the budget limits.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. TALENT). The Senator from Oregon.

Mr. WYDEN. Mr. President, as Congress considers Medicare and prescription drugs, I keep remembering the older people whose stories spurred me to choose a career in public service. For 7 years, before I came to the Congress, I worked with seniors and spent many hours visiting with them in their homes. During those visits, seniors would often bring out shoeboxes full of health insurance policies that were supposed to fill the gaps in their Medicare. It was common for a senior then to have seven or eight of these policies, and many of them were not worth the paper they were written on. Slick, fast-talking insurance hucksters kept coming around and scaring the older folks, and it was heartbreaking to see seniors ripped off this way.

After working all their lives, seniors would go without each month because they were paying for junk health insurance policies with the precious funds they needed to pay the heating bill or buy some groceries.

When I got elected to the Congress, I vowed to stop this fleecing of America's seniors. I helped to write the first and only tough law to stop the ripoffs of private health insurance sold to the elderly. This statute has worked to drain the swamp of fly-by-night Medigap policies that used to rob seniors blind.

The days of the shoebox full of health insurance policies are gone, but the skyrocketing drug costs and lack of access to medicine—two of the problems that plagued seniors even back then—are more of a problem today.

During those home visits I made with seniors, I saw firsthand the pain they felt when they couldn't afford life-saving medicine. Their anguish was physical, and it was emotional. They feared for their futures. They worried that the choices that financial constraints forced on them would not be the right ones.

We are very familiar with those stories today. Caseworkers in every office in the Senate hear them constantly. A senior is supposed to take four pills, but because they can't make ends meet, they take three or two. Eventually, that senior ends up in the hospital where the hospital portion of Medicare, known as Part A, covers drug treatment, but often it is too late.

I have tried to rewrite stories such as that since I came to the Congress. That is why I worked with Senator PRYOR's father so that States could bargain aggressively and get more for their Medicaid dollar when buying prescription drugs that would help the low-income elderly. I have tried to expand coverage for generic drugs. I have worked to supplement those efforts by creating new health care options for seniors, including in-home care and increased payments for providers in low-cost areas, funds that can be used to offer prescription drug benefits to some of the elderly. Because of my history, I am acutely aware that there is so much more to do. The reason the debate on this bill is so important is that Government has the obligation to do right by a generation that deserves our respect and care and not give those seniors the runaround.

My years working with the older people have governed the decision I have made on this bill. I have tried to keep the focus on determining whether this prescription drug benefit legislation would make a genuine positive difference for a significant number of older people or whether it falls short of that objective.

As part of the process, I have developed a set of criteria to evaluate this legislation. I would like to describe the questions I believed were key and the answers I have found.

The first question I asked was: Does this bill help a significant number of older people with low incomes or big prescription drug bills? In their editorial endorsing this legislation, the New York Times stated:

> The bill is strongest when it comes to the most important target groups: Elderly people with low incomes or very high drug bills.

It is not my job to take the word of editorial writers simply because they are just one voice in a chorus that comes from both sides. So I have gone to some length to examine the figures and data from all perspectives. I looked at the data that has been available from those strongly in favor of the legislation, such as the Federal Center for Medicare and Medicaid Services. I looked at the information from those strongly opposed to the bill, such as the nonprofit Center on Budget and Policy Priorities.

The critics say the legislation has significant gaps in coverage for seniors, especially those of modest income. Proponents of the bill claim that millions of seniors will have coverage they did not have before. There does seem to be truth on both counts. So I have tried to keep the focus on figures that were beyond any doubt. Using data from the 2000 Oregon census, my staff and I have determined that 78,829 older people in Oregon had prescription costs that exceeded $5,000, and under this bill these seniors would have their prescription drug costs reduced by one-half.

Using 2001 data from the nonprofit Kaiser Family Foundation, my staff determined that Oregon has 106,765 seniors on Medicare with incomes at or below $12,123 for an individual or $16,362 for a couple.

Under this legislation, this low-income group would pay no premium for their drug coverage and would be responsible for a copay of no more than $2 for generic drugs and no more than $5 for brand name drugs. The least fortunate would pay only $1 for generics and $3 for brand name drugs.

Most seniors with low incomes and high drug costs are likely to be eligible for both Medicaid and Medicare. These older people are known as dual eligibles. This legislation assures that they receive at least some measure of prescription drug coverage through Medicare so they are not left at the mercy of perennial State budget crises and so they will not have to compete against other vulnerable groups in State budget battles.

Another factor I considered was the expectations for this legislation. What I hear from seniors at senior centers and at meal sites is that expectations are very high. I know some seniors will find that this bill does not offer benefits that match their expectations. Some seniors fear this bill is going to fence them in and require that they participate in a program they do not support. So at the very least, because this program is voluntary, it strikes me as a plus that no senior will be forced to accept the terms of this legislation.

So on this particular issue, with respect to who benefits, what we found that seniors in my State with very high drug bills would have their costs reduced by half. We found a great many low-income people who would receive very significant benefits with no premium and a very modest copay for their drugs.

The second question we asked was: How does this bill affect seniors who currently get their prescription drug coverage through corporate retiree benefit packages? Almost every day now we pick up a newspaper and read about another employer dropping their retiree benefits or cutting them back significantly. There has been a dramatic reduction in corporate retiree health benefits, and it is taking place right now before the enactment or rejection of any legislation.

The percentage of large employers offering retiree health benefits over a relatively short period of time has dropped from 66 percent to 34 percent. Consistently, the employers who keep coverage have required the retirees to shell out for higher copayments and premiums. Employers say they have to make these cuts because of the rising costs of health care and the effects of a lousy economy. Now along comes the Congress with a bill that many believe will dramatically affect retiree plans in the future.

It seems to me that with legislation offering $71 billion to employers to keep their coverage, these funds can only be a plus in developing a strategy for getting more employers to retain existing coverage. This is a subsidy the companies are not going to see absent this legislation.

So I ask the Senate: Will companies not be less likely, not more likely, to drop coverage if they get the funds offered tax free under this legislation?

I would also note that corporate retiree provisions in the conference report are better than the provisions in the original Senate bill which was approved by more than 75 members of this body.

Bernstein Research says employers spend about $1,900 per year per senior on retiree drug benefits. Based on my calculations, this bill gives corporations a significant tax-free incentive to cover not only retiree drug benefits but other senior health care costs as well.

The next question I asked was: Does this bill significantly undermine traditional Medicare? Critics of the bill have focused on this issue, and I share their view that seniors believe in Medicare, want to modernize it, and do not want it undermined.

The critics seem to believe that any effort, however, to create more choices outside the basic Medicare fee-for-service program is a mistake. I disagree. I believe seniors need good quality choices beyond fee for service. I simply believe those choices must be accompanied by strong consumer protections and that it is essential to strike a balance, making sure that the new choices never, ever cut off access to traditional Medicare that seniors know so well and a program with which they feel so comfortable.

I have never been opposed to private sector involvement with Medicare. In many Oregon communities, upwards of 40 percent of the elderly get their Medicare through private plans. The law I wrote stopped the rip-offs of private health supplements to Medicare, standardized 10 private sector policies to help seniors fill the holes in Medicare, and consumer advocates across the country believe that law is working.

The key to making the private sector choices work is a combination of strong consumer protections and a level playing field between the private sector choices and health services offered by the Government. I have considerable ambivalence about how this legislation will affect that balance.

In the bipartisan prescription drug legislation I drafted with Senator SNOWE, we offered private sector options for seniors that contain strong consumer safeguards. Our bill was known as SPICE, the Senior Prescription Insurance Coverage Equity Act. It did not tilt the playing field toward the private sector the way the legislation before Congress does today with its health savings accounts and premium support. Unfortunately, the health savings accounts in this bill, which are tax breaks for purchasing health care, are structured to disproportionately benefit the healthy and the wealthy. Seven billion dollars of tax subsidies are directed to these accounts. This has gone from a demonstration project to a major expense, one that siphons away funds that could go to beef up the drug benefits.

Another drawback of the legislation is the premium support provisions, which are designed to test competition between traditional Medicare and private plans. These could drive seniors out of the fee-for-service programs they want. Premium support demonstrations could allow insurance companies to cherry-pick the healthy seniors, leaving the truly ill to go to poorly funded Government programs that are sicker than they are. Even though premium support doesn't start until 2010, I don't believe it has a responsible role to play in this legislation.

I don't believe this legislation is going to wipe out traditional Medicare. I do believe that Congress is going to have to be extraordinarily vigilant with respect to ensuring that traditional Medicare can coexist and prosper along with the new choices. Without careful management, it is certainly possible that health savings accounts and premium support could tilt the Medicare Program away from providing traditional fee for service for all the seniors who want it. If this legislation passes, it will be the job of the Congress to make sure that does not happen.

The next question I asked is especially important. Virtually every senior in America wants to know: What will this legislation do to keep their prescription drug bills down? In my mind, the key to effective containing of prescription costs is to make sure older people have bargaining power in the health care marketplace. Today, when a senior gets his or her prescriptions through a health plan with many members, that plan has significantly more bargaining power than that same senior would have by walking into a Walgreen's, a Safeway, or a Fred Meyer to buy medicine. Getting seniors more purchasing power by getting them into large buying groups is an absolute prerequisite for a long-term strategy for keeping prescription costs down for older people.

That was the principle behind the Medicaid drug rebate law that I helped author with the first Senator Pryor. That is the principle that Senator SNOWE and I have proposed in our bipartisan legislation. We looked to a market-based proposal that was built around the Federal Employees Health Benefits Plan, a program that has been proven to contain costs because of the sheer size of the group of Federal employees for which it bargains.

I think it is very unfortunate that this legislation did not put in place a model like the Federal Employees Health Benefits Plan to contain costs. But I think it has to be noted that some baby steps in the right direction have been taken with respect to cost containment. The bill begins to leverage the potential bargaining power of 30 million seniors by giving older people the opportunity to join large managed care plans and big fee-for-service plans that can use their sheer numbers to negotiate discounts for older people on their medicine. The bill also removes some of the barriers to getting cheaper generics to market faster.

It also recognizes that there is great value in comparing the effectiveness of similar drugs so seniors, providers, and the Government can spend funds on the best medicines at the lowest cost. This is very much in keeping with the way my own State has approached cost containment.

I do wish this bill went further on cost containment. There should be a way to bargain for even bigger segments of the elderly, not just the fractions of the population who end up in HMOs or various private health plans.

I am concerned that while private plans have the power to bargain under this bill, the Medicare Program is barred from giving seniors the kind of bargaining power that Senator SNOWE and I wanted them to have in our model that looked to the Federal employee program for seniors.

I am also concerned that there is not ongoing monitoring to assure that drug prices are not increased unfairly before the bill takes effect, or in the first few months after it does.

So the legislation does not contain costs the way Senator SNOWE and I would have liked. It does take some modest steps in the right direction. It borrows from the principles of our legislation, but in the end I strongly believe that more and better cost containment measures with respect to prescriptions are going to be needed in the future.

Next, I asked: Does this legislation address Medicare's broader challenges, including the large number of retirees that will join in the near future? A demographic tsunami is about to occur in our country. As the baby boomers come of age, there are going to be extraordinary pressures on our health care system. Health care advances mean that seniors will live longer, and many of those advances will come in pill form. What is exciting is that the more researchers learn about the way medicines affect individuals, the more personalized treatments, emphasizing pharmaceuticals, will become. Drugs that work one way for Bob will work differently for Mary. In the years ahead, I believe a new field known as ''personalized medicine through pharmaceuticals'' is going to help to increase the quality of patient care and cut down on wasteful spending.

As of now, however, baby boomers face the prospect of joining a Medicare Program that is already short of funds. That is why the $400 billion authorized in this legislation is a lifeline for the baby boomers who are going to retire in just a few years. Those funds provide some measure of security for future retirees, and some tangible evidence that Congress is laying the groundwork to support the growing Medicare population which will need both prescription drugs and the broader program.

There are several modest benefits in this bill, in addition, that sounds exciting to me for Medicare's future. One would focus on an approach known as disease management. This is going to be attractive in the years ahead because it will allow many of our country's future seniors to have better, more cost-effective care for chronic conditions. Medicare has lacked this benefit.

In addition to these direct benefits for seniors, the legislation helps gear up Medicare for the baby boomers with significant increases to many deserving health care providers. Over 10 years, hospitals in my State will receive almost $95 million. I am especially pleased that a number of medical providers, a number of our hospitals that now see a small number of patients and those that have a large share of patients who are too poor to pay for their care, would get help.

In addition, doctors across the country who are expecting decreases in Medicare reimbursements in 2004 and 2005 would find this reduction blocked in this legislation. In fact, the legislation increases Medicare provider payments in both of the years where otherwise there would be cutbacks. This is important because Government cost shifts have already cut reimbursement to doctors, many of whom have large numbers of low-income patients, to record lows.

I would also note that these benefits to providers will be especially useful in rural areas where we have the nationwide crisis with respect to declining access as a result of providers simply not being able to stay in business.

Finally, I ask one last question that looked beyond the issue of prescription drugs. I asked: Is there any way this legislation could provide a path to a health care system that works, not just for older people, but for all Americans?

There is a provision in this bill that offers health care hope, not just to seniors, but for all Americans. It is a provision that I helped to write with Senator HATCH, based on our Health Care that Works for All Americans Act. This legislation would ensure that, for the very first time, the American people would be involved in the process of comprehensive health care reform. There would be a blueprint for making health care more accessible and more affordable, not just to seniors, but for all Americans.

Senator HATCH and I have been able to convince those on the Medicare conference committee that the key is to make sure that the public understands what the real choices are with respect to health care, how the health care dollar is used today, and how it might be used in the future.

In 1993, then-President Clinton announced his intention to create a health care system that worked for all Americans. But by the time that 1,390-page bill was written with no input from the public, sent to the Congress, and torn apart on the airwaves by special interest groups, the people couldn't distinguish the truth from the special interest spin, and the effort died. Without public support, the opportunity for change was lost.

The bipartisan leadership of the Senate at that time has told Senator HATCH and I that, had our bill been in effect in 1993, our country would be well on its way to implementing a system that ensured coverage for all our citizens. So I think it is of additional benefit that this legislation gives us a chance to restart the debate that died in 1994. Our legislation creates a Citizens Health Care Working Group that would take steps, through on-line opportunities, townhall meetings and other forms, to involve the public; and then there is a requirement, after that public involvement, that the Congress follow up on the views that come from the citizens' participation.

There are tough calls to be made in today's health care system, including in the Medicare Program. But it is time to make them together. I think if one lesson has been learned in the last few months of discussion about prescription drugs, it is that health care is like an ecosystem. When you make changes in one area, such as prescription drugs, it can affect many other areas, such as corporate retiree benefits, provider payments, and various other parts of the health care system.

The legislation Senator HATCH and I have put together and which is included in this conference report treats health care as an entire and a system-wide concern for the American people. Nothing is taken off the table. I believe there is in that legislation a path to making sure this Congress helps not just older people but sets out ways to ensure that all Americans have access to good quality and affordable health care.

Finally, let me note that collegiality hasn't exactly been one of the watchwords of the debate over this legislation. There have been some very cold considerations entering into this discussion. I know that some believe passage of this legislation will hand the President a great victory. Others on the other side of the aisle say Democrats who oppose this bill shouldn't dare raise questions. Those aren't the concerns that ought to drive the debate on Medicare at a time when the country has to get ready for a demographic phenomenon. Polarization and division do not do our country any good.

This legislation is a very tough call for me and I think for many others.

Congress could make a mistake by believing the $400 billion available in this legislation will still be there in February of 2005. As a member of the Budget Committee, I know how hard it has been to get funding for this benefit. When Senator SNOWE and I began in 1999 to work for funding for a drug benefit, the Senate thought we lassoed the Moon when we successfully got $40 billion in the budget. How then can you argue that Congress should walk away from $400 billion?

I wish there were a better bill. I wish it didn't include medical savings accounts and premium support and had done better in the area of cost containment.

There are going to be various procedural considerations that may come out, and I intend to weigh each of them before I vote on those procedural concerns. If it finally becomes clear that the bill, as is, represents the Senate's sole opportunity to inject $400 billion in long-sought prescription drug benefits in Medicare, I will vote yes.

At the end of the day, I will not vote to let the last train that leaves the Senate go out without $400 billion that can be used to help vulnerable seniors and those who are getting crushed by prescription drug costs. I will continue to fight to make this legislation better and for better health care for all Americans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, the opponents of this bipartisan Medicare bill have made the claim that 6 million seniors are hurt by this bill. The other side has also claimed that 25 percent of seniors will be forced to pay more for their prescription drugs under this bill.

I want to be very clear that this is not accurate at all. I'm here to tell the American public the truth.

The truth is that 14 million lower income seniors and disabled Americans are benefited greatly by this bipartisan bill. These 14 million people will get very generous prescription drug coverage through Medicare in this bill.

First, as you can see on this chart, 7.8 million seniors and disabled Americans get full coverage with no deductible, no gap in coverage, and would pay only $2 for generic drugs and only $5 for brand name drugs. And if these seniors reach the catastrophic coverage limit, then they will get their prescriptions fully covered with no copays. That's right, no copays at all.

Next, as you can see on the chart, an additional 4.4 million lower income seniors will get even more generous coverage. These Seniors will pay only $1 for generic drugs and only $3 for brand name drugs. And if these seniors reach the catastrophic coverage limit, then they too will get their prescriptions fully covered with no copays.

In addition, some of these people are enrolled in both Medicare and Medicaid and are living in a nursing home—about 1.3 million of them. This bipartisan bill creates a special benefit for these people. For them, Medicare will cover 100 percent of the prescription costs. They pay nothing.

These groups of seniors in total represent 12.2 million seniors and disabled Americans.

The bill also provides coverage to about 2 million more lower income seniors and disabled Americans. These seniors have 85 percent of their drug costs covered after meeting a $50 deductible, and if they hit the catastrophic coverage limit, they would pay only $2 for generic drugs and $5 for brand-name drugs.

This is full coverage with no coverage gap and 85–98 percent of drug costs covered for about 14 million seniors and disabled Americans. That is about 36 percent of all Medicare beneficiaries.

That is what this bill does. It provides very generous prescription drug coverage through the Medicare program for about 14 million lower income seniors and disabled Americans. And it provides this full coverage to 8 million lower income seniors who have no coverage at all today.

On top of that, of course, this bill provides all beneficiaries with access to basic prescription drug coverage with protections against catastrophic drug costs. The average beneficiary who does not quality for the low income benefits I have just described will still have about half of their drug costs covered under this bill.

Finally, no one is forced into this drug benefit. It is a purely voluntary benefit. No one is forced to enroll and any senior or disabled American that does not see the drug coverage offered as a good deal for them does not have to enroll.

So this bipartisan bill before us does not harm seniors. That is an absurd charge to make by the opponents of this bill.

This bill provides an affordable, voluntary and universal drug benefit for all seniors and disabled Americans in this country. And it provides very generous coverage to those 14 million lower income beneficiaries.

It is time to put the partisan rhetoric aside and approve this bipartisan bill that the AARP calls ''an historic breakthrough and [an] important milestone in the nation's commitment to strengthen and expand health security for its citizens.

I yield the remainder of this half hour to Senator DOMENICI.

The PRESIDING OFFICER (Mr. ENSIGN). The Senator from New Mexico is recognized. He has 23 minute 20 seconds remaining.

Mr. DOMENICI. Mr. President, today I rise in support of the Medicare Prescription Drug and Modernization Act. I thank the Senate and the House conferees, as well as the leadership of both bodies, for their work over the past few months. Their perseverance has paid off. This bill represents a major step forward for this body on behalf of the seniors of this country.

Experts and fair-minded people have known for many years that the Medicare Program must be reformed. For more than 6 years, Republicans have led efforts to overhaul the Medicare system and ensure American seniors continue to have access to high-quality, comprehensive health care in the future. First, a little history. The Budget Act of 1997, when I was chairman of the Budget Committee, created the National Bipartisan Commission on the Future of Medicare. This Commission was created to address the issue of modernization. The Commission supported changes to the program that would have provided an additional prescription drug benefit as well as modernized the Medicare system—not one without the other, but both.

Unfortunately, that Commission failed in part because of lack of support from the previous administration's appointees to address the fundamental problem of the program's design. A majority of the Commission was for it, but we structured it where 60 percent was required, and the President withheld his support after all the work that was done. The point is, clearly even back then we were tying modernization to prescriptions.

In 2001, again as chairman of the Budget Committee, the budget resolution provided $300 billion, and we are now up to $400 billion. The budget resolution said $300 billion for prescription drug benefits and it required modernization of the program. It said $300 billion way back then. DON NICKLES, as chairman, took it up to $400 billion. It did not say for prescription drugs, it said for prescription drugs and modernization. Why? Because one without the other is never going to work. If you have a prescription drug benefit for the seniors and do nothing to the underlying Medicare Program, you have taken care of one of the problems for a couple of years but you will be back with a bigger problem. That bigger problem is the Medicare system itself. With the great change in demographics this country is going to be experiencing, we will be in big trouble.

Medicare beneficiaries have waited too long for prescription drug coverage. I am pleased this year appears to be a breakthrough year. Before we are finished, there will be many Senators we will be able to thank. This will be the year we finally help millions of Medicare beneficiaries obtain affordable prescription drugs. The bill will also provide substantial relief for those with the highest drug costs. It will also provide prescription drug coverage at little or no cost to those with low incomes.

When this bill passes, we will be providing seniors with prescription drug coverage for the first time since the program's creation in 1965. Across America, there are still millions of people who do not know that Medicare provides by law not one nickel's worth of prescription benefits. It is not that the benefit is inadequate or that it is written wrong, it just did not provide for a benefit; that need was not contemplated in 1965.

It has been hard to get a bill that really has a chance. This bill has a chance. It contains new accounting safeguards that put the program on a stronger financial foundation. The legislation contains preventive care measures, including screening for diabetes and cardiovascular disease. It provides benefits for coordinated care for people with chronic illnesses. None of these benefits was provided under the 1965 act because the need was not contemplated as part of the health delivery system. These benefits are needed today, but they are excluded from the current Medicare system.

This is by far the best opportunity, speaking on behalf of my constituents in my home State, that New Mexico has had to get doctors, hospitals, home health care providers, nursing homes, and Medicare beneficiaries fair and equal treatment. Before this bill, each of these groups had been shortchanged by the health care laws of our country.

I am particularly pleased this bill contains $25 billion in initiatives aimed at providing health care in rural areas. We can thank Senator GRASSLEY for being so steadfast on that provision. The Finance Committee estimates my home State of New Mexico can expect approximately $140 million over the next 10 years in increased doctor and hospital reimbursements. That is because we are so low. This brings us to parity and fairness.

This bill includes $50 million to equalize payments between large urban hospitals and rural and small hospitals, $15 million to increase payments to disproportionate share hospitals, $1 million in payments to critical access hospitals, $50 million in increased payments for doctors, and $3 million in incentive payments to encourage physicians to practice in areas where there are shortages.

Beginning in 2006, again for my State, all 250,000 Medicare beneficiaries living in New Mexico will be eligible to get prescription drug coverage through a Medicare-approved plan. This bipartisan agreement will give 55,000 Medicare beneficiaries in New Mexico access to drug coverage they would not otherwise have. Nearly 17,000 of those beneficiaries will qualify for reduced premiums, lower deductibles, coinsurance, and no gap coverage. Unquestionably, these provisions will help improve access to health care and treatment for seniors.

We have a great opportunity, fellow Senators, to fulfill our promise to the American people and provide our seniors with high-quality prescription drug benefits. I believe prescription costs will be manageable, even with the baby boom generation that will then be retiring. Some worry about the costs of this bill, but I am confident about the future of American ingenuity and competition, America's science achievements, and America's wellness achievements.

As I said this spring when we were debating this bill, we are not living in a stagnant world. American scientists today are reaching for health care breakthroughs linked to the mapping of the human genome. Advances in nanoscience and microtechnology will change medicine and health care as we know it today. However, while that work continues, this long-awaited prescription drug plan is what we need now. I am suggesting when I talk about the future breakthroughs that we may be astonished at how much we are going to be able to do that we cannot do today that may save lives and save money.

I encourage my colleagues to put their differences aside today and, most of all, to put their politics aside, and do what is best for the American people. Overwhelmingly, my constituents have contacted me and asked that I support this legislation.

Seniors need affordable prescription drugs, and if Congress fails to act this year, it will likely be many more years before beneficiaries are able to access prescription drugs through Medicare.

It is for those reasons—all of them; the national reasons and the parochial New Mexico reasons—that I have indicated that lead me to saying I will support this bill. And I hope we do it quickly.

Now, we have an additional Senator. Mr. President, how much time do we have left in this block of time?

The PRESIDING OFFICER. Thirteen minutes fifty seconds.

Mr. DOMENICI. Mr. President, I understand we have a Senator who is coming over to use that time. Until they do, I will yield that time to Senator GRASSLEY.

Mr. REID. Mr. President, if I could just be heard briefly.

Mr. DOMENICI. Sure.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. We had a Senator who took an extra 5 minutes today because of various reasons, so it is my understanding that the distinguished Senator from Kentucky wants an extra 5 minutes. We would be happy to agree to that. So we would just add that on to what time he has.

Mr. DOMENICI. I say to the Senator, Senator GRASSLEY is in charge. I will just wait to see what he says.

Mr. REID. Is the Senator on his way down?

Mr. GRASSLEY. I say to the distinguished Democratic whip, it is my understanding the Senator is on his way to the Chamber from Senator FRIST's office right now.

Mr. REID. We would agree to give him that extra 5 minutes.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. MCCONNELL. Mr. President, finally, after 38 years, Medicare will finally give our most frail citizens help in acquiring the miracle of modern medicine: prescription drugs. They save lives, but they are not cheap.

After decades of talking, while our seniors waited, tomorrow we vote yes or no on a Medicare prescription drug benefit. It is now or never for our seniors. And for their drug benefit, this is the bill and this is the time.

On one side stand 40 million seniors, the American Medical Association, the AARP, and hundreds of other citizen groups. On the other side stand some Senate Democrats itching to kill this bill. Do not be fooled by those who think we can do something better at some point later. We are already 38 years late, and this is as close as we will ever come.

So for our seniors to get a Medicare drug benefit, it is now or never. Incredibly, there are those in this Senate who say never. They plan to filibuster the Medicare drug benefit or use procedural measures designed to do the same thing as a filibuster—kill the bill.

Let me repeat that. Some of our Democratic colleagues are trying to kill this bill. For 38 years there has been no prescription drug benefit, none. Now, when it comes time to actually pass a drug benefit, some of our Democratic colleagues are filibustering. That is truly astonishing.

Now, we will hear a lot more debate about whether there is too much or too little Medicare prescription drugs. And we will hear a lot of talk that there is too much or too little reform to preserve Medicare.

Mr. President, I believe we do more for Medicare prescription drugs than most could have ever expected. We do more to preserve Medicare for the future than most presently expect.

Before I discuss the reforms to preserve Medicare, I would like to focus on the new Medicare prescription drug benefit. The facts are that we provide $400 billion for a Medicare prescription drug benefit over a decade, about a third more than our Senate colleagues proposed just 2 years ago—a third more than was proposed just 2 years ago—and one and a half times more than President Clinton proposed for a Medicare drug benefit.

This unprecedented investment in our seniors' health translates into an incredible amount of relief for our seniors.

Back home, in my State of Kentucky, for example, there are about 650,000 seniors who will share in that relief. So what does this relief mean to them? The first comfort is that all 650,000 Kentucky seniors—whether rich, poor, or in between—will never again face the fear of being wiped out—completely wiped out—by catastrophic drug costs.

Under this plan, Medicare will cover a minimum of 95 percent of all catastrophic prescription drug costs.

Next, all Kentucky seniors currently paying full retail drug prices will be able to cut their prescription drug costs by an estimated 50 percent or more once they enroll in this new plan.

For those 235,000 Kentucky seniors with low incomes—low-income seniors—they will never again have to choose between food on the table or medicine in the cabinet—never again. They will get 95 percent to 99 percent of their prescription drug costs fully covered. None of those 235,000 Kentuckians will pay more than $2 for generic drugs or $5 for brand-name drugs, and most will pay even less than that.

Another 56,000 Kentuckians, with moderate incomes, will get assistance with their premiums, deductibles, and coinsurance.

While the full drug plan will not start until 2006, all Kentuckians can benefit from an immediate helping hand thanks to the Medicare prescription drug discount card available as soon as April of next year. This prescription drug benefit card will be available by April of next year. Through group purchasing power and negotiated prices, this card can save seniors between 10 and 25 percent of their drug costs, starting, as I indicated, just next April—right around the corner.

Finally, also starting next April, about 123,000 low-income Kentucky seniors will be credited up to $600 on that same prescription drug card to help tide them over until the full plan takes effect.

So this is real relief, and it is just around the corner. But we did not just give Kentucky seniors that real relief, we also gave them real choices.

Today, Medicare offers no prescription drug benefit and few choices in health care. All that is offered is the traditional hospital and doctor benefit, with a limited managed care option called Medicare+Choice.

Tomorrow, Medicare also could provide seniors a prescription drug benefit and almost unlimited choices in health care. If we act now, every senior on Medicare will soon have the choice of two prescription drug benefit plans, along with a Federal backup.

But if not now, then when will seniors get that benefit? Or, if we act now, every Medicare senior can choose from a variety of Medicare+Choice plans, with a full drug benefit added. But if we do not offer that to them now, when will we offer it to them?

Another choice is every Medicare senior can choose from three or even more preferred provider organizations. But if we do not offer this choice now, when will we? Or, if we act now, every Medicare senior can get help to maintain their current employer-based drug plan. But if we do not offer that now, when are we going to offer it? When would be a better day than now? Or every Medicare senior can do nothing at all and keep exactly what they have today. Every senior, I repeat, can stay in exactly the same coverage they are in today, if they choose to.

That is a lot of freedom and a lot of choices—much like those which Federal employees and Members of Congress enjoy today. But if we do not offer these choices now, when are we going to offer them?

This bill provides an excellent prescription drug benefit, a great array of choices to get that drug benefit, and a host of new benefits, such as preventive care, disease management, and comprehensive chronic care.

But after all we did for prescription drugs, what did we do to secure Medicare's future, you might ask? The reforms may not have gone as far as some would have liked, but the good news—the paramount good news—is for our Medicare system, a little reform can go a long way.

So how far can it go?

When a scam artist can make $7 million by selling gauze pads that cost a penny but sell them to Medicare for as much as $7, a little reform can go a long way.

When a shakedown artist can bilk Medicare for as much as $300,000 by allegedly providing health care services to a deceased patient—I repeat, a deceased patient—a little reform can stop a real abuse. When two rented mailboxes and a beeper is all one fugitive needed to scam Medicare out of $2.1 million, a little reform can go a long way. When Medicare imposes 110,000 pages of regulations, a tower of paperwork 6 feet tall that requires a regiment of clerks to handle, a little reform can mean real savings. When estimates suggest that as much as $33 billion a year is wasted in Medicare and Medicaid—$33 billion a year in waste in Medicare and Medicaid—a little reform can do a lot of good.

When computational errors at Medicare cost $4.5 billion a year, when $2.2 billion is paid out annually to phony businesses, when $23 billion is annually overpaid to doctors, hospitals, and other health care providers, and when study after study shows not just poor business practices but rampant and outright fraud, waste, and abuse throughout Medicare, costing tens of billions of dollars a year, year after year, decade after decade, then a little reform can do enormous good.

The reform in this bill is real. We infuse real competition, market forces,

and private sector dynamics to provide the best health care at the best price for our seniors. A wide array of health care providers, insurers, plans, and organizations will compete to offer the best health care at the best price, and seniors will be free to choose the best plan for themselves.

With all of these choices, with all of this competition, ordinary people providing health care across this land are soon going to do a very extraordinary thing. They are going to figure out how to provide seniors all the quality health care they want without all the waste, fraud, and abuse in Medicare that no one wants.

And who will benefit? Of course, our seniors will benefit. And so, too, will our children. When our seniors get a quadcane such as this one for $15, like the Veterans Administration pays—the VA pays $15 for this quadcane, but Medicare pays $44 for the very same cane—stopping this kind of abuse is going to save our parents and our children. When our seniors get a catheter for a dollar, as most Federal Employee Health Plans pay, instead of the $12 Medicare typically pays, our parents and children both win.

These potential savings are not conjecture. This is not guesswork. We know that under imperfect—if not hostile—rules and regulations, the health care providers in the Medicare+Choice Program were able to give our seniors all the services of traditional Medicare and wring out enough savings to provide seniors an average drug benefit of about $857 a year. With this bill, the power to convert Medicare waste into Medicare benefits, which we only saw a flash of in the Medicare+Choice plans, will now be fully unleashed.

There was always a riddle to the Medicare drug benefit. That riddle was: Could we help our parents without harming our children? Could we add a prescription drug benefit to Medicare today yet still preserve Medicare benefits tomorrow? The answer to the riddle was always reform. In this bill, we have done enough reform to rein in the waste I have touched upon earlier.

To my colleagues on this side, I would agree there could be more reform in Medicare than we have in this bill. But there can be no reform of Medicare without this bill. We could have more reform than we have in this bill, but we will have no reform without this bill. The reforms are more than a first step. They reflect a bold, new direction. That new direction for Medicare flows from the market-based incentives in this bill that I believe will do more good to reform Medicare than our colleagues can possibly imagine.

Our colleagues need to recall that every time we have placed our faith in the ability of free market forces to provide for our people, our Nation has been richly rewarded. When we infused our energy markets with market competition, the gas shortages and economic stagnation of the 1970s were replaced by energy stability and two decades of solid economic growth. When we reformed Welfare-to-Work, we relied on the private sector to provide the best welfare program man had ever devised—a job. And the welfare reform of 1996 has worked better than we could ever have imagined.

Today we tap those same forces that saved our economic security and improved the well-being of the neediest to save Medicare for our children and improve Medicare for our parents.

I believe this new drug benefit will meet the needs of our seniors. I believe the reforms will meet the needs of our children. Now is the time to act. Now is not the time to filibuster. Our seniors deserve better than that from us. Thirty-eight years of waiting is long enough. We must not filibuster and kill the bill providing a prescription drug benefit for 40 million seniors.

Doctors, hospitals, and seniors have all said this Medicare prescription drug plan is the right plan at the right time. They all strongly support this. We should support it, too. Our seniors, the greatest generation, have been there for us. Now we need to be there for them.

I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. Mr. President, here it is, about 675 pages of a bill. I have spent the better part of this past week trying to comprehend all of the nuances in this legislation, and of course a lot of that was difficult since the conference committee was still negotiating up through Thursday night, and some of the final things that are in the legislation we didn't find out until late in the game.

But having spent a considerable bit of time, I believe I have a fairly comprehensive knowledge of it. I want to give my comments and conclusions as to why this legislation is not in the best interest of this country and is it not in the best interest of our seniors. Therefore, I am going to give my reasons why I am going to vote against this legislation.

At the end of the day, what we need in America is a health care delivery system that is organized in a logical manner. The way we organize health insurance, as it has grown up historically around employers, if the employer is large enough, then the group of people who are insured for their medical expenses, you can spread the health risk over that large group. That brings down the per-unit price or the costs, the premiums that people pay.

But all employers are not large. Indeed, in my experience for 6 years as Florida's elected insurance commissioner, what I found was that not only was it very difficult for individuals to get health insurance and pay the prohibitive costs of the premiums but there was a gaming of the system that went on by some insurance companies. By having group coverage, a group was established, a rate was set for that group. Usually the rate was a very low rate or premium in order to entice people into that group to be insured for their health care. And then, as the group got older and it got sicker, they would not expand the group, so the size of the group began to contract. Yet people in the group are getting older and sicker, and you can guess what happens to the cost of that health care; and as those costs rise, so do the premiums and those people in that group had no other choice. They could not go out and get into another group, unless they happened to join an employer who had a large one.

That is the way the system in America is organized. That is not a logical system. What we ought to do is be creating the largest groups possible, the largest pools, so that you can take the health risk and spread it over that large number of people—young and old, sick and well, geographically disbursed—so that the cost of that health care is spread over the larger number and, therefore, the cost per person, the premiums, are much lower.

One of the reasons I oppose this legislation is that it is the beginning of the violation of that principle of insurance, for what this legislation is doing is beginning to fragment the seniors as a group and beginning to create groups where well senior citizens will be encouraged to join, leaving the sicker senior citizens for the traditional fee-for-service Medicare and for the prescription drugs that go along with that Medicare.

For example, what we have in this bill is that prescription drugs will be provided in an area. I think the country is divided into 10 areas. I heard it said earlier that it may be as many as 50. But whatever it is, the whole country is divided. In that particular area, there has to be a prescription drug plan for Medicare, as the basic underpinning of fee-for-service, and also the opportunity for managed care, either a PPO or an HMO.

Now, here is what is going to happen. First of all, the PPOs and the HMOs, under this bill, are heavily subsidized by the U.S. Government. There is $12 billion in this bill that is a subsidy to PPOs, money to be released at the discretion of the Secretary of HHS. This money would be to help the PPOs, managed care, to become more competitive. And guess what. It is going to help them go out and recruit senior citizens to come into the PPOs.

So, too, there is a subsidy here for HMOs. Medicare fee-for-service is reimbursed at 100 percent. In this bill, a kicker is given to HMOs of 109 percent; they are going to be reimbursed for those medical expenses.

So, by this legislation, we are setting a policy that says we are going to encourage seniors to go into those managed care plans—managed care plans that, in fact, will then take away a lot of the choice for seniors to select their own doctor.

What is that going to leave then? As they recruit the more well senior citizens, then Medicare, with its own prescription drug plan, is going to have all others. And guess what is going to happen to that $35 premium that has been promised. It hasn't been promised that it is going to stay the same. To the contrary, that $35 premium per month is going to start escalating. It is going to be hiked. Therefore, what is going to happen to the poor and the sick among our senior citizens? It is not going to be as it has been represented here.

So I see this as a giveaway to HMOs and PPOs. I see it as pushing seniors into managed care, where they will lose their choice of doctors. That is my first objection.

Of course, there is a lot in this bill that is salutary. I voted for the bill when it came through the Senate because I believed that it was a first step in what I thought was a very important policy goal—that we modernize Medicare with a prescription drug benefit.

But what has been added has made it too onerous for me to support. Let me tell you about the second reason I am not going to vote for this legislation.

It is widely acknowledged by several very respected studies that the private sector employers who are covering the prescription drugs for their retirees, from their private employment, are going to drop that drug coverage that is now coming from the private sector. It is estimated by several, including CBO, the Congressional Budget Office—an arm of the Congress of the United States—that some 2.7 million seniors in this country are going to be dropped, which means they will only have the choice of getting prescription drugs under the deficient plan that comes under this bill. So they are going to be getting less.

You talk about being mad. You talk about being upset. When they have a very robust plan and they could go to the pharmacy and have their former employer, under that retiree plan, pay for their drugs and suddenly they get dropped because now there is an inadequate prescription drug plan, well, in my State of Florida alone, it is going to be 166,000 people who are going to be dropped. There is going to be, indeed, some increase under the bill of those who are not covered now up to 150 percent of the poverty level of senior citizens, and I salute that.

You would think that in a State such as mine, which only covers poor seniors with Medicaid, a Federal and State health care program, you would think, since our State of Florida only covers up to 88 percent of poverty level, that would be a big benefit—to go from 88 to 150 percent of poverty level. Yet, in fact, there is some help there, but it is not much because this 675 pages includes a new assets test that is going to drop a lot of those people who are not covered by Medicaid in Florida, who would be covered under the bill—they are not going to be eligible because there is now a new assets test and there is a part in this 675-page bill that will not allow them to receive all of the brands of drugs that they want because there is a limitation in here on the class of drugs, and how it is defined.

Let me tell you, Mr. President, there are going to be some upset seniors who think they are in the range of 150 percent of the poverty level and below, and they are going to get covered and then they are going to suddenly realize they are not. That is going to happen a lot in my State of Florida. This is another reason I am not going to vote for the bill.

A third reason is that there is no competition for the prescription drug plan. I happen to think if we want to have a comprehensive, overall health insurance plan in this country, it ought to be as wide as possible with the biggest possible pools, and there ought to be private sector competition so we get the efficiencies and economies through competition.

That is not what happens in this bill. What happens in this bill is if you don't have two prescription drug plans attached to Medicare in that particular region of the country, there is no competition between the two. You can't say there is just going to be competition with the PDP and the PPO or the HMO. No, they are going to siphon off the more well seniors so if you don't have two prescription drug plans competing in price and there is only one, what do you think is going to happen to the cost? What do you think is going to happen to the monthly premium that was set initially at $35 a month? It is going to go one way. It is going to go up because the cost of those drugs is going to go up.

This bill is not pro-competition. This bill is pro private plans.

Another reason 35 bucks is going to go up is the fact that right now under the Medicare system, Medicare Part B, seniors pay the same premium throughout the country, but we know in some parts of the country health care costs are higher than in other parts. The costs in South Florida are higher than the costs in Iowa. But now the country is going to be divided up, in how many regions? I thought it was 10. I heard earlier in the debate it is 50. However many regions, it is going to be divided up, it is going to more reflect the cost in that region.

You might say that is a good thing unless you come from a State such as mine which has a higher percentage of the population of seniors than any other State because, why? When they retire they want to come to the land of sunshine and enjoy the benefits of our environment.

So because there is no competition and because the universality of the Medicare premium that has been in effect since 1965 is going to be abolished for prescription drugs, what is going to happen? The prescription drug premium is going to get hiked all the way to the Moon.

A fourth reason for opposing this legislation is that $400 billion is a lot of money, indeed, and if we were getting a true comprehensive drug benefit for $400 billion, it would well be worth it because Medicare needs to be modernized. If we were doing Medicare again in 1965, would we include a prescription drug benefit? Of course we would, because of all the wonders of these miracle drugs.

So $400 billion is a lot of money, but it is not being efficiently spent in this bill. Why? Aside from all of these provisions I talked about—about splitting up all of the groups and making them inefficient and siphoning off well seniors and leaving the sick seniors for the remainder—we cannot do anything in this bill about the prices of drugs.

In this bill, there are two little paragraphs that do not allow Medicare to negotiate the price. I always thought the free market was about economies of scale, of being able to get better prices. That is the whole theory of Wal-Mart. In bulk purchasing, they bring down the price. This is an anti-Wal-Mart policy bill because it does not allow bulk buying, as has been stated many times before, which has been done with other agencies of Government, particularly the Veterans Administration.

Mr. President, I supported the bipartisan bill we crafted in the Senate earlier this year. Unfortunately, this agreement does not adequately protect seniors' retire coverage, moves too many seniors into private plans, and fails to do anything about the escalating costs of prescription drugs.

When Medicare was passed 40 years ago, we promised our seniors they would have access to medical care as they grew older. As a matter of fact, since the passage of Medicare, seniors' life expectancy has increased about 25 percent.

The agreement that we will be voting on has little to do with providing a prescription drug benefit to seniors and a lot more about enticing private insurance companies to take over for the Government.

The financial incentives to private companies and creative trappings inserted in the bill will do nothing less than limit seniors' choices—mostly because of cost. Seniors may be forced into HMOs or PPOs because it may be the only affordable way to at least have access to a prescription drug benefit. Affordable, because the bill provides a $12 billion subsidy for PPOs and a reimbursement rate of 9 percent above Medicare for HMOs.

Since 1999, in Florida alone over 260,000 seniors and people with disabilities were abandoned by their private Medicare HMOs. As Florida's former insurance commissioner, I recall having to beg these plans to stay in our

State and continue providing care to our seniors.

This conference agreement, with its various incentives—from a $12 billion slush fund, to its risk buyout, is nothing more than a give-away to insurance companies.

Private health plans are in the business of making money, and have routinely blamed low profit margins as their reason to drop seniors. In comparison to Medicare, they have failed to be as effective in controlling their own costs.

HMOs have managed to lure the healthiest of our seniors in order to maximize their reimbursement from the government. Currently, they receive about 16 percent more per beneficiary than is paid out through the traditional Medicare program. If these savings aren't enough to feed their profit margins, then the increased payments included in the bill will.

The agreement proposes payments to HMOs of 109 percent of the fee-for-service rate. This cumulative effect results in our government paying private plans 25 percent more than what it would cost Medicare to provide that same care. How can that be considered competition?

I am also concerned that the agreement before us could create premium variations across the country, and even within my own State of Florida.

While we all keep hearing about this $35 monthly premium, there is nothing written in the law that limits the premium to that amount. That number is simply an average which between now and 2006 could certainly increase just as the rest of the costs of health care are.

In addition, I am envisioning a scenario where seniors who do not have access to a fallback because there is one HMO or PPO plan and one prescription drug plan are left without any real choice. Then, if the drug plan, PDP, has no competition, it can raise the annual premium at will.

Since there are no limits and the premium from a private drug plan could be hiked to the moon, they could essentially create a situation where a senior has no other choice—based on costs—but to join an HMO or PPO and give up their choice of doctors.

Again, we see an example of this bill's failure to allow true competition to take place.

Under the fallback plan included in the Senate bill there would be at least two of the same kinds of plans competing in each region. This would have created an incentive for the drug plans to keep their premiums competitive.

During a careful examination of this agreement, I also became aware that the private drug plans are allowed the greatest flexibility possible. Little consideration is given to the particular needs of the beneficiary.

For example, each Medicare drug plan could have its own list of covered drugs, or formulary. The only requirement is that the private drug plan covers at least one drug in each ''therapeutic class.'' The definition of a therapeutic class; however, is left up to the plan itself. A plan might choose to exclude certain high-cost drugs for financial reasons, leaving seniors who depend on those drugs without coverage for them.

I am also very disappointed that this agreement prohibits Medicare from negotiating better prices from drug manufacturers.

In 2001, the cost of prescription drugs rose more than 15 percent—the seventh straight year of double-digit increases.

When we consider the fact that drug prices have been increasing by double digits in recent years, it does not make any sense to let these prices go unchecked.

In light of our limited resources, wouldn't our seniors have been better served if we had addressed the issue of drug costs? We even have a proven model for success in the Veterans Administration, which has used its bulk purchasing power to negotiate with the drug companies for dramatically reduced prices. Medicare could do the same, saving our seniors and the taxpayers billions of dollars.

Our Nation's seniors, when unable to afford their own drugs, turned to Canada for relief. This bill continues the stalemate between supporters of importation and the FDA by including the poison pill provision requiring a certification from the Secretary of Health and Human Services before medications can be legally imported.

At a Commerce Committee hearing last week on this exact issue, supporters of importation argued that in the absence of trying to control the increasing prices of drugs, importation should be at least an option to provide short-term price relief.

In making my decision to oppose this legislation, I considered who would be better off versus who would be worse off.

One-third of Medicare beneficiaries have no drug coverage at all, another one-third of them have access to prescription drugs through their retiree health care plans.

The legislation before us will cause private employers to drop 25 percent of their retirees. In the State of Florida, that could mean over 166,000 retired seniors would lose the coverage they worked all of their lives to earn.

Another group that fares worse under this agreement are those seniors who are over 65 and also eligible for Medicaid. We fought long and hard to have these duel-eligible seniors covered under Medicare. However, provisions in the agreement raise the asset tests and restrict the Medicaid program from paying the senior's copayment, and that leaves seniors worse off.

Medicaid beneficiaries in Florida have access to all classes of drugs and all drugs within those classes. Should patients have trouble getting their medications, their physicians are allowed to appeal directly to Medicaid. The limited formularies allowed under the agreement for Medicare could jeopardize a senior's access to the drugs they need.

Despite our best efforts in trying to minimize cuts to cancer care in this legislation, the agreement will result in an $11.5 billion cut. The ripple effect of these cuts and the reaction of private sector insurers will threaten community cancer centers' ability to continue treating patients.

I reiterate my support for the providers of care to America's seniors. To our doctors, our hospitals, and nursing homes—I support the provisions in this bill that will allow them to continue to serve our seniors.

For Florida's hospitals alone, this bill means almost $740 million in improved Medicare reimbursement over the next 10 years, and I am pleased about that. But these reimbursements to health care providers should not be held hostage in a 675-page bill that has many defects.

In the final analysis, this agreement fails to fulfill my promise to provide comprehensive prescription drug benefit to seniors. We can do better. Regardless of whether this bill passes or fails, I intend to keep working to provide that comprehensive benefit. Our seniors deserve nothing less.

I want to yield the rest of my time to one of my colleagues who needs some time. I wanted to state at least these reasons and try to give the comprehensive overview of the health insurance marketplace, where we need to go eventually to straighten out the mess so that all people can be insured and not just the ones who have it and the 42 million people in this country who don't have it. Indeed, this bill is not the first step toward that kind of health care reform.

I yield to the Senator from North Carolina the remaining time that I have, which should be about 13 minutes.

The PRESIDING OFFICER. It is about 10 minutes. The Senator from North Carolina is recognized.

Mr. EDWARDS. Mr. President, may I inquire how much time the Senator from Florida has remaining?

The PRESIDING OFFICER. About 10 minutes.

Mr. EDWARDS. Mr. President, I thank the Senator from Florida very much for yielding time and allowing me to speak tonight.

Medicare was created 40 years ago with the idea of giving seniors health care to allow them to live out their lives in dignity and self-respect. It was a promise that they could choose their own doctor and afford their health care.

We clearly need a real prescription drug benefit under Medicare, there is no question about that. The problem is that this bill does a great deal more harm than good. It is very good for the drug companies, it is very good for the HMOs, but it is very bad for seniors and very bad for America as a result.

Here are some of the reasons: First, it has billions of dollars in giveaways to HMOs and insurance companies, money that could be and should be used to provide a better benefit to seniors who desperately need prescription drugs.

Second, it does almost nothing to control the skyrocketing costs of prescription drugs which seniors all over America face every single day when they go to the pharmacy.

Third, it contains billions of dollars in tax breaks for millionaires, for the wealthy, which is part of a long pattern by this President of trying to shift the tax burden. The President is in the middle, as I speak, of shifting the tax burden in America from wealth to work. He wants to get rid of the dividends tax, capital gains tax, taxation of the largest estates, and shift that tax burden right on the backs of middle-class working Americans who are already struggling, already having a difficult time saving, putting money aside, having any level of financial security. And here we go again, the President of the United States is in the process of putting an additional burden on the very people who are struggling and who are so critical to getting this economy moving again.

This is just another in a long series of efforts by this President and this administration to shift the tax burden. There is no question the lobbyists all over Washington are popping the champagne corks as we speak. The drug company stocks are going up. The HMO stocks are going up. Do not the drug companies and HMOs make enough already? For all the seniors who go to the pharmacy to try to buy medicine and cannot afford it, is the really nice thing for us to do right now to help the HMOs and drug companies? Are they not doing all right?

The truth is we ought to forget the drug companies, forget about the HMOs. They are doing a terrific job of taking care of themselves. We in the Senate ought to be focused on trying to help seniors who are struggling.

Let me say a word about the giveaways to the HMOs. This bill contains something that is called a stabilization fund of $12 billion, which is nothing but a giveaway to HMOs. The idea is we have been hearing all along that it is important to have competition and the HMOs can be more cost-effective than Medicare. I am missing something. If they can be more cost effective than Medicare, why in creation are we giving them $12 billion of taxpayer money? At least where I come from, you do not have to give somebody $12 billion to be more cost effective. That is taxpayer money that could be used to help seniors who desperately need prescription drugs. But, oh, no, we are going to give them $12 billion, money that could go to the seniors, money that could give them a decent benefit. Instead, we are going to give it to HMOs. I guess they are struggling so much, they need our help.

Then on top of that, we see that the justification for this is that they need money so they can ''compete''? What in the world is that all about?

On top of what is being done for the HMOs, we have the drug companies. This bill does almost nothing to control costs. We have been fighting in the Senate to bring down the cost of prescription drugs for months and years now. The battle is always uphill because the drug companies have more lobbyists in this town than people who live in my hometown where I grew up. They are all over the place.

So we are trying to bring down the cost of prescription drugs. The Wall Street Journal itself calls this a big win for the drug companies. Their stock is going up.

Why have we not been able to do the things that need to be done to bring the cost of this program under control and, more importantly, to bring the cost of prescription drugs under control? I will tell my colleagues why. Because the drug companies are against it. It is just that simple. It is the answer to everything we try to do on the Senate floor to bring down the cost of prescription drugs.

We try to do something about misleading drug company advertising on television. No, no, we cannot do it. The drug companies are against it.

We try to allow the reimportation of prescription drugs from Canada to bring down costs for everybody, but we cannot get it passed. Why? The drug companies are against it.

We try to do all of this, to allow the market power of the Government to be used to negotiate a better price to bring down the cost of prescription drugs. We cannot get it done. Why? The drug companies are against it.

We are never going to get health care costs under control in this country until we stand up to these people, stand up to the drug companies, stand up to the HMOs.

I know in Washington, DC, they are powerful, but out across America, the American people have a great deal more power in this democracy than these lobbyists in Washington. We need to stand up to drug companies and HMOs and stand up for the American people.

In the middle of not controlling costs, billions of dollars of taxpayer money going to HMOs and drug companies, we have another effort to shift the tax burden in this country. It is not as if working, middle-class families are not struggling enough. It is not as if over the last 20 years we have not gone from them saving money, having financial security, to today not being able to save, having negative savings as a matter of fact, with one medical emergency or one layoff keeping them from going under.

Here is a good idea: Why do we not take another step to shift the tax burden away from the wealthy and to the middle class and working people? That is exactly what is happening with these medical savings accounts. The only people who are going to be able to afford to take advantage of it are the wealthy. Regular folks cannot save anyway. They are not going to be able to put money away in one of these accounts.

The bottom line is, this is a bad bill. It is not a first step; it is a misstep. It takes this country in exactly the wrong direction. We need to stand up and say so. The American people need to hear our voices loudly and clearly. They also need to know what it is we actually need to do to provide a prescription drug benefit because they deserve one.

I will tell my colleagues what we need to do—put controls on the cost of prescription drugs by allowing reimportation from Canada, by doing something about misleading advertising on television, by cracking down on some of the price gouging that is going on. We ought to provide this prescription drug benefit under Medicare. We can give people choices and still stand by the very program that has provided seniors with health care for 40 years now, that so many seniors have depended on for four decades now.

At the end of the day, the American people, seniors, want us to do something about prescription drugs. We ought to do it. We ought to give them a real benefit. We ought to bring down the costs. We ought to make it cost efficient in terms of taxpayer dollars. In order to do it, we are going to actually have to have the backbone to stand up to these drug companies and these HMOs and their armies of lobbyists all over Washington.

I, for one—and I believe some of my colleagues will join me in this—intend to stand up to these people, and I intend to stand up for the American people and fight with everything I have for a real prescription drug benefit under Medicare that does not give billions of dollars to HMOs and drug companies.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Senator BAUCUS is the next scheduled speaker. I will ask for a quorum call, but I also ask unanimous consent that the time be taken off his time. It is not fair to wait because we have 4½ hours' worth of speakers.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

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

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

Mr. GRASSLEY. Over the last couple of days there have been many assertions from my colleagues on the other side of the isle that this bill does nothing to lower the cost of prescription drugs.

I would like to take this opportunity to set the record straight.

The conference report contains a number of significant reforms to lower the cost of prescription drugs for not just Medicare beneficiaries, but for all Americans.

This bill provides immediate relief to 40 million Medicare beneficiaries by providing a discount drug card starting in April 2004.

The voluntary drug card program will save beneficiaries an average of 10 to 25 percent on the cost of their prescription drugs. Beneficiaries will have the choice of at least two Medicare-endorsed drug discount cards.

The drug discount program included in the Medicare Prescription Drug and Modernization Act also provides low-income beneficiaries with an additional subsidy of $600 to help with the costs of their prescription drugs.

This program provides immediate relief to Medicare beneficiaries now paying extremely high prices for their prescription drugs.

This bill also lowers the price of prescription drugs for Medicare beneficiaries, by eliminating the Average Wholesale Price, AWP, paid for prescription drugs.

This provision significantly reduces the prices that Medicare and many private insurers pay for physicians-administered drugs.

Under this agreement, Medicare reimbursements will now be based on actual prices paid by physicians, rather than fictitious numbers reported by manufacturers, providing a ripple effect lowering the cost of prescription drugs for not just Medicare beneficiaries but individuals in the private market.

The conference report also contains a ''non-interference'' provision that will protect patients and deliver lower prices through market competition.

The conference bill specifies that the Government ''may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors'' and ''may not require a particular formulary or institute a price structure.'' It is right here on page 53.

Opponents claim that this provision, which originated with Democratic proposals, is a concession to the pharmaceutical industry. That is plain wrong.

The noninterference provision is at the heart of the bill's structure for delivering prescription drug coverage through market competition that gets a good deal for consumers, rather than through price fixing by the CMS bureaucracy. As CMS Administrator Tom Scully explained in the November 21, 2003 issue of the Washington Post, if Medicare negotiated prices, ''I wouldn't be negotiating; I'd just be fixing the price. Let's get seniors organized into big purchasing pools that get bulk discounts and see how they fare.''

Ironically, this provision was created by the Democrats and first appeared in May 2000 in a bill sponsored by Senator DASCHLE and 33 Democratic cosponsors. In June 2000, Mr. STARK included the same language in his motion to recommit H.R. 4680. That motion received the support of 203 Democrats and Mr. SANDERS.

The provision protects patients by keeping the Government out of decisions about which medicines they will be able to receive. Under this section, CMS will not be able to dictate that drugs must be excluded from a PDP formulary or subjected to reimbursement limits that effectively deny access.

The bill relies on market competition, not price fixing by CMS, to deliver the drug benefit. The bill's entire approach is to get seniors the best deal through vigorous market competition, not price controls.

CBO scores the bill's approach of relying on at-risk private sector plans to deliver the prescription drug benefit as getting a higher cost management factor for Medicare than bills where private sector competition is handicapped by Government. The noninterference provision protects this approach, by preventing politicians and bureaucrats from getting into the middle of the very negotiations that drive these savings.

Private plans have strong incentives under the bill to negotiate the best possible deals on drug prices, because they are at risk for a large part of the cost of the benefit. They also will have the market clout to obtain large discounts. By driving hard bargains, they will be able to offer lower premiums and attract more enrollees.

The alternative is a command-and-control system that would not be responsive to consumer desires or marketplace realities. Bureaucrats would swing between adding benefit requirements without a means of paying for them and restricting choices and access in an effort to contain costs. This bill wisely rejects that approach. The noninterference provision is the fundamental protection against it.

Finally, the conference report lowers the cost of drugs for all Americans by reforming the Hatch-Waxman drug pricing laws.

The agreement will speed the process of allowing generic drugs to come to market, which will significantly reduce drug prices.

The agreement will provide brand drug companies only one 30-month stay on the approval or a generic competitor.

Generics would be forced to forego their 180-day generic exclusivity if they do not bring a product to market within a specified time period.

These reforms are the most aggressive since Hatch-Waxman laws took effect in 1984.

These reforms have also earned the strong endorsement of the Generic Pharmaceutical Association and dozens of allied groups who are advocates of increased generic usage and low drug prices.

So to my colleagues who say there is nothing in this bill to lower drug prices, they are not talking about this bill.

My friend and colleague on the Finance Committee, Senator BAUCUS, has come to the floor. He is primarily responsible for the legislation that is before us because he has been very willing to work in a bipartisan way to get things done. We would not be here today if it was not for the hard work of Senator BAUCUS, the ranking Democrat on the Finance Committee, and a person with whom I can work very well.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, first I deeply thank my good friend from Iowa, Senator GRASSLEY. I know people in his home State greatly respect him. I read somewhere that he has the highest approval rating of any politician in the State of Iowa. I am sure that is true and I can understand why. It is because he is straight, down to Earth, and honest. He tells it like he sees it, no guile. I want Senators to know that this is my impression, as well. I say this because when he explains the provisions of this bill, I hope people listen. Senator GRASSLEY is not one to gild the lily, not one to indulge in inflammatory rhetoric, not one to exaggerate. He is someone who tells it like it is. This is a very important personal quality of his, and one that I revere deeply.

I thank the Senator for allowing me to work with him as the chairman of the Senate Finance Committee.

I would like to take a few minutes to discuss the Medicare conference report before us. I am sure a lot of people across the country have heard statements by many Senators and House Members and are wondering who is telling the truth. They hear a set of allegations from one side and lots of responses from the other side. It must be incredibly difficult to determine the truth.

A few days ago, Senator BREAUX and I met with 20 or 25 House Democrats. The group is known as the New Democrats. Senator BREAUX and I explained to them what was in the bill.

Over and over again, the New Democrats asked: What is going on here? Our leadership tells us one thing and you are telling us something else. Whom are we to believe?

Senator BREAUX and I explained the bill to the best of our ability. We tried to be honest and straight with the facts. It is my belief that the facts are usually controlling. Once people understand the facts of a bill or legislation, they can make up their own minds. It was our intention to just give the facts so these House Members could make up their own minds.

I suspect that a lot of them were in a difficult place: stuck between their leadership, which was pressuring them to do one thing, and the facts which were inclining them in the other direction.

I further suspect that many people watching across the country tonight

are wondering the same thing. There are compelling speeches on both sides of this debate. Who is telling the truth? After all, that is what it is all about.

I am going to do the best I can to explain why I am supporting this Medicare legislation, why I personally think it is a good bill. I am going to use the facts, as opposed to rhetoric. I am not a great rhetorical speaker. As with the Senator from Iowa, I tend not to embellish. Maybe it is because we are from agricultural states. We have learned to accept that we cannot control everything—we cannot control the weather for the crops and the livestock; we cannot control the market price. We accept reality for what it is and tell it like it is because that is the way we have grown up. I will do my very best to give a fair take on facts of this bill.

Why do I support this bill? For many years, Congress has been trying to pass legislation that gives prescription drug benefits to seniors. For many years we have been talking about it. Some years we have come pretty close. Last year, for example, we were very close. I can remember a meeting I had convened in my office with the key Senators: OLYMPIA SNOWE, TED KENNEDY, CHUCK GRASSLEY, Senator GRAHAM, and four or five or six other Senators from both sides of the aisle—liberals and conservatives. We came very close.

But in the end, partisan politics dominated—I think because some wanted an issue, not a solution. We were pulled apart, and in the last moments, we were unable to pass a prescription drug bill.

Here we are again today. We are even closer this year because we have actual legislation that has passed both bodies of the Congress, and a conference report before us. It is not possible to get any closer. If we do not pass legislation this time, I do not know if we ever will. And this would be a tragedy. This bill provides $400 billion over 10 years to create a prescription drug benefits for seniors. This is what the debate comes down to.

We know the importance of this bill because drug prices are increasing rapidly, while at the same time, drugs are becoming ever-more important. They oftentimes replace expensive hospital procedures. And new medications are constantly being developed. New, so-called miracle drugs are being developed today that will help treat many different illnesses in the future.

Many of our seniors with low incomes and fixed incomes simply cannot afford the drugs they depend on. It is critical that we pass this legislation. Every other country in the industrialized world provides prescription drug benefits for their seniors. We are the United States of America. Why in the world do we not provide prescription drug benefits for our seniors?

We should.

And we now have the opportunity before us. I do not know when we are going to get this opportunity again. If we do not act now, the chances of passing prescription drug benefits for seniors in the next several years is very slim. Next year we will be faced with higher budget pressures: The national debt is increasing; our deficits are rising due primarily to uncertainties overseas—Iraq and Iran; due to terrorism; and due to greater domestic needs. If we do not pass prescription drug benefits now, we are unlikely to have another opportunity again. If we do not act today, the $400 billion will not be there next year.

I also support this legislation because of its very generous low-income subsidies for one-third of all senior citizens. These senior citizens, one-third of all senior citizens, will have 90 percent of their drug costs paid for. Under this legislation, 90 percent of their drug costs are going to be paid for by the federal government.

This is a very important measure in this bill. It provides very strong low-income protections. I do not know if we are going to have these protections again in future Medicare legislation, if we even have future Medicare bills. When are we going to again have such generous assistance for our low-income seniors?

An additional reason I support this legislation is that it contains a strong government fall-back plan. This is a technical term which means that when there are not two private drug plans available in any region, a senior is able to access a guaranteed government fall-back plan for their drug benefits.

The only question is: Are there two private plans in any given region of the country? If there are, your prescription drug benefits are covered through the private plan with all of the guarantees that are written in the legislation to ensure that seniors are not taken advantage of. If there are not two private plans in the area, then the Government fall-back plan goes into effect.

The bottom line is that all seniors in America will get a prescription drug benefit. All seniors in America are covered by this bill, whether it is in a private drug plan or through the government fall-back plan. This is what we mean by a strong Government fall-back—all seniors will get the prescription drug benefit.

It is true that the House bill did not include a strong government fallback. But we are talking about the Conference report. And in this legislation, all seniors will have access to the drug benefit.

The fourth reason I support this legislation is rural payment equalization, as well as other strong provider provisions.

During the many years I have been in this body, I have worked hard to make sure that Montana and other rural States get the same payments for hospitals and doctors as urban States, as the big States.

We have been fighting for this for years. Finally this legislation addresses this inequity. If this bill does not pass, I do not know when we are going to be able to address this issue. Nothing is guaranteed in the future. Times change. Congresses changes. It is difficult to predict the future. A bird in the hand is worth two in the bush. We have a bird in the hand now.

We have strong rural provisions in this legislation. If it does not pass now, the chances of rural areas getting a square deal and a level playing field are going to be in serious jeopardy.

I say to those Senators from rural states, how can you vote against a bill and deny increased payments to your home states when you are probably not going to get them again, when you have been fighting so hard to get them for so many years?

I would now like to turn to another issue that has been discussed frequently and which is of great concern to many Senators, and well it should be.

As indicated on this chart, employer-sponsored retiree coverage is declining.

Eighty percent of companies offered retiree health care coverage in 1991. In 1996, it fell to 71 percent. In 1999, it fell to 66 percent. In 2001, it fell to 62 percent, and 2003, 61 percent. There is a steady decline of companies dropping or reducing their retiree coverage.

You might ask, Why is that happening? It is happening because of competitive pressures. Companies want to cut back on costs wherever they can to maximize their profits. Retiree health benefits is one area where they are cutting down their costs. They are reducing coverage for their retirees. It is inevitable and it is happening.

Why do I mention this? What does this bill do to address this phenomenon? This is an extremely important point, and I hope Senators and staff are listening. This bill discourages employer retiree droppage; discourages, not encourages, it. It provides tax-free subsidies for companies to discourage them from dropping their retiree benefits.

This bill provides $88 billion—$88 billion—to companies for their retiree plans. Eighty-eight billion dollars is going to companies to discourage them from dropping their retiree plans.

The Congressional Budget Office said under the Senate bill that there would be about a 37-percent droppage rate; in the House bill, about 32 percent.

But in this Conference report, we have provided additional funding. The rate is now down to about 22 percent. But that 22 percent would be higher if this additional money was not provided.

The actual number in the conference report is 17 percent. This number reflects a more accurate calculation. 22 percent is apples to apples to the 37 and 32 percent in the Senate and House bills. The 17 percent is a more accurate figure.

The net effect is the droppage rate is about 50 percent less as a consequence of the provisions in the conference report. Companies are getting $88 billion to maintain their retiree coverage.

I ask my colleagues, if you vote against this bill, what are you going to say to those employees who lose their retiree coverage when you had the opportunity to vote for a bill that would have provided funding to address this problem? What are you going to say to those retirees when you tell them you voted against a bill which would have discouraged retiree droppage? What are you going say to them? I don't know; it wasn't perfect.

This bill has the effect of discouraging—not encouraging—retiree droppage. I hope Senators pay very close attention to this point. This issue concerns many Senators.

I would like to address another issue—the impact of this bill on dual eligibles.

We have heard criticism that the effect of this bill is to make drugs more expensive than current law for dual eligible senior citizens.

This is completely inaccurate. The assumption behind this argument is that this bill has a $1 and $3 copay for drugs for dual eligibles. For seniors who are under 100 percent of poverty, this bill has a $1 copay for generic drugs, and a $3 copay for brand-name prescription drugs.

The assumption behind the argument that the 6 or 7 million dual eligibles will be worse off is that these seniors do not currently have copays under Medicaid. That is not true. Most States, at least 38 States, already have Medicaid copays. The 6 or 7 million worse off is simply a false figure.

In fact, most States are under tremendous pressure to reduce the costs of their Medicaid programs. One of the ways they decrease costs is through increasing copays.

For those Senators who have been claiming that 6 or 7 million will be worse off, please look at the Medicaid copays in many States and anticipate what will be the situation in the year 2006. It will be worse; 38 States have copays. Not all are greater than $1 in $3 now, but if States continue to cut back on Medicaid to balance their budgets, then the copays will rise.

Today, Illinois already has $1 and $3 copay. The bill does not hurt low-income seniors in Illinois. In Maryland, there is a $2 co-pay for brand-name prescription drugs. In Massachusetts, it is for all drugs. The same is true for Nevada. I see my good friend Senator REID is here. He knows more about Nevada than I hope to know. North Dakota is $3 for a prescription. South Dakota, about the same. And these are just some examples.

If you look at the facts, the 7 million figure is closer to about 1 million.

Another inaccurate criticism is premium support. There has been a lot of talk that premium support will undermine Medicare as we know it. I would never vote for a bill that I thought would undermine fee-for-service Medicare. I would not do that because I know how important it is to seniors, certainly in my State of Montana.

In the year 2010 there will be six demonstration projects. That is far better than the House bill which wanted a full-blown nationwide premium support. We have heard a lot of horror stories about premium support, but that is based upon the House bill, which had full-blown, nationwide premium support. This is not a fair criticism. People are talking about another bill, not the Conference report before the Senate.

What is before the Senate is a bill which says in the year 2010 there will be up to six MSAs, metropolitan statistical areas, that could test this concept of premium support. I might add, as I have said before, that Medicare fee for service is held harmless. People in these areas who want to stay in fee for service can. There is no requirement they get out of fee for service.

Remember, the President earlier proposed legislation that would have required people to join private plans to get a drug benefit. That was then. This is now. This bill does not say that. This bill says, if you want to stay in fee for service, that is fine. You do not have to join a private plans.

Some Senators also worry that Part B premiums might rise because the private plans will take the healthiest seniors, forcing up the fee-for-service Part B premium.

This argument is not true.

All low-income people are held harmless in Medicare fee for service. Their Part B premium cannot go up. They are held totally harmless. As I mentioned earlier, a third of America is classified as low income in this bill.

What about those who are not low income? This bill limits any premium increase to 5 percent. This is significant.

Part B premiums for next year, 2004, are going up about 13 percent for all senior citizens. Why is that? Because this Congress, using its best judgment, has decided to increase dollars to doctors. Seniors pay for 25 percent of this increase through higher Part B premiums.

In this bill, the premiums cannot go up by more than 5 percent in the premium support areas.

Another point: A maximum of 1 million beneficiaries may be affected. I mention this number because there are a lot of other figures being discussed, including that 10 million senior citizens will be affected by premium support. Ten million is not an accurate figure. It is not true. We went to an objective source to find out what is true and accurate. We went to the CBO. CBO told us that between 670,000 and 1 million people could be affected by this bill in the six areas. Even so, these people can stay in standard fee for service. They are not required to go into private plans. There is no incentive, unless a premium support plan does offer a much better package, much more in benefits, much lower in costs. That is possible. I don't think it is likely, but it is possible.

The main point is that very few people could be affected by premium support. It is not the 10 million figure we have heard. Take the figure of 10 million, cross out the zero, and you get the real figure of 1 million or fewer.

Next, this legislation limits the number of sites to six. There can be no more than six MSAs in the Nation. The Secretary has no discretion to add more.

In addition, this legislation says these demonstrations are limited to 6 years. That is in statute. That is not regulation. The Secretary cannot change that at his discretion.

It takes an act of Congress to extend or expand these six. After 6 years, the issue will be before Congress to decide what to do: Do we want to extend the premium support areas? Do we want to eliminate them? Do we want to change them? This cannot, by regulation or the Secretary's decision or by the President's decision, be changed; it takes an act of Congress to change.

I might add, as well, that there are payments in this legislation that go to preferred provider organizations to see if they can work.

But preferred provider organizations have to be regionwide. They have to serve the whole region. They cannot pick and choose individual MSAs. As we know of today, HMOs pick and choose. They go to the counties they like and avoid the counties they do not like. They cherry-pick the healthiest people. They do not go to the counties they don't like, those with the less healthy people. This is not the American way.

This legislation provides for additional funding for the regionwide PPOs which go into existence in the year 2006. There is a $12 billion fund which helps get these plans up and started. But again——

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

Mr. BAUCUS. Mr. President, may I ask for a few more minutes?

Mr. REID. Mr. President, we have 4½ hours of speeches still tonight, and that is why we have limited it to half an hour each.

Mr. BAUCUS. If I could just have 1 minute?

Mr. REID. Sure.

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

The Senator from Montana.

Mr. BAUCUS. Mr. President, I will just sum up by saying, I have spent a lot of time on this legislation. I am not going to do anything to hurt senior citizens. It would be foolhardy, foolish, stupid. And this bill does not hurt senior citizens, it helps them.

There have been a lot of charges against this bill. It is very easy to be negative. It is very easy to find fault with anything.

This bill is not perfect, but it is very good.

I urge all of us to remember, this is a very good bill. It gives great assistance to our seniors. We have subsequent years to work on it, build upon it, and to make changes. But if we do

not pass it now, the chances are very slim we will be able to pass prescription drug benefits for seniors again.

So I strongly urge my colleagues to support this bill and oppose procedural motions which will impede passage of this bill.

The PRESIDING OFFICER. The assistant Democratic leader.

Mr. REID. Mr. President, first of all, I want to underscore the comments about the Senator from Iowa, Mr. GRASSLEY, which were made by the senior Senator from Montana.

Senator GRASSLEY is a dedicated Senator, a gentleman, and I have great respect for him. So I appreciate the Senator from Montana saying those nice things about the senior Senator from Iowa, Mr. GRASSLEY.

But I also want to say that on our side we have two people who have been so heavily involved in getting a bill here. One is the ranking member of the Finance Committee, Senator BAUCUS, who, as he said, is my friend. I have the deepest respect for him, and I know how hard he has worked on this legislation. He has kept me apprised of his progress and slippage on occasion.

Senator BREAUX and I, of course, came to the Senate together. There is a bond of friendship between us that will last forever.

So even though I do not agree with my two friends, Senators BAUCUS and BREAUX, on this legislation, no one can take away how hard they have worked on it and how they believe they are doing the right thing.

Mr. President, the Presiding Officer knows that my father was a hard rock miner. As I look back, the best times we spent together were when I was a little boy.

My dad worked in a number of mines, but the mine that I remember is a mine called The Elvira. My dad worked underground alone, which was, of course, against the law. No one ever prevented him from doing that. The mining inspectors rarely came to Searchlight.

It was during the summertime, when I was out of school, the first summer I can remember going down with him, keeping him company.

As I look back on my father, those were times we had together underground. I had my own little hat, with a carbide lamp. I was not much help to him, but I kept him company.

My dad was a very quiet man, but he would talk to me. We had wonderful times. I would have my own lunch. My mom would pack my lunch.

But my dad taught me a lot of things. As I indicated, the finest memories of my dad are from those days we spent together underground.

As I got older and stronger there were things I did later, as I became a teenager, that I could do to help him physically other than just keep him company. But those days were not like the days I spent alone underground with my dad.

He taught me a lot of things. But one of the things he taught me how to do was to pan for gold. Of course, we never had much. He never found much for what he did. There was not much gold there.

But I knew how to pan for gold. You would take the rock and grind it up real fine into a little metal bowl. Then you would put it in like a frying pan, a pan that was made just for that, and shake it with water coming down. And gold, of course, is very heavy, and the gold would be at the bottom. You could see if there was any gold there.

The other way, of course, you could find if there was gold is you could send it to an assayer and find out. But the first preliminary thing you did was pan for gold.

Mr. President, one of the things I learned as a boy in Searchlight is there was a lot of something called iron pyrites. It is fool's gold.

I have this little rock in my hand. It is the same kind of rock I have pictured on the right side of this chart. If you were up close, you could see this glittery, gold stuff on the rock. It is all over the rock, and it looks like gold. It glistens like gold. The only way that you can find out if it is real gold is if you either pan it or assay it.

What I have shown on the left side of this chart is gold. And what is shown on the right side of the chart looks like gold, but it is fool's gold.

I say to my friends within the sound of my voice, even though this product looks like gold, I think if you examine it, if you assay it, you will find it is not gold. It is like the iron pyrites in the mines of Searchlight. It is something we call fool's gold.

This legislation started as a Medicare prescription drug benefit for seniors. Now, this large bill we have here, of approximately 700 pages—approximately 700 pages—about 150 pages of it deal with prescription drugs for Medicare. The rest of it is something that I never thought was to be part of the legislation; it is to reform Medicare.

Now, my friend, JOHN BREAUX, has spent a lot of his legislative life talking about the need to reform Medicare. And I have not talked in detail with Senator BREAUX, but I am confident he was much more involved in and concerned about reforming Medicare than the prescription drug aspect. That is not necessarily bad, but that is what he was focused on.

Senator BREAUX believes that Medicare needs reform. During the Clinton years, he was the chairman of a committee to come up with some Medicare reform. And he came up with it. He was the chairman of that committee. More than 50 percent of the people who served on that panel believed that his program was good that they had come up with. But under the rules of engagement, it took a supermajority to do that, and he could not get that.

So Senator BREAUX, as I have already said about my friend—Senator BAUCUS and Senator BREAUX, fine people, wonderful Senators, but I think this legislation, which started out as a prescription drug benefit for seniors, has gone way beyond that and is now a bill mostly dealing with Medicare reform.

This legislation is OK at first glance, but if you look at it closely, I believe, as I have indicated on this chart, it is really not the gold, shown on the left, but it is the fool's gold, the iron pyrites, shown on the right.

This summer, we passed a bipartisan prescription drug bill, which was not perfect. As it returned from the House, though, the prescription drug bill that passed the Senate has taken a step backward. It is not imperfect; it is bad.

I think there are millions of people worse off. It gnaws away at the foundations of Medicare.

Seniors have trusted this program for 40 years. My position has been that we should make health care available to every American, we should cut costs, we should improve quality, and we should expand access. Upon review of this legislation, we don't have that. We have what I believe is an image, an image that looks like gold, but it isn't, it is fool's gold.

All you have to do is look at the facts. In Nevada, 20,000 low-income seniors will have to pay more when this legislation goes into effect. This bill contains an unfair and confusing assets test. Why would we charge someone negatively because they have planned ahead and have a burial plot, maybe a car, maybe some furniture? This bill contains an unfair and confusing assets test. More affluent seniors are going to be punished. That is not right.

I have been through this once before as a Member of Congress. On catastrophic, I introduced legislation in the Senate that the chairman of the Finance Committee, Lloyd Bentsen, personally criticized me for introducing. That legislation was to repeal catastrophic. I did it because the seniors of America were up in arms. I was a relatively new Senator, and I won't say my colleagues shunned me, but they weren't happy for a while. But that legislation passed. It repealed catastrophic.

Catastrophic was directed toward people who had taken care of themselves, had provided for the future. They were being punished for having done a good job, taking care of the future. They rebelled. And that is what we are going to find here.

Clearly, they will pay more in Medicare premiums. The costs of Medicare will go up for them. They already pay more than their share of payroll and income taxes. They already pay the greater share of Medicare costs.

I have received some letters from people in Nevada, constituents of the Presiding Officer and me. Let's note what some of them say.

Mrs. Betty Sweet of Las Vegas: Don't sell the seniors out to big business HMOs. The HMO plan will be a step down in our care.

Martha Pruter of Reno: This plan is only going to benefit the pharmaceutical companies. It will not benefit consumers.

Mary Ann Brim of Henderson: I oppose the Medicare bill. Has anyone done the math? I can't believe they would support this bill if they had. Certainly you can come up with something better than this.

Now, these people, Mrs. Brim in particular, actually did their homework on the math. The actual drug benefit created by this bill is confusing and offers seniors only a meager drug benefit. Someone who spends approximately $5,000 a year on drugs will be stuck with almost 80 percent of the bill.

People have come to me and said: Vote for this. Nothing is going to kick in for a couple of years. You are protected. You can talk about the benefits of this bill. Maybe they are right. But in a couple years I would look back on this vote saying, I didn't do the right thing because thousands of retirees in Nevada will lose their coverage as a result of this bill.

In Nevada, tens of thousands of seniors stand to lose their current retiree drug benefits. The Nevada senior prescription program that Governor Guinn of Nevada tried, it was one program, and nobody even signed up for it. He has one now that is good, people like it, and we don't know what is going to happen. We don't know what is going to happen to this program.

We heard the distinguished ranking member of the Finance Committee, Senator BAUCUS, talk about demonstration projects, six of them. We could get as many as three of them in Nevada. I don't think we should be used as guinea pigs in an ideological experiment that would force them to give up their doctor and join an HMO or pay higher premiums to remain in traditional Medicare. Those who opt for private plans would have to use a doctor approved by the insurance company in these areas. Over time the seniors who remained in the traditional fee-for-service Medicare would likely be the oldest, the sickest, and the poorest. They would have to pay an ever-increasing premium to maintain their coverage.

This bill would make a wide range of seniors worse off than they are today, from seniors who are eligible for Medicaid, seniors who have coverage through former employers, seniors enrolled in State pharmacy programs, to seniors who will be forced to pay higher premiums to stay in traditional Medicare. That is not the type of prescription drug coverage our seniors deserve. It is fool's gold.

Many of my colleagues support this bill because they like the concept of competition. I like competition, too. But I am in favor of competition where there is a level playing field. This bill does not provide for fair competition.

This rigs the rules in favor of private insurance companies by paying them off to serve a patient whom Medicare would also take care of without the additional incentive that these companies get. It siphons off $12 billion that should be used to help our seniors. It pushes it off into a fund for private insurance companies. That is why we have read in all of the papers around the country that the insurance industry is wild about this legislation. The pharmaceutical companies are wild about this legislation. They wiped out the reimportation we had in our bill, something that went to the House, where we could reimport drugs which are much cheaper in Canada. That is eliminated, and that is too bad. It was a concept that both the House and the Senate approved. This is something that is hard to comprehend.

This bill even says that when Medicare becomes the largest purchaser of prescription drugs, it is expressly forbidden to negotiate prices with the drug companies. That is why we want these large purchasers of pharmaceuticals, so they can go to the drug companies and get lower prices. In this legislation, they are forbidden from doing this. If we really believe in a free market, why shouldn't Medicare also be able to bargain for good prices? It is no wonder big insurance companies and big drug companies are spending millions of dollars on lobbyists and ads to support this bill.

I have to say they have done a good job. I want everyone to know that the drug companies and the insurance companies have spent their money well. Because the lobbyists have really done well by them, this bill is a dream for the insurance industry and the big drug companies. It tilts the playing field in their favor at the expense of senior citizens. That is not competition, it is corporate welfare.

This bill is not what it claims to be, and seniors are smart enough to see this bill for what it really is, fool's gold. Betty Sweet, Martha Pruter, Mary Ann Brim, they all did their homework and understand that this legislation is not good.

As I have indicated, the actual drug benefit created by this bill is confusing and offers seniors only a meager drug benefit. It is a poor trade when you spend approximately $5,000 a year on drugs and you will be stuck with 80 percent of the bill. When we talk about a pharmaceutical benefit for Medicare, people think they are going to get the drugs at a reasonable price.

The Medicare conference agreement would make fundamental changes to Medicare as we know it, changes that have nothing to do with a prescription drug benefit or building a stronger foundation for the program. It would use our senior citizens as guinea pigs to test the theories of Newt Gingrich and other ideologues.

Am I off base on this? I carry this with me because I have used it on a number of occasions, and now it is kind of withered and dilapidated. I have seen Newt Gingrich, with whom I served in the Congress—a fine person. I like him. I think he has a great mind. And he has been able, with his great mind, to do some things with which I don't agree. But I have here some statements made by leaders. I believe their whole concept is what is behind this legislation.

First of all, this is Senator Bob Dole's direct quote:

> I was there fighting the fight—
>
> He was 1 of 12 against Medicare—
>
> because we knew it would not work in 1965.

He and many colleagues believed it would never work. Senator Dole was 1 of 12 who voted against it then.

Former House Speaker Newt Gingrich, said:

> Now, we didn't get rid of it in round one because we didn't think it was politically smart, but we believe Medicare is going to wither on the vine.

Former House Member Dick Armey said this:

> Medicare has no place in a free world. Social Security is a rotten trick.

He goes on to say:

> I think we are going to have to bite the bullet and phase it out over time.

Those are direct quotes. I think part of what we have behind this legislation is an effort to have Medicare wither on the vine, and it will be withering on the vine. I think we should understand that this legislation is not what it purports to be; it is not. As a result of that, I believe we should vote against this legislation.

Mr. President, how much time do I have left?

The PRESIDING OFFICER (Mr. ENZI). The Senator has 11 minutes.

Mr. REID. Mr. President, I yield that time to my colleague from Nevada, Senator ENSIGN.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, I want to talk about one Senator's journey through this bill, trying to make a decision based on the facts and trying to get through the rhetoric, because there is a lot of that going on in any piece of legislation. So I am trying to write down the pros and the cons of this legislation and go through them in a systematic fashion and try to make a decision based on policy and not based on politics, a decision based on what is in the bill, not on what people are saying is in the bill.

As I have gone through this, I have a whole list of general principles that I believe are good. I have still not made up my mind on this final piece of legislation because it is really a balancing act. There are good things and there are things that are not so good. Just to mention a few of the things that I believe are good in this bill, probably the best thing is something called the health savings account, which has nothing to do with Medicare today. It has to do with reforming the overall insurance system in our country for health care. It is something I have been fighting for, for many years and introduced legislation on when I was in the House of Representatives on the Ways and Means Committee.

We passed it several times, but unfortunately, when we passed the final version, we had to water it down so

much that we enacted a piece of legislation that did not work. So the health savings accounts in this piece of legislation, I believe, are going to be one of the most significant reforms we can possibly enact for the future of bringing the patient back into the accountability loop. When you have a third-party payer system—what I mean by that is the person receiving the care doesn't directly pay for the care; it is a third-party payer system.

So when you walk into a doctor and the doctor says we need to run this test and that test, the person doesn't even say how much do those tests cost or is there a cheaper place to go get an MRI, for instance, or is one place better or cheaper or is a certain specialist better than others or is one cheaper than others, and maybe of the same quality—none of those kinds of discussions happens because they are not paying the bill. The health savings account allows them to put money into an account tax free. It builds up in the account tax free, and when it is taken out for health care expenses, it is taken out tax free. Then that person directly pays the doctor.

Now, why is that significant? It is significant because in our current system, whether it is traditional Medicare fee for service, or even the HMOs or the PPOs, all the payments go through some kind of bureaucracy, whether it is a Government bureaucracy or a private one. Anybody that has experienced our health care system today knows that maybe companies are not trying to deny payment but it certainly seems like that in a lot of cases.

My in-laws are dealing with this right now. My father-in-law had cancer last year. They have been battling for almost a year now on whether the insurance company should pay for a large part of their coverage or not. That takes a lot of time for people to process, to answer phones, go through the whole process. If somebody is paying out of their own pocket to the doctor, none of these conversations has to take place, and that money that is saved through the bureaucratic process can go directly to health care. I believe health savings accounts are one of the most positive things in this bill.

Mr. President, will the Chair please notify me when there is 1 minute remaining?

The PRESIDING OFFICER. The Chair will do so.

Mr. ENSIGN. Second is the means testing idea of Part B, the affluence testing, as it is being called. I think it is wrong. This is not a part of Medicare where people are paid in their taxes over the year. Part B is something that younger generations—such as the pages we have here—people paying taxes out there are paying for seniors, and we should, at least for those wealthy seniors, have them pay for that benefit they are getting, instead of shifting the benefit on to middle-class taxpayers. That is also very good.

Another part that is good in the bill is this idea of a disease management pilot project. Right now in Medicare, you go to one doctor and Medicare pays, and maybe you have diabetes and you have to go to several specialists, internists, or whatever; there is nothing really coordinating care. So you get different prescriptions and different doctors. There is no real coordination of care and also not a lot is being done preventively. So we end up with poor-quality care, poor outcomes, and we spend more money.

We have a great demonstration project, a pilot project that Republicans and Democrats actually should like in this bill on the disease management part of it. In the future, I believe it will improve outcomes for seniors healthwise, and it will also save costs.

As to some of the negative parts of the bill, first of all, it does not kick in right away. A bill that I introduced would have kicked in as soon as the drug discount card kicks in. That is the only thing that really kicks in, in the next 5 or 6 months—the drug discount card. The legislation I had introduced actually would have fully kicked in. The Democrat bill and Republican bill we had debated, none of those kicked in right away, and neither does this bill.

The other problem with this bill is there is a cliff at 150 percent of poverty. After that, you kind of drop right off the cliff. So for those below 150 percent of poverty, this is too generous. With a $1 and $3 copay, we are going to incentivize people to overutilize drugs, pure and simple. You are going to see overutilization of drugs. We see it in Medicaid today because of the low copays and we are going to see it here. That was a huge mistake that we didn't once again have people receiving the drugs having anything financial at stake. And $1 and $3 copays will not change behavior in any way whatsoever.

The other thing that actually we have to consider—and we should at least go into this with open eyes—this is the largest wealth transfer since Medicare was first put into effect. We just have to know that. The $400 billion is being taken from younger people and given to older people. The older people didn't pay for it. We are giving that. So we have to go into this with open eyes.

The other thing I believe is a problem with the drug benefit we have in Medicare is that it is giving it to the wealthy. I don't believe we should be. We should be helping and putting almost all the benefit into the people who are literally having to choose between prescription drugs and rent and maybe whether they are going to eat that month or what kind of food they are going to eat that month.

Instead, this bill gives coverage for everybody on Medicare. I don't believe that is right. When Bill Gates turns 65, I don't believe he should be getting a prescription drug benefit that is paid for by some union worker who worked hard all of their life and paid taxes. I don't believe that is right. So I believe the prescription drug benefit should be means tested. That is another negative in this particular piece of legislation.

Just mentioning a couple of the things, there are some really good pieces of this bill, but there are some major negatives in this bill.

When we are going through all of the rhetoric, I think all of us have to be honest. The supporters of the bill should be honest that there are some problems with it, but the people who are against the bill should also be honest. This does not end Medicare as we know it. This is a bill incredibly generous to low-income seniors. Even if I vote against this bill, I have to say this is incredibly generous to low-income seniors. That is just being honest. All seniors pay out of pocket is a $1 copay for generics and a $3 copay for brand name prescription drugs. That is an incredibly generous benefit.

In conclusion, as I go through this next 24 to 48 hours—whenever we are going to vote on final passage of the bill—it is a 700-page document we got a couple of days ago. I think we have to take our time to go through the bill.

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

Mr. ENSIGN. Taking our time to go through the bill is very wise to do because my biggest fear—and we see this happen with legislation all the time—when we have this kind of complexity in a document is the law of unintended consequences.

We enact bills all the time. When we enacted HIPAA—and the majority leader is on the floor and he knows better than anybody—the HIPAA law is a terrible piece of legislation, and we are suffering consequences today. We are driving up health care costs unnecessarily because of that legislation. That is why I am still trying to go through this legislation to make up my mind.

I thank my colleague, the senior Senator from Nevada, Mr. REID, for yielding me the time to speak tonight. I look forward to hearing the majority leader's comments on this legislation as I am still battling through what I am going to do on it.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, I will be speaking for about 30 minutes. I ask that the Chair notify me when I have used 25 minutes.

The PRESIDING OFFICER. The Senator will be notified.

Mr. FRIST. Mr. President, we are at a truly historic time. A lot of times we exaggerate a bit to make a point. It seems as if on every bill somebody says: This is a historic bill.

As a physician, as someone who has had a great privilege in life, a blessing in life to have served as a physician and to have taken an oath to serve humankind in such an intimate and personal way, I truly believe it is an historic time because with the action we are almost certainly going to take tomorrow night, we are going to change

the lives of 40 million seniors and also 77 million baby boomers who will be seniors over the coming years by this single piece of legislation.

It is rare we can say that. It is so rare. Everybody gets sick at some point later in life—everybody. If it reaches a certain threshold, you seek medical care. This bill will affect the type of care you receive, whether or not you have appropriate access, the quality of that care, and the response of the type of care that is given to you. That is why I say it is a historic bill.

I am confident we will pass this bill tomorrow night. I know there are a lot of statements that have been made: We are going to obstruct; we are going to filibuster; we are going to use procedural moves. But at the end of the day, nobody from this body, I believe, can go home and say—when we are an eyelash away, after 6 years of hard work of trying to put together the very best bill possible—that we would go home having denied the President, with the leadership he has shown, and the House of Representatives, with the leadership they have shown, and the hard bipartisan work on this floor, and then tell seniors: It is not going to happen. Once again the promises that have been made have been denied you.

Why do I say that? That is the question I wish to answer over the next few minutes.

I want to start from afar and then come down to some of the specifics of the bill and paint a picture, paint a portrait that I think helps, at least in my own thinking, to explain to the American people why this is a pivotal time, why we have to act now, why we can't wait another year or 3 years or 5 years, why at this moment in history events have come together in conversion. There is a reason, and when we act, we will have a much more dramatic impact in improving health care and improving health care security than if we were to wait.

In 1965, Medicare began. I didn't start practicing medicine until the eighties, but through that period of time, it is just amazing. We have seen health care advances that are remarkable in terms of medicine, science, and technology. The half-life of medicine—that is a statistical way of looking at medicine and advances. It got smaller and smaller and smaller and smaller because of our knowledge and understanding. Advances have been made in both health services delivery—that is how health care is delivered and how it is organized—as well as scientific and technological advances.

I am going to show three graphs using this same format. On this Y axis is change. It is fairly arbitrary in describing change, but it is improvements, it is how things change over time. Along this X axis, it starts in 1965 when Medicare started and ending in the year 2005, as we project ahead.

We can see this change came along pretty steadily, and all of a sudden it started to go up, up, up, and I would put it way up off the chart. That is where this change is going.

The first successful heart and liver transplant was in 1965. That is a fascinating history. That is the field I ended up going into, heart transplant surgery.

Coronary angioplasty, when people have drug-eluting stents, and we hear about it all the time. It wasn't that long ago. That was just in 1977. We had the first open heart surgery cases in the 1960s.

In 1974, the HMO Act was passed in this body. Prozac, a drug many people are on today, was first used in 1988. It is interesting, when the PPOs—and I will talk more about PPOs shortly—began in 1985, 1 million people were enrolled. Within 13 years, 90 million people are enrolled in these PPOs.

We had the human genome project, a fantastic project which just finished this year. It was a successful public-private partnership. This chart shows all the advances. The point is, these advances are getting faster and faster.

The next chart uses the same format, but it shows what Medicare has done. Has it changed as well? Medicare has not changed very much. It started in 1965. It was enacted into law in 1965. It is a great program, a fantastic program. I had the opportunity to treat thousands of patients in Medicare. It has given them health care security.

But, contrast Medicare to all the health care advances, and we can see it hasn't changed much over time.

In 1972, it was expanded to include end-stage renal disease and dialysis. That was a a good advance.

There was a good advance in 1985 with prospective payments for patients who are actually in hospitals. It was pretty revolutionary at the time.

We have had people refer to catastrophic coverage. Notice line went up and went down because catastrophic coverage was repealed. A lot of people said: Is this bill going to be repealed? If I have time, I will comment on that because there is a clear answer to why that is different.

There were prospective payments for physicians 1990. In 1997, we added the Medicare+Choice Program and other prospective payments.

Now we are in 2003. And tomorrow night are we going to improve and change Medicare in a positive way. People say you can change Medicare and that is bad. That is not bad; that is good.

We are going to strengthen and improve Medicare, and that is the whole purpose. The next chart shows very clearly the advances in technology go on up, but Medicare is too rigid. It does not change. We are not capable of changing the structure of Medicare fast enough in this body and therefore that rigid structure cannot adapt to new drugs, new pharmaceutical agents, new ways to deliver health care, new types of PPOs. We just do not change.

So the gap, is what we are addressing. If we do not pass this bill tomorrow night or tomorrow afternoon—the sooner the better on my part—I think we are not going to fill this gap, and we are going to be stuck down here when all of these advances are up here and these advances are being denied seniors.

That is why when people say ''filibuster,'' use procedural moves to stop this, do they mean they want to stay down here when we have the opportunity, to catch up and let these health advances be delivered to our seniors? So that is the way I think about things—in terms of what is at stake.

I do not think anybody can defeat this bill and go home from here. They cannot face 40 million seniors and say we are not going to give them the advances that are available to the rest of the world. It is not right, if that is the case.

Now, why today? I have heard from the other side of the aisle again and again: Let's do it next year, 2 years from now, 3 years from now.

It is because we have this earthquake, or this mountain, moving towards us, defined in 1945 by the baby boomers. This is a fertility curve. We know after the war, fertility went up 3.5 births per woman. Then it fell back down. This is moving through the system to the point that in about 2008 or 2010, this curve will begin to move through the Medicare program as these baby boomers age, beginning in about 4 to 5 years.

When they hit the system, what happens is potentially catastrophic if we have not prepared the system for that.

To explain that, I will use the following several charts. No. 1, let's say I am the Medicare system right here. I have seniors who are taken care of over here, and I have people who are paying—that is all the working people today—to support the Medicare system which takes care of these seniors. Well, what is happening is we are having a doubling of the number of seniors because of the baby boom. So the population is getting bigger because of the baby boom demographic shift. It is this point in history that it occurs. It was not 10 years ago, and it is not 30 or 40 years from now. It is beginning right now. We have a doubling of the number of seniors.

At the same time, because there is a big curve moving through, we have fewer people working to pay. So we have fewer and fewer people paying the health care of more and more people over time because it is a pay-as-you-go system. The people supporting the system today are the people working today.

I will show my colleagues graphically exactly what I said. Medicare enrollment—that is the number of seniors over 65 years of age—in 1970 it was only 20 million. What is important is that there are 40 million people today, but because of the baby boom—look at this curve going up—we are going to have twice that in 2030, right at 77 million, this chart says, but it will be right at

80 million. So we have a doubling of the number of people we are going to be taking care of over the next 30 years.

What about the people who are actually taking care of each one of those? In 1970, there were seven people over here working to take care of every senior, but because the fertility curve is moving through in the year 2000, it was about four people working. So for every person working to support one, they are having to work a lot harder. There are fewer people. Instead of seven working, four are working for each one.

What is even worse is that over the next 30 years, instead of four people, it goes to two people. So they are going to have to be working twice as hard for every one person that is benefiting. Yet we have twice as many people who are benefiting. That is the challenge that we have and that is the reason for ''why now.'' That answers the question as to why we should do it in this Congress. We should have done it 2, 4, even 6 years ago. If we do not do it now, it is too late.

That is the reality of Medicare. So people say, why do we not give a drug card and leave it at that, take care of a group of people and give them 50 or 70 percent on the card? The point is, that does not address everything that I have said to date. It does not address the challenge of having a rigid, inflexible, outdated, antiquated Medicare Program, and that is why not just a drug card, though a drug card is important, and I will come back to that. But that is why that is not the answer.

A lot of people say we should not be spending $400 billion. They say we should spend $100 billion and take care of the people who need it the very most. But, that approach does not address the fact that we have an outdated system.

I have said on this Senate floor many times the most important tool a physician or a nurse has today to treat a patient is not the surgeon's knife that I used every day. It is not the hospital bed. It is not even the hospital. It is pills. It is medicines. It is prescription drugs.

Why today? Why are we acting today? That was not true 10 years ago. It was not true 20 years ago. But today it is the most important tool a physician has. Yet it is denied seniors in the Medicare Program. Seniors cannot get outpatient prescription drugs through Medicare today. It is the most important part of health care. Yet we deny it to our seniors. That is why nobody can filibuster this bill in good conscience because we are denying our seniors the most important tool in medicine today.

Tomorrow, after we pass this bill, since it has been passed by the House, and the President is going to sign it, for the first time in the history of this Medicare Program we are going to have the most important part of health care as a tool. The most important tool in a physician's armamentarian is prescription drugs. It is being denied seniors today.

Now, just an example: Cancer, diabetes, rheumatoid arthritis, osteoporosis—there are drugs for all of these diseases. There are 402 drugs right now in clinical development for cancer. So whatever we do, we do not want to destroy the research that is going on in this country. If drugs are the most important part of health care today, we want to make sure that we promote research and development. That is why we do not engage in governmental price fixing, setting prices by Government, because it destroys all of this in terms of research.

NIH does a good job, and we can fund it. We fund several billion dollars through our NIH, but the private sector's contribution to research is many fold what the government provides. So we have to continue to support that private sector research.

So what do we do? Where are we today? Here we go in terms of how we modernize this system, and at the same time address the issue of prescription drugs. How do we marry it? This bill does it in a bipartisan way.

I predict this bill will pass tomorrow with a bipartisan vote. I know a lot of people are bringing partisan issues to the floor and saying we are going to stop it with such things as procedural votes, but this bill is going to pass with a strong bipartisan vote tomorrow.

Again, what are we going to do? Today, a senior right now has a choice. They can stay in traditional Medicare, just like 35 million have, with good care and a strong system. It is antiquated, it is out of date, and it is inadequate compared to other options that people have today. It does not include prescription drugs, for example. Or a senior can go into Medicare+Choice. Five million seniors have chosen to go into Medicare+Choice. They do get some prescription drugs. Prescription drugs are in green on these charts. For my colleagues who are in the Chamber tonight, they can see the green.

So seniors can get some prescription drugs, but there are no prescription drugs in traditional Medicare today.

No. 1, I mentioned the drug discount card. In this legislation, maybe 6 or 8 months from now, after we pass this bill and the President signs it, seniors will have access to a drug discount card. It will last for a 2-year period. What it says is while we are developing this system, they can get immediate relief through a card. This card will allow a senior to go to the local pharmacy and get an additional 20-percent discount. Maybe it is a 10 or 25-percent discount, but however a senior gets the drugs they might get today, they will have an additional discount.

It is voluntary. This word ''voluntary'' is key because everything that we put into this program today in terms of prescription drugs or giving a choice of a health care plan that might better suit a senior's needs is voluntary. They can keep exactly what they have today—and this is important for people who are listening. They can keep exactly what they have today, with no change in their benefits. They might already have prescription drugs so they would not want prescription drugs. All of this is voluntary. It is not mandatory. Nobody is making any senior even make a decision to do anything. They can keep exactly what they have if they are satisfied.

In addition to this discount, there is a $600 value if a senior is low income, less than 135 percent of poverty. The chart I just showed my colleagues was Medicare today. Remember, the senior could choose either traditional Medicare, which 35 million people have, or Medicare+Choice. After this bill passes, we are going to expand the opportunity to choose, so seniors for the first time can choose the health care plan that best suits their individual needs. If you have Alzheimer's you might choose a plan that specializes in Alzheimer's. If you have Parkinson's disease or coronary artery disease or you have had a stroke or you have seizures, there may be plans out there that can best suit your needs that for the first time you will have access to. That is not available in traditional Medicare.

So a senior can choose under new Medicare. Either the traditional Medicare, keep what you have, don't change anything. If you stay in traditional Medicare, for the first time, if you want it—you don't have to take it—you can choose from one of two and maybe three or four drug plans. They will have equal value, but you can have that choice.

People say what if the drug plans don't show up? If they don't show up, there is a fall-back Government plan there. Everybody can have this new choice, but if you don't want to, keep what you have.

In addition, you can choose Medicare+Choice, which are primarily HMOs. HMOs are maligned on the Senate floor a lot. You talk to these 5 million people who are in them, they really like them. But if you want to, you are also going to be able to choose, from a preferred provides organization or PPO or C. There may be five, there may be three, there may be two, there may be one PPO. These PPOs are integrated health care plans. They have disease management. They have this little green down there showing all of them will have access to prescription drugs.

People say sick people may stay here or they may go into here or they may go into here. You don't really know. My heart transplant patients, who are among the sickest patients going in—before they get their transplant they are all going to die. Coming out, they require a lot of medicines. I would encourage a lot of those who are among the most challenging to take care of, I would encourage them to go into these PPOs. Why? Because they can have a health care plan that is tailored to their needs, that is able to respond to infectious disease, acute care, chronic

care, disease management, coordinated care, none of which is available under traditional Medicare. So this is the design. Opportunity to choose all of this. Nobody is forced to choose at any point in time.

Transformational: I won't go through all of this, but I wanted to show this because it is hard as you listen to everybody. Everybody is talking about little pieces. Using the same format, let me show some of the things we do.

In the PPOs, in the choice over here that we are going to give for the first time—I say it is FEHBP-like. What that simply means is we in the Senate have a choice among a group of plans. I happen to take the Blue Cross/Blue Shield plan. That might be one of these plans. But seniors will be able to choose, just like we choose, a plan that might best suit their needs.

These are integrated plans; that is, acute care, chronic care, preventive medicine, coordinated care. You have a choice. You can choose among these plans. There is competition in that these plans will compete one versus the other based on quality, access, and cost. They give the same benefits as traditional Medicare, but there will be competition among those plans based on any of the issues that I just mentioned.

The flexibility: What that really says is that this PPO may be different than this PPO, different than this PPO. It may give a different range of benefits, although all of them will give at least the benefits given in traditional Medicare.

If you look at the drug plans, I have down that they are risk bearing. Risk bearing means the Government itself shares the risk with the plan. That plays into the marketplace. That is the way the private sector works. It captures the dynamism of the marketplace and, over time, and with the element of competition, that can bring the cost of drugs and Medicare down. These are competitively bid. Again, they have the flexibility.

Traditional Medicare: You have heard people talking about income relating, means testing. For the first time, the very rich, the Ross Perots of the world, will no longer have their assistants or their secretaries subsidizing their Part B premiums, their health care. For the very rich, they are going to have to be responsible for more of the subsidy—not all of the Government subsidy for them but more. There is cost containment built in. There are disease management programs that are going to be part of the traditional Medicare.

Quality is going to be rewarded. This is fantastic. I will come back to this if I have time. For the first time, the hospitals, for example, if they report the quality data, they will get their full, what is called, market basket update. The important thing is if they don't report that quality data over time, they are not going to get paid as much. Quality is being rewarded.

It is amazing; as a heart specialist, 50 percent of people in this body are going to die of heart disease, probably. It is higher for women than it is for men. A lot of people don't realize that, in terms of morbidity. More women will die of heart disease than men this year.

Right now there is no screening test reimbursed. Your cholesterol level right now, as a screening test, in Medicare is not reimbursed. Once we pass this bill tomorrow, and it is implemented, cholesterol screening and lipid profiles, preventive tests will be reimbursed for the first time. People say, come on; it has got to be reimbursed today. It is not reimbursed today. That is just an example—prevention.

As to physical exams, people know that is important as a screening measure. A lot of people get to 65 years of age and have never had a physical exam. For the first time in Medicare, everybody is going to have available to them, under Medicare, an entry level physical exam. Before, it wasn't there. It is not there today, but it is going to be there under the bill.

Information technology, I mention that because it has to do with medical errors. Right now we know there are too many medical errors that are being made. We need to facilitate, and adapt information to come into the system and be handled in a way that is consistent, in which the data can be assimilated and reported back. There will be e-prescribing for prescriptions with incentives—not mandatory, but incentives to encourage physicians to be able, instead of writing each prescription and have it go through 10 or 15 different hands and come back where mistakes can be made, by computer it can go all the way through the system where the mistakes are less likely to be made.

It is a complicated chart, but it gives my colleagues the feel for everything that we are accomplishing in this bill—not everything, but how important the various elements of this bill are.

Senator KENT CONRAD in this body is the person who is probably as focused as anybody on this particular issue. I agree with him 100 percent.

How much time do I have?

The PRESIDING OFFICER. The leader has 5½ minutes.

Mr. FRIST. Five and a half. OK. I will move fairly quickly.

The issue is that most people in Medicare today are not very expensive, in terms of their health care. But 6 percent are.

In this body there are 100 people. Not everybody is here right now, but 6 of the 100 people in this body would account for 50 percent of all expenditures in Medicare. That is amazing.

Wouldn't it be great if you could identify which 6 it is, and if you identified them you could focus resources, coordinate their care, get preventive medicine, give them disease management, and that would take care of 50 percent of the cost? In this bill we establish data collection to identify and begin that disease management.

This bill is good for doctors and hospitals. Physicians right now, if we don't do anything today, are going to be cut by 4.5 percent, under current law, as to what they are reimbursed. When we pass this bill, it will increase, instead of being cut, by 1.5 percent.

Hospitals, if they give us the quality data—which they should give do—will get full market basket.

Paperwork: You hear physicians all the time, and hospitals, complain about the regulations and the paperwork. We have significant paperwork reduction in this bill.

Back in Tennessee, the most common request is: What is this bill to me? What does it mean to me?

To seniors, it means a lot. To individuals with disabilities, it means a lot. But in addition, the State of Tennessee, above current law, is going to receive for hospitals, $655 million more; for doctors, $240 million more; and for our Medicaid Program, almost $700 million more, because of this bill.

We hear regarding prescription drug costs that there is nothing in this bill to control prescription drug costs. That is not true. It is simply not true. I encourage my colleagues to read that bill and continue to read it tonight.

We speed generic drugs to the market. All of us know brand-name drugs are expensive. Generic drugs are not very expensive. What we do through this bill and the work of Senator SCHUMER and the work of Senator JUDD GREGG is speed generics to the market in this bill.

We have competition. All the competition, the marketplace dynamics—competition is the only thing we know that over time can slow the growth of, whether it is drug prices or any prices. Price fixing simply does not work. It hasn't worked in Germany, it hasn't worked in England, and it hasn't worked in this country when we tried it in health care. I am going to keep moving here.

Are we helping the people who need it the most, poor people? The answer is yes. Below 100 percent of the poverty level: If you have $100 in monthly drug spending, 95 percent of the cost of drugs is paid for through this plan.

Let's take another example. If you are below the poverty level and you have $500 a month in drug spending, you have 97 percent of all of the costs taken care of by this plan; $1,000, you have 98 percent.

These are the people who need it the most. This plan is generous to the people who need it the most.

In closing, again, I will keep it very short. Hopefully, I can speak for a couple of minutes tomorrow morning.

We are providing access to prescription drugs, the most important tool in medicine today. Seniors don't have it today. They are going to have it after we pass this bill.

This program is voluntary. If you do not want to change anything, if you like what you have today, then keep what you have. Nobody is forcing you to choose. All of this is voluntary.

Private health plan choices: Why? Because private health plans today capture the advances I showed you earlier—coordinated care, disease management, and integrated care. That is what it is in private plans today that is being denied to our seniors. Seniors don't have access to them.

Appropriate reimbursement and regulatory relief to providers, to doctors, to hospitals, to nurses—I just mentioned what the impact is for a State such as Tennessee. Payment linked to quality is not done today. It is not done today in Medicare. For the first time, reimbursement is being linked to quality care.

Lastly, preventive care, physical exam for the first time, if we pass this bill; lipid profile; improvement in mammography screening; chronic care management and disease management.

I know my time is up. Let me close by saying this bill does four things. It strengthens and improves Medicare; it offers prescription drugs for the first time in the history of our Medicare Program; it does it on a voluntary basis; and for the first time in the history of this program it gives seniors access to plans that better suit their needs.

I encourage every Member in this body to vote for this bill.

Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, would you notify me when I have 5 minutes remaining?

The PRESIDING OFFICER. The Senator will be notified.

Mrs. MURRAY. Mr. President, I have been fighting for a real prescription drug benefit for years. In the 106th Congress, I helped draft the MEND Act, and year after year I have used my seat on the Budget Committee to set aside money for a good drug benefit. I voted for several Medicare prescription drug bills, including S. 1 last June and the Graham-Miller-Kennedy bill in the last Congress. I have written and I have introduced legislation to make Medicare more fair to the people of my home State of Washington. I have worked to improve health care for seniors on the HELP Committee, on the Labor-HHS appropriations subcommittee, and here on the Senate floor.

After all of these years of work, no one wants prescription drug benefits more than I do. But I am very troubled by the proposal that is now before us.

I am unhappy at the prospect that this plan could force seniors and the disabled into an overly restrictive health care rationing regime in which they could lose their choice of doctors just to get a pretty meager drug benefit.

I am unhappy at the prospect that this plan could tell our seniors they must give up the good retirement health plan they have worked all of their lives to earn.

I am unhappy at the prospect that this plan could leave our seniors and disabled at the mercy of ever-increasing premiums.

I am unhappy at the prospect that this plan could tell patients who have complex medical conditions they cannot get direct access to specialists they need to see.

I am unhappy at the prospect that this plan could tell patients with MS, or Parkinson's disease, or ALS they can't get the drugs they need because their plan will not cover them.

I am unhappy at the prospect that this plan could tell our rural seniors they will have to roll the dice on how they receive health care coverage because this is not a real choice in their communities.

I am unhappy at the prospect that this plan would tell disabled Americans who are fighting poverty that the drugs they get today can be off limits tomorrow.

I am unhappy at the prospect that this plan would tell seniors if their drugs cost more than $2,300, they won't get a dime of help until they pay $3,600 out of their own pockets.

I am unhappy at the prospect that this plan could break the promise that Medicare has had for our seniors and our disabled since 1965.

This isn't just about plans and formularies and medical services areas; this is about people. It is about our parents and our grandparents and generations of Americans coming behind us.

I have sat down with seniors in my State, and I have heard how badly they need a real drug benefit. Just last August, I met with more than 200 seniors in Edmonds, WA, at the South County Senior Center. They told me in their own words just how important the drug benefit is.

During this debate, I have listened to my colleagues. I have listened to seniors and the disabled in Washington State. I have heard from doctors and hospitals at home. I have read the key provisions in the package, and I have reviewed the Congressional Budget Office estimates. Without a doubt, this is one of the most complex and controversial proposals this Congress has considered.

One needs only to review what happened in the House a few days ago to see how controversial and political the vote was. What occurred during that vote speaks volumes about the failures of this bill and the lengths the majority will go to in order to pass this flawed measure.

At the end of the allocated time for that vote in the House, the bill had been rejected. But the majority leadership refused to close that vote. They held it open for many more minutes, and those minutes turned into hours, and finally at about 6 o'clock in the morning, after holding that vote open for 3 hours, the majority managed to pressure a few Members to switch their votes.

An issue this important deserves a thorough debate. I am troubled that it appears as though this bill is being railroaded through Congress on twisted arms and backroom pressure.

When I look at Social Security and Medicare, I don't just see a program, I see a promise. It is a promise from one generation to the next. It is a promise from our Government to our seniors. And it is a promise that reflects our values.

Coupled with Social Security, Medicare is the most important antipoverty program ever. In fact, before Medicare, in 1963, 44 percent of our seniors were uninsured. Today, it is just 1 percent. In 1966, 29 percent of seniors lived in poverty. Today, it is down to about 10 percent. Since 1960, life expectancy for those over 65 has increased by 25 percent.

Medicare is a success story. It promised our seniors that they will have health care security, regardless of their ability to pay, regardless of where they live, and regardless of their medical condition.

Not only has Medicare helped seniors, but it forms the foundation of all of our health care. Medicare helps train our doctors. Medicare payments help keep our rural hospitals open. And Medicare helps keep emergency rooms and neonatal units operating. Medicare is open to every doctor and every hospital. It doesn't force providers into restricted networks. It lets doctors make decisions based on what their patients need—not on some mandate from some accountant.

It is troubling to think of what rural America would be today and whether inner-city trauma centers would even be in existence today without Medicare.

Let us not forget the reason we created Medicare in the first place. The market failed our seniors.

I approach this debate with a clear understanding of the importance of Medicare to our seniors and to our entire health care system. When I look at this bill, I want to know what it means to the seniors I represent. So far, I have found five big dangers for Washington State seniors.

First, this plan jeopardizes the health benefits retirees have earned during their working years. In Washington State, 47,250 seniors could lose their retiree health benefits. In return, they get much less coverage and they will pay for more than they had planned.

This plan is an unpredictable benefit that requires huge out-of-pocket costs and has massive gaps in coverage. This bill changes the ground rules on seniors in the middle of their golden years, and that is just not right.

Second, seniors could be forced into an overly restrictive health care rationing regime if they want a drug benefit. On paper, it looks as if seniors have a choice. That is what the proponents keep repeating. When we take a closer look, we see what is going on. Supporters claim that seniors can stay in traditional Medicare, but that is

only if insurance companies decide to offer drug-only plans. They could offer drug-only plans, but the affordability of those plans is unknown and unknowable. That is because there is no limit on how much a plan can charge, so seniors will not be protected from price gouging.

On paper it may look as if seniors get a choice, but in reality many will face a new system that rations their health care in exchange for a very small drug benefit. Seniors could get fewer choices and less coverage than they have today. They will face fewer choices because of an imposed system of rationing that may not let them pick their own doctor, and they will have less coverage because the plans they will be forced into do not need to cover every drug that is medically necessary.

Third, if you get a chronic, life-threatening disease such as cancer or AIDS, you are not guaranteed the drugs you need. Here is what one client of The Lifelong AIDS Alliance in Washington State had to say:

> The current bill as it is written will affect me personally as it limits the drugs I can have access to because it only allows for up to two drugs under the prescription part of the bill. Since I am on a multiple-drug regimen, I will not have access to the other life-saving drugs that I will have to take to stay HIV healthy.

Those are the chilling words of one of my constituents who is HIV positive and understands what this bill will mean for him. That is why AIDS service providers in my State oppose this bill.

In addition, if you need access to a clinical trial, forget it. This bill does not require any plan to give you access to experimental treatments.

This plan will mean fewer choices and less coverage for millions of seniors.

Fourth, this bill is especially bad for seniors and disabled Americans who are fighting poverty. Today, about 6 million Americans are eligible for both Medicare and Medicaid. Through these two programs, they get the coverage for the drugs they need. But this new bill we are looking at strips away what is known as wraparound coverage. In Washington State, that means about 92,000 people will get less coverage than they have today. That is just in my State. Those are the most vulnerable among us, the very people Medicare and Medicaid were designed to protect.

Fifth, there is a huge gap in coverage. Many seniors will see a big hole in their coverage. Payments will not stop. What you have to pay will not stop, but your coverage will. If your drugs cost you more than $2,250 a year, you will get zero help until you spend a total of $3,600 out of your own pocket. You get no coverage, but you still have to pay the premium.

When you look at what the average Medicare beneficiary spends for drugs, this coverage gap gets even worse. According to the Kaiser Family Foundation, in 2003, the average Medicare beneficiary paid $2,322 for prescription drugs. If you spend the average, you are already in the coverage gap. Those figures were included in the Los Angeles Times article that appeared in the Seattle Times on November 21. They show that the average senior will end up with a gap in coverage from which few seniors will ever emerge.

When I ask, what does this bill mean for the seniors I represent, I am pretty troubled by the answers. I am troubled this could force 47,000 seniors in Washington State to give up the retiree health benefits they have worked for their entire lives. I am troubled this could force seniors in Washington State into overly restrictive health care rationing, to get a limited drug benefit and to lose their choice of doctor. I am troubled this could force patients with cancer, AIDS, and other life-threatening diseases into a system that will deny them the drugs they need. I am troubled this could force 92,000 low-income seniors or disabled Washingtonians out of Medicaid into a market where they lose access to the drugs they get today. I am troubled this could force millions of seniors into a coverage gap where they have to spend more than $3,600 out of their own pocket without getting coverage or benefits.

This bill is also bad for Washington State in seven ways:

It could result in unequal benefits throughout Washington.

It could force providers and seniors to reevaluate their participation every single year, and they will get very little in return for that added unpredictability.

It could encourage seniors who are healthier and financially secure to leave traditional Medicare.

It could undermine Medicaid in Washington State.

It could require my State to send to the Federal Government a very large chunk of the savings it realizes.

It could force Washington State to manage new bureaucracies to test the assets of seniors in my home State.

And it could put Washington State even further down the list in Medicare reimbursements per beneficiary.

Let me walk through how this program would work to show how it is bad for my home State. Under this plan, the country will be divided into as many as 50 regions. States such as Washington could be divided into as many as three regions. Within these new, undefined regions, private insurance plans would be able to run the Medicare Program—not just the drug benefit, but Part A and Part B of the Medicare Program as well.

Washington State will be an attractive market for the PPOs and HMOs because we have areas that are healthier and wealthier and a tradition of health care delivery.

Currently, Washington State has one of the highest Medicare+Choice participation rates in the country with 18 percent of Medicare beneficiaries receiving Medicare through a Medicare+Choice plan.

Washington State also has a long tradition of managed and efficient care, so we will be a prime target for the new PPOs and HMOs. That means Medicare benefits in my State, just within my State, will vary from region to region and county to county depending on where you live. In theory, seniors in my home State may have more choices, but they give up a guarantee of a defined benefit.

Providers in Washington State could also face the same changes and uncertainty. Every year, seniors in Washington State would have to evaluate each insurance plan to find the one that best meets their needs.

Here are some of the things seniors every year in my State will have to figure out. While not knowing what medical conditions they may confront, they will have to figure out how much they have to pay out of pocket. Without knowing what their future holds, they will have to predict what providers they will be able to see. Without knowing, they will have to figure out what doctors have dropped out of their plan or may drop out, what restrictions will be on drug coverage, what their copayments will be, what plan formulary includes expensive new drugs, what hospitals are in their network.

That is an awful lot to figure out, especially since health plans, as we all know, are never written in plain English and no one knows what medical conditions they may confront in their future.

Today, Medicare provides predictability. An 85-year-old woman in her home knows what Medicare provides. Under the Medicare+Choice plan, seniors got more than they gave up.

I do want to state there have been some managed care success stories in my home State. We have some great providers in Washington State that led the way in providing innovative, comprehensive care that puts the focus on patients, not profits. But overall, we need to think how this plan would expand the Medicare+Choice model.

Medicare+Choice has worked only in limited parts of Washington State. A total of 131,391 seniors in Washington State participate in these plans. But they are not open to all seniors and they are limited to a very few select regions. Even in this limited program, we have seen significant changes and instability just within Washington State. I am not at all convinced this is a model we should now expand for all seniors and disabled.

If these new plans that are coming in attract higher income, healthier seniors, we need to ask, what will be left of traditional Medicare? I am afraid traditional Medicare will begin to look more and more like Medicaid.

The prospects for this plan are deeply troubling. They could have a massive financial impact on Washington State.

I will turn to how this plan will affect Washington State and its Medicaid Program.

I received a letter from the Democratic Governors' Association. It is signed by three Governors, including Governor Locke of Washington.

Mr. President, I ask unanimous consent that letter be printed in the RECORD at the conclusion of my remarks.

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

(See exhibit 1.)

Mrs. MURRAY. Mr. President, the Governors' letter urges Congress to give the States time to determine the impact on their Medicaid programs before enacting sweeping changes in how we treat Medicaid beneficiaries and how States pay for coverage for low-income seniors and the disabled.

So under this plan, if States save money by shifting drug costs from Medicaid to Medicare, States have to give a portion of those savings that they get back to the Federal Government every year.

Many States, such as Washington, have stepped up to the plate and have tried to fill the gap in Medicare by providing affordable, comprehensive prescription drug coverage through Medicaid for people who are eligible for both programs.

Over the past 10 years, as drug costs have rapidly increased, this burden has become overwhelming. Many States are now being forced to scale back their coverage in access.

In 2002, Washington State spent an estimated $212.8 million on drug costs for people who are eligible for both Medicare and Medicaid. That was a huge strain on my State.

Under this plan we are considering, the States will see some relief by shifting Medicaid beneficiaries to Medicare for drug coverage. But, unfortunately, the plan gives with one hand and takes back with the other.

Washington State, under this plan, will be forced to surrender much of the savings it sees back to the Federal Government. That could reduce Washington State's Federal Medicaid dollars by almost $2 billion from 2006 to 2013. That could devastate the entire program and result in further Medicaid reductions for low-income children and families. It could force the State to again implement reductions in provider payments for doctors, hospitals, and nursing homes.

A $2 billion give-back, just for my State, will mean more uninsured, lower provider payments, and more children losing any health care safety net they have today.

Let's not forget that States will be handed a massive new administration burden under this plan. Washington State will now have to administer new asset tests to determine who qualifies under Medicare for low-income assistance. These tests are extremely restrictive and will result in many low-income seniors being pushed into higher income categories.

Under the conference agreement, assets will be limited to $6,000 for a single person and $9,000 for a married couple.

In order to get any additional financial assistance under this plan, many seniors and the disabled will be forced to impoverish themselves and give up almost everything they have worked so hard to earn. Even if the States want to provide a more humane benefit or assistance, they will not be allowed to do so.

Now, many of us fought to provide relief to States just this year by temporarily increasing the Federal Medicaid match. This was a critically important fight to save Medicaid and prevent massive Medicaid cuts on doctors and hospitals. Our success in achieving a small measure of relief is now being undone by imposing an even greater burden on the States.

Finally, Mr. President, this bill will punish Washington State even further in Medicare payments. For several years, I have been working to address the geographic disparities that punish providers and seniors in my State of Washington. For years, Washington State has received unfair treatment.

Today, Washington State ranks 41st in the Nation in Medicare payments per beneficiary. We are being penalized because we have a tradition of low-cost, efficient health care, and healthy seniors. Medicare should reward that. Instead, its outdated reimbursement formulas are causing doctors to leave my State or close their practices to new Medicare patients.

I have spoken at great length on the Senate floor before about this, and I have introduced legislation to correct that inequity. But under this bill, the situation would be even worse.

Washington State would fall from 41st in the Nation to 45th in the Nation. Even though there will be a slight increase in payments to Washington, because of what happens to other States, we end up falling even further behind. This is a fundamental shift in the Medicare entitlement, in exchange for a very weak benefit.

Philosophically, this plan goes in the wrong direction. We should be strengthening the foundation of Medicare, not experimenting with imposing a new health care system on seniors.

This plan undermines the role of the Federal Government in ensuring that every senior can live with the dignity and respect and stability they deserve. It could force seniors into an overly restrictive, ever-changing health system.

Let's not forget why Medicare was enacted in the first place. It was created because the private insurance market failed seniors and the disabled. Coverage was sporadic, expensive, and unpredictable. Medicare, when it was enacted, changed all of that for our Nation's seniors. Now I am afraid we are flirting with that original failed model. I believe we can do better.

During my time in the Senate, I have been proud to work on prescription drug coverage—from helping to draft the MEND Act in the 106th Congress to working on the Budget Committee over the past 4 years to fund prescription drugs.

I was proud to support the Graham-Miller-Kennedy bill in the 107th Congress that would have provided an affordable, reliable, comprehensive prescription drug benefit as part of Medicare. We had a chance to do much better.

I believe a prescription drug benefit ought to be a seamless part of Medicare. It should be treated just like a doctor's office visit or an outpatient surgical procedure.

By implementing a seamless, affordable benefit as part of Medicare, as we did when we added the Part B benefit, we would guarantee that all seniors have access to the same level of care, regardless of their health status or their age or their income or their assets or where they live. That access would be stable, and it would be predictable.

I know we can do this. Many of us in this Chamber, on both sides of the aisle, have worked to significantly boost our investment in NIH funding. We have fought to reform and modernize the FDA to ensure timely approval of new, lifesaving drugs. I want all of my seniors and disabled constituents to benefit from those kinds of investments.

Under the plan before us today, I cannot be sure they will reap the rewards of this Federal investment.

The PRESIDING OFFICER (Mr. GRASSLEY). The Chair is responding to the request that the Senator be notified when she has 5 minutes left.

Mrs. MURRAY. Thank you, Mr. President.

Mr. President, we should be on the floor today debating a prescription drug benefit package, not a proposal to radically alter Medicare. This should be a fight about providing good, affordable, stable coverage, not about experimenting with Medicare.

I do want to thank my friend and colleague, Senator BAUCUS, for his efforts. I know he worked hard to do the best he could. Senator BAUCUS understands the importance of Medicare for seniors and the disabled, and I know he fought against incredible odds. He was sitting across the table from Members of Congress who tried before to privatize Medicare, and many who still hope to turn Social Security over to Wall Street. He faced an impossible task.

I know he did all he could, and I thank him for his fight.

Mr. President, I do want to note there are some things in this bill that I fought for that are important.

It does prevent additional cuts in payments to doctors who are scheduled to take effect early next year. The scheduled reduction of 4.5 percent, as we all know, is unacceptable. I worked hard to prevent that scheduled reduction of 4 percent in 2003, and I do applaud the conferees for meeting our demands on this issue.

The package also provides additional relief for rural hospitals, home health care agencies, and rural health care providers. This relief is truly a life line

for saving rural health care. I have always supported these provisions, and I will continue to fight for fair and equitable rural payments.

I can promise health care providers and patients in my home State that regardless of the outcome of this legislation, I remain committed to stabilizing Medicare payments.

Now, Mr. President, I know many organizations representing doctors and hospitals think we can come back in 2006 and correct the mechanisms in this bill that undermine Medicare. That is a pretty dangerous gamble. Not only that, but we don't know what the people who put this bill together will demand down the road in exchange for changes—premiums support or vouchers for States; larger gaps in coverage; more copayments; more restrictions on access; more deals on the House floor in the middle of the night?

We do not know what the pricetag will be to undo the damage that this bill will impose. I assure everyone, it will not be easy.

I had looked forward to the day when the Senate would pass a Medicare prescription drug benefit. That day is upon us, but I believe that the price of this benefit is far too high.

In the coming months and years we will see the theory behind this bill put to practice. As more and more people discover what this bill and this President have done to their health care, I am confident we will hear from seniors as we have never heard before.

This is a difficult decision. The $400 billion in this bill does represent a step forward. The provider payments contained in this bill are needed in my State, and seniors deserve the prescription drug coverage they have been asking for. Passage of this bill and being signed into law is not the end of the story. A tremendous amount of work will be required to fix the deficiencies in this bill. I will be there, as I have been all these years, working the best I can to do the right thing for the people I represent in my State and the people across this country.

I yield the floor.

EXHIBIT 1

DEMOCRATIC GOVERNORS' ASSOCIATION,
Washington, DC, November 21, 2003.

MEMBERS OF THE U.S. SENATE,
U.S. Capitol,
Washington, DC.

DEAR SENATOR: As you know, the near 700-page Medicare reform bill was unveiled yesterday. As a consequence, states have not thoroughly reviewed the language or seen individual cost estimates needed to make an accurate determination of its benefits and/or costs. Late yesterday, the Congressional Budget Office (CBO) released numbers portraying a net savings to states of $17 billion over ten years. Notwithstanding this projected rosy scenario, neither CBO, nor any other independent entity has completed a state-by-state impact analysis of this legislation. Even CBO is projecting that states will be $900 million in the red in the first year of the Medicare's program implementation in 2006. States need to ensure that their reading of the legislation confirms that the projected new state costs have not been underestimated by CBO.

With this in mind, we urge you to reject any effort to vote on this legislation before you know its full content and cost impact on your state and the people we both serve. To this end, CBO estimates on Medicare reform impact and expedited state reviews of the direct and indirect cost/savings impact from this legislation must be done and fully disseminated. Any rush to judgment, without this information, may have both short and long-term consequences that could prove to be irrevocably severe.

Early in the deliberations of the Medicare reform conference, governors were advised that at a minimum, the conferees were committed to ensuring that states would face no new costs as a consequence of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This commitment was made for each and every state, for each and every year, of the ten-year budget. For this reason, we are writing to urge you to not vote on this legislation until it is absolutely clear that this assurance has been upheld.

In recent days, there have been reports that the new administrative and other indirect state costs of this program—combined with the bill's exceedingly high ''claw-back'' of state savings—would more than exceed any Medicare savings for many states. Such an unacceptable outcome would be in addition to another misguided policy, reportedly seeking to mandate states and the territories to permanently pay 75 percent of the current Federal prescription drug cost-shift to states. In 2006, the first year of the bill's enactment, states would have to pay 90 percent of these costs.

Some have already suggested that this is a poorly crafted bill and in the long run it would do more harm than good to the very population it was intended to benefit. Although some states are witnessing a small increase in revenues, most states will continue to experience budget shortfalls for the current fiscal year. Some analysts believe that the overall shortfall will likely be $25 to $40 billion. With the continued sluggish growth in state revenues, any increases in state costs imposed by this legislation would be yet another unfunded federal mandate, creating additional pressure on states to cut essential programs and/or raise taxes.

Similarly, any permanent continuation of the Federal government's prescription drug cost-shift to states runs counter to existing National Governors Association (NGA) policy that, ''if Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states and territories'' and establishes a damaging precedent.

Sincerely,

GOV. GARY LOCKE,
Washington, DGA Chair.
GOV. TOM VILSACK,
Iowa, DGA Vice-Chair.
GOV. BILL RICHARDSON,
New Mexico, DGA Federal Liaison.

The PRESIDING OFFICER. The Chair recognizes the Senator from Wyoming.

Mr. ENZI. Mr. President, as we all know by now, the Medicare conferees have reached agreement on the most significant changes to the Medicare Program in history. I thank the Presiding Officer for the hours he has spent working on this, the agony he has gone through at understanding and reaching agreement with this diverse body of Senators. There are 100 of us. We usually amount to probably 150 opinions on anything. The Chair has had to put all of that together into a bill that not only the 100 Senators agree with—and not all 100 Senators do—as many of the Senators as possible, and as many of the House as possible, because a bill to go through to the President has to pass both the House and the Senate. When it gets this complicated, it is an extremely talented person who is able to put together the kind of legislation that reaches a compromise that will be able to pass.

This is a copy of the bill. If anybody thinks it is simple, they haven't looked at it. It takes a long time to wander through this. We have been working on it for a few days and now have the finalized copy, the copy that has passed the House. It is the most significant change in the history of Medicare. It may be the most significant change in medical delivery in the history of the world.

I congratulate the Presiding Officer, the Senator from Iowa, Mr. GRASSLEY, for all the hard work he put in on this bill. We will soon be voting on it.

This bill will add a prescription drug benefit to Medicare, it will offer new Medicare coverage options to seniors, and it will expand tax incentives for people who save money to pay for their own health care needs. That is quite a package.

I want to strengthen Medicare. Seniors and disabled people in Wyoming depend upon Medicare to pay for their health care needs. We have relatively few major employers in Wyoming so most of our retired seniors don't have access to health care coverage through their former employers. Medicare is critical to the health and well-being of 66,000 elderly and disabled citizens in my home State. That may not sound like a lot of people, but it is over 13 percent of Wyoming's population.

Adding a prescription drug benefit to Medicare makes sense. Medicare is the only traditional insurance plan in the United States that does not cover outpatient prescription drugs. The reason Medicare does not cover prescription medications is that pharmaceuticals were not a major part of medical care in the 1960s, when Medicare was founded. It is a different story today. Today, prescription drugs are absolutely integral to providing quality health care. All of us rely on them. It makes sense for Medicare to keep up with the times by offering voluntary prescription drug coverage to seniors.

Let me emphasize the voluntary nature of this program some more. We have heard that the AARP is going to regret supporting this Medicare bill just as they regretted supporting the catastrophic coverage bill of the 1980s. I will come back to that a little bit later. The reason seniors revolted against the catastrophic coverage bill back then was that it was mandatory. They didn't have a choice. They had to pay for the coverage even if they didn't want it.

This bill does not make that mistake. This bill is different. If seniors

don't want Medicare drug coverage, they don't have to pay for it. If they have coverage through their former employer, they can keep that. Plus we provide a lot of support in this bill for employers to continue providing their retirees with drug coverage so that seniors won't be forced to buy a Medicare drug plan because they lost their retiree coverage. So this is indeed a voluntary program.

It gives seniors a chance to sign up for Medicare drug coverage or stay in the traditional Medicare and keep what they have. Choice is a great concept. America was built on the idea that people should have the freedom to choose how to live their lives, as long as their choices don't infringe on the freedom of others.

When it comes to health care, choice is also important. Today seniors don't have choices. Medicare is a one-size-fits-all program, take it or leave it. But we all know that most seniors cannot afford to leave it. So right now they are stuck with Medicare, warts and all. The fact that Congress has to pass a law to add a prescription drug benefit is part of the problem with the Medicare system. Medicare is not flexible enough to adjust and adapt to the complex nature of health care today.

As I have noted, prescription drugs play a much greater role in treating disease today than they did when Medicare was created nearly four decades ago. But unlike private health plans, Medicare has not changed with the times. Under this Medicare agreement, seniors will have the option to choose drug coverage through Medicare. They will also have options that go beyond voluntary drug coverage.

The conference agreement would allow a variety of private health plans to offer coverage of Medicare beneficiaries. I am not talking about HMOs. Despite what I have heard here on the Senate floor, this bill does not force seniors and disabled into HMOs. Medicare HMOs exist today, and no one is being forced into them. What this bill does is allow preferred provider organizations, or PPOs, to offer Medicare plans.

Most of us are familiar with PPOs. They are the type of health plans to which more Americans belong than any other type. HMOs give you a list of doctors. If your doctor is not on the list, you can't visit him. The great thing about PPOs is, you can use any doctor you choose. And if the doctor is part of the plan's network, you get a discount on the cost of his or her services. These private PPO plans will compete to serve seniors by offering new choices and benefits, choices that are currently unavailable under Medicare's one-size-fits-all structure.

To be blunt, I believe the legislation could be bolder in stimulating competition. But it represents a good step in the direction of flexibility, innovation, and here is that word again—choice.

Let's be clear on what the Medicare bill would do. It would offer security to seniors who are without drug coverage. It would provide incentives to employers to encourage them to maintain the coverage they provide to their retirees. At the same time, the bill would create new Medicare options for seniors. It also would create incentives for private health plans to innovate and compete for the businesses of today's seniors and invigorate the Medicare Program for future generations.

Let's also be clear on what the bill won't do. It won't force seniors and the disabled to pay for a Medicare drug benefit if they don't want it. It won't encourage employers to drop drug coverage for their retirees. It won't force seniors and the disabled into HMOs.

I should also point out that the Medicare bill won't pay for every dollar of a senior's prescription drug costs. A drug benefit for needy seniors is important, but it is also important that we preserve Medicare for future generations. Already 30 percent of Medicare funding comes from the general government revenues. Projected expenditures are expected to exceed projected tax and premium revenues after 2015. I will be keeping a careful eye on Medicare spending, especially now that we have passed this drug benefit. If we are going to add anything new to Medicare beyond a basic and sensible drug benefit, we need to pay for it directly.

This drug benefit isn't free, but it is responsible. We set aside $400 billion of the Federal budget over the next 10 years to pay for this benefit. That is how much the agreement is projected to cost. Actually, it comes in slightly under that. But last year when we were doing the appropriations, we set aside the $400 billion. Some people say $400 billion is not enough. They point out that seniors are expected to spend $1.8 trillion on prescription drugs over the next 10 years.

Well, nothing in life is truly free, and prescription drugs will not be an exception. We need to remember that every new Federal program comes at a price. We need to be aware of just what that price is when we ask for a new program. It is not always the people receiving the benefit that are paying the benefit. The $400 billion is the equivalent of $1,600 from every taxpayer over that 10-year period. What would taxpayers say about the need for any program if we put it into that kind of a form for them? There would be increased concern just like there is increased concern when people have to pay their own costs of medical treatment.

That is how the competition comes into the market. I suppose we could have passed a $1.8 trillion drug benefit. Of course, we would have had to raise taxes by $1.4 trillion to do it. I cannot speak for the rest of my colleagues, but I just became a grandfather this year and I am not willing to put that kind of a tax burden on my grandson.

Even the critics of this agreement acknowledge that low-income seniors would be eligible for substantial subsidies for their prescription drugs. Even the critics admit that seniors with catastrophic drug expenditures get measurable relief under this bill. There is a generous 95 percent coverage of a seniors' drug cost over $5,000.

This bill also includes important projections for which I fought on the Senate floor this summer, which protect every senior's right to visit their community pharmacy and receive the high level of service they are accustomed to receiving from them. We have put a huge burden on our pharmacists in this country, the local ones that are right there to answer your questions face to face. There is a provision in the bill that will help to keep that local pharmacist in place and operating. It gives them an equal chance under the bill to be providing prescription drugs for seniors on Medicare. It is important that we keep those small businesses and pharmacists—local people that you can talk to—in place.

This bill doesn't cover every dollar of every prescription for every senior. But that is not a reasonable expectation. What this bill does is provide help and protection for the two groups that need it the most—those who can least afford prescription drugs, and those who otherwise would be bankrupted by a serious illness that requires expensive drug therapies. These are worthy objectives and this agreement accomplishes those goals.

I want to discuss a couple of other aspects of this agreement. First, the bipartisan Medicare agreement would establish health savings accounts, HSAs. These HSAs are tax advantaged savings accounts that all people could use to pay for medical expenses. This is a huge advancement in taking care of the uninsured. Health savings accounts would be open to everybody with a high deductible health insurance plan. The higher the deductible, the less the cost to the insurance plan. The higher the deductible, the more a person is allowed to put into a HSA. Employers would also be able to contribute to the employee's health savings account, and neither the employer's nor the employee's contribution would be taxable. Tax free, you can set up this account.

If you have an HSA, your total yearly contributions to it would be as large as your health insurance plan deductible. Just like an individual retirement account, the interest and investment earnings your health savings account would generate are not taxable. Furthermore, the money you take out of HSAs to pay for medical costs are not taxable, as long as the money is used to pay for health care expenses. Let's see, you don't pay taxes on it when you put it in, you don't pay taxes on the earnings, and you don't pay taxes when you take it out. It is a little incentive to put away money to cover deductibles, or anything to do with health care later on. I hope that every young person in this country will establish a health savings account. No matter what their income level is, no

matter how good their health is, it is an opportunity to put away money for when the health is not as good, and to take care of any deductibles that are necessary at any point in life with an insurance plan. It is an opportunity to be insured from the time you enter the job market, and to put a little away and perhaps have a lot for the years when 50 to 80 percent of the health care costs come up.

One of the best features of health savings accounts is they would be portable. That means that if you change jobs, the health savings account goes with you, you still have it. It is yours. Health savings accounts are a great innovation. Health savings accounts create a tax incentive for everybody—not just seniors—to save for health care expenses, plus it doesn't matter whether your employer offers health insurance or not; you can still save money in a health savings account and receive the tax benefit. This provides some tax fairness for those of you who don't have access to tax advantages of the employer-sponsored health insurance. Let me say that again. This provides some tax fairness to those who don't have access to the tax advantage of employer-sponsored health insurance. Employer-sponsored health insurance is tax free. It doesn't even show up on anything that you have to file. This would give the average person the same opportunity to have tax-free health coverage.

Health savings accounts are an idea whose time has come. Giving people more flexibility and responsibility in their health care spending will result in healthier and wiser consumers. I wholeheartedly support this part of the Medicare agreement. It is long overdue. It needs to be advertised. Young people of this country need to understand that that is their part of Medicare, that they can get into this now and it will save them costs later. It will be a part that will shore up the system.

I also want to speak to the provisions that would address a very sore subject on the frontier, the inequity in Medicare reimbursement between urban and rural areas. I am pleased that the conference agreement ensures reimbursement equity to doctors, hospitals, and other providers of health care in Wyoming and other rural States.

Right now, Medicare underpays rural hospitals, home health alleges, and other providers, as compared to urban counterparts. This limits the ability of these providers to maintain their services and their infrastructures and to recruit qualified personnel.

Some people do not understand the challenges that rural health care providers face in providing quality care to seniors and the disabled. For instance, I read a column in the Washington Post last Friday by a gentleman named Steven Pearlstein. I think it was supposed to be a semi-humorous column—I hope so—although it was in the business section. Well, to those of us in rural areas, it wasn't even semi-humorous, and it wasn't accurate either. I suppose I could ask that this column be printed in the CONGRESSIONAL RECORD, but I would not want to waste the space. I will, however, cite a paragraph from the column in which this gentleman called politicians from rural States ''nothing more than welfare queens in overalls.'' At this point, I'll state that I still believe Senators ought to be able to bring laptops onto the floor. But I assure my colleagues I will not be petitioning them to wear overalls on the Senate floor.

Let me read one of the paragraphs that Mr. Pearlstein wrote:

> Then there is Medicare bill, which was supposed to be about providing drug benefits to seniors, but wound up being yet another chance to whine about the plight of country doctors and hospitals. Although the cost to providing medical service is actually lower out there in God's country [the God's country is true] that hasn't stopped your guys from squeezing $25 billion more from the Federal Treasury over the next decade to pad Medicare payments to rural providers.

I don't know if this gentleman has ever been to God's country or not. Maybe he has flown over God's country, Mr. President. I doubt he has ever visited the Niobrara Health and Life Center, a very small hospital in Lusk, WY. Lusk has a population of 1,500. Lusk is the county seat Niobrara County, population 2,500. That is Wyoming's least populated county. Incidentally, it is a little bigger than the State of Delaware. It has one person for every 524 acres of land.

The hospital in Lusk has been closed since May of 2000. Since then, folks in Niobrara have had to travel to Douglas and Torrington for surgery or other hospital care. Douglas and Torrington are in different directions from Lusk. They are both about 55 miles from Lusk. That is a long drive any time, but in winter—and we are having winter there now. I don't know if you saw pictures of the Bronco football game where they were scraping snow off of the field; but yesterday there was a blizzard in Colorado and in Wyoming, and the temperatures were about 16 degrees, and it gets a little tough to get around, if you can at all.

Fifty-five miles is a long drive in winter when the winds are howling and the snow blows across two-lane roads. That is an important hospital for the people of Niobrara County, and they are getting ready to reopen it. They are hoping to be able to afford it. It is also important for the State of Wyoming because there is a State prison for women in Lusk. The State tried to keep the hospital open in the 1990s, but the financial pressures were simply too great.

Hospitals across rural America are struggling, particularly the smallest hospitals, such as the one in Lusk. If it were really true that the ''cost of providing medical service was actually lower out there in God's country'' then why are the rural hospitals struggling to stay open?

Our Federal Government's own Medicare Payment Advisory Commission published a report in 2001 on Medicare in rural America. That report found that the Medicare ''payment system does not recognize factors that have a greater effect on the cost of rural hospitals.'' The study also found that there are aspects of Medicare's prospective payment system for inpatient hospital care that tend to work against rural hospitals.

Every hospital has to buy a certain amount of medical equipment from hospital beds to x-ray machines. If rural hospitals get a rural discount on this equipment, it is news to me. In fact, I think there are probably some quantity discounts on which they lose out.

Rural hospitals also have to hire nurses and technicians, just as urban hospitals. It is hard enough to recruit nurses because we have a nationwide shortage. Trying to recruit nurses to come to the Wyoming frontier is even harder. So our rural hospitals have to offer a competitive wage.

Most rural hospitals also have a low patient volume compared to their urban counterparts, and this contributes to a higher cost of rural hospital care. There is a certain amount of staff and everything that has to be on hand ready for patients if they show up.

As the Medicare Payment Advisory Commission rightly points out in its study, hospitals in small and isolated communities ''cannot achieve the economies of scale and service scope of their larger counterparts and thus have higher per-case costs.'' The current Medicare rates do not directly account for the relationship between cost and volume, potentially placing smaller providers at a financial disadvantage relative to the other facilities.

I am pleased to note that the Lusk hospital is scheduled to reopen in October 2004 after completing some important upgrades and renovations. I am confident the hospital will be able to survive this time because Congress passed a law in 1997 to allow for special payments to hospitals in rural areas that are too sparsely populated to support a full-service facility.

The Medicare conference agreement would increase payments over the 1997 law to critical access hospitals, such as the one in Lusk. Despite Mr. Pearlstein's criticisms, he ignored the fact that urban hospitals have higher Medicare margins than rural hospitals.

The additional support for rural health care providers in this bill will help close the gap between higher Medicare margins of urban hospitals and the lower Medicare margins of the rural hospitals. This additional help will not come a moment too soon for the people of Niobrara County, WY, and other counties in Wyoming and other counties throughout the United States. I hope Mr. Pearlstein will visit Lusk if he ever visits Wyoming. I have been there, and I can tell you that the Medicare payments he considers ''padding'' are critical to the hospital in

Lusk and to the seniors who depend on it.

It is a long drive to Lusk from Yellowstone National Park or skiing in Jackson Hole, but I think it would be quite educational for him or anyone else who makes the journey.

There are a lot of good aspects about this Medicare agreement. Adding a prescription drug benefit to the program is good. Providing seniors and the disabled with new Medicare options is good. Offering all Americans new ways to save money for their health care expenses is good. Providing fair Medicare payments to rural doctors and hospitals is good. Having health savings accounts is outstanding.

For these reasons, I am going to vote for this bipartisan Medicare agreement, and I am going to work in the future to ensure that Medicare continues to offer a reasonable drug benefit for many of America's seniors, but one that does not place a huge financial burden on future generations.

Earlier the majority leader, Senator FRIST from Tennessee, the only doctor in this body, gave an outstanding speech outlining the reasons that in a bipartisan way he and others have worked on this for 6 years to bring this to fruition. A person from the other side of the aisle who has worked on that for 6 years has been Senator BREAUX from Louisiana. They served on a special task force to come up with a way to make Medicare be solvent for generations to come. This will be the first significant piece of legislation to address what they have talked about for 6 years.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator from Wyoming has 4 minutes 15 seconds remaining.

Mr. ENZI. I thank the Chair.

Mr. President, in the Senator's remarks he did point out there have been a lot of health care advances. Science has played a great part in health from genetically engineered vaccines, to coronary angioplasties, to heart transplants, to the human genome project that is coming up with a lot of new medicines that will take care of us. That project, incidentally, came in 2 years ahead of time, in 2003, and has led to a massive increase in the number of projects that are being done to come up with new drugs that will help us.

This is the way Medicare has advanced. It is pretty inflexible. There has not been much advancement. We have an opportunity to correct that right now. We need to get the flexibility of Medicare to increase the same way that medical advances are increasing, and those are mostly in the area of prescription drugs. So it is time we added a prescription drug benefit.

The bill also takes care of some problems we have with Medicare. I mentioned this task force that Senator BREAUX and Senator FRIST were on. The task force recognized the problem that when Medicare got underway, there were 20.4 million people under Medicare. Today there are 40.8 million people under Medicare. That is a doubling. By 2030, 77.6 million people will be under Medicare. That is another doubling. That is a huge increase in the number of people who will come under Medicare.

How is it paid for? It is paid for by people who are in the workforce, not the people who are retired—the people in the workforce.

In 1973, there were 7.3 people. That tenth of a person probably didn't feel too well. But 7.3 people were paying for every person under Medicare. In the year 2000, there were 3.9 people paying the bill for those in Medicare. By the year 2030, 2.4 people per person will be paying the bill for those on Medicare. These people have to pick up the costs of all of Medicare for those people. So it is important we have some cost containment, that we put in some reforms to make sure the system is available for those 77 million people in the year 2030.

Prescription drugs are the most important treatment factor now. They were not in 1965. We have come a long way on the issue of prescription drugs. This is where we are headed. These are the number of drugs in clinical development: Cancer, 402 different kinds in clinical development. The percentage of drugs that actual make it is very small. Is there a high cost to develop a drug? Yes. Diabetes, there are 30 different kinds of medicines; rheumatoid arthritis, 24; osteoporosis, 20; obesity, overweight, 29; depression 19; congestive heart failure, 18; Alzheimer's disease, 17; schizophrenia, 16; hypertension, 11; hyperlipidemia, 10; migraine headaches, 20, and so on.

There are a lot of drugs that are being worked on. That is a new treatment. That is a tool that has to be put in the hands of doctors.

Now, we have heard some comments, as well as different versions, about surprise that AARP has backed this bill. It is not a perfect bill. We never pass a perfect bill out of the Senate.

AARP has had some comments on it. I hope my colleagues all pay attention to them. AARP believes that millions of older Americans and their families will be helped by this legislation. AARP also endorses the Medicare bill. On November 17, they stated, ''The integrity of Medicare will be protected.''

These are the most significant reforms. It provides access to medical prescription drugs. It dramatically expands voluntary, private health plan choices. I hope my colleagues will look at the comments the leader made and read them in full.

I thank the President for the time, and I yield the floor.

The PRESIDING OFFICER. The Chair now recognizes the Senator from New Jersey.

Mr. CORZINE. Mr. President, I rise today to join this historical debate on health care for America's seniors. I also rise so that I can provide a perspective to the people of New Jersey on why I will regrettably be voting against this Medicare conference report.

I particularly find it unfortunate and disappointing because there are 300,000 seniors in New Jersey, out of about 1.2 million, who lack any prescription drug coverage. Those seniors make tough choices between medicine and other of life's expenses, as we have heard talked about in political debate for years.

I truly want to be a positive participant in assuring access to quality drug coverage at an affordable price for all of America's seniors. I think all of us do. That is why I voted affirmatively on a bipartisan Senate bill. I worked very closely with the senior Senator from Iowa to put together what I thought was an outstanding bill, one I would have been proud to support.

Those 300,000 seniors badly need and deserve affordable, quality coverage. But just as badly as they need it, we need to make sure their gain does not come at the expense of harming others. If the left-out seniors were the only ones impacted by this bill, I would vote for this plan we now are debating. I would vote for it because I thought it was going to provide access to those 300,000 folks and that would happen regardless of all the ideological or political arguments that have been made over the last several days.

Sadly, hundreds of thousands of other seniors in my State will be seriously and negatively impacted by this bill. The fact is, this plan harms more New Jersey seniors than it helps. I calculate that, at a minimum, 500,000 seniors will be harmed, breaking the first rule of medicine: ''Do no harm.''

The negative impact comes at a very high financial cost not only to my State but to the Nation at large. I believe the scarce resources we are using would be better used to make the limited and complex benefit more substantial and to reduce the harm to those who already have benefits that they will lose.

This Senator can only wonder in that context that we feel compelled to lavish $14 billion of subsidies on HMOs and other insurers to provide them profit incentives to compete with traditional Medicare as opposed to improving the benefits to uninsured seniors who are constructively a part of this bill. We could close that so-called donut hole, that gap.

With all due respect to the Herculean efforts of those on both sides of the aisle who cobbled together this compromise—and I really do want to congratulate and thank those who worked so hard. Ranking Member BAUCUS, and Senator BREAUX, the senior Senator from Louisiana, as well the senior Senator from Iowa, have done a great job of trying to get to a conclusion on which we could all agree. In my case, the cost/benefit for New Jersey seniors just does not work. It just flat out does not work.

My staff and I have done the numbers. We have worked very hard, to the

best of our ability, to really scrub down these numbers and to come up with a conclusion on whether this works for our folks. Considering we are in a mad dash to absorb and analyze this 1,100-page bill, I will bet there is not a single Senator who has read it. I could be wrong. Maybe there are one or two who just did not have anything to do in the last 24, 36, 48 hours, but I doubt if there is anyone who has read this. The result is that the only certainty about this bill is that in addition to its unintended consequences, even from the well-intended, it is certain to have unfortunate consequences for many American seniors, as well as all of us who might hope to be seniors one of these days.

So my reason for opposing this legislation is that this body should be thoughtful and careful when we are spending $400 billion for a good cause, but we ought to make sure we are not doing more harm than good. That is objection 1. Objection 2 is if we do not plan to implement this bill in its broad form before 2006, I do not understand why we need to cram all of this analysis into 48 hours or 72 hours over a 3- or 4-day period.

Why before Thanksgiving? What is the hurry when we have a bill this complex, this big, and we only have 3 or 4 days to look at it? I think there are a lot of problems stuck right in here.

So let me repeat what I do know. For roughly $4,000 of out-of-pocket payments, a senior will get $5,000 worth of return, plus a catastrophic coverage for everything above $5,000 of drug spending.

Let me repeat: A $4,000 payment for $5,000 worth of coverage will come with a complex concoction of HMOs, PPOs, PDPs, premiums, deductibles, copays, formularies, annual price increases, shifts of providers, and a bevy of choices that are more to the confusion of seniors than they are to the security of seniors. In fact, the complexity of navigating this proposal for an individual senior is almost enough of a reason for me to vote no on the bill to start with.

I have stood in all kinds of townhall meetings with seniors just trying to explain the simple first steps of this bill. I think we are going to be creating a tremendous industry of opportunity out there informing seniors about what is going to be borne from this 1,100 pages, 1,200 pages of work. Somebody is going to have to tell folks how they get through this.

That said, this bill does provide favorable relief to doctors, as I have heard some talk about, serving Medicare patients. It gives some needed aid to hospitals, particularly America's rural hospitals, as the Senator from Wyoming adequately presented. Of course, in a thousand pages plus, there have to be some good things, and there are. We are spending $400 billion.

A few of the benefits I have talked about are good but, in my view, they come at too high a price, and that is before one weighs in on the serious push in this bill to get Medicare on a pathway to privatization and the dismantling of the social safety net and coverage of our seniors' health which has been so fundamental to the success of moving so many of our seniors out of poverty into longer, healthier lives.

While this bill fundamentally being debated is in the context of prescription drugs in general, spending $400 billion, one would think that might have some positive implications for the broader health care system. To that end, I believe this bill falls far short of the mark. Once again, at least from my perspective, it does more harm than good.

Cost containment through Medicare negotiating the cost of drugs with the drug industry could have led to lower prices for everybody in America. You have unbelievably strong buying power out of Medicare—if they were negotiating those prices. We are talking about reimportation? We could do a heck of a lot better if we just had Medicare go out and negotiate those prices. That would help all Americans: Children, generation Xers, juniors, seniors, corporate America. That is not happening.

Other missed opportunities? Cost containment is omitted in this bill. The only containment of costs that I see falls on the shoulders of beneficiaries with escalating copays and premium hikes.

Equally troubling, reforming reimbursement rates for cancer treatment by doctors would have strengthened Medicare, as opposed to limiting oncological drug payments that undermines cancer care. For my State, this is really a troubling and unacceptable aspect. The fact is, we have the third highest incidence of cancer in our State. I think we are putting at risk the treatment of that not only for our seniors but for the whole of the community.

Egregiously—and this is where I strongly disagree with those who would make this case—the diversion of $6 billion into these health savings accounts in this bill I think is a big mistake. It encourages the healthy and the wealthy out of the employer-based health care system, leaving the older and sicker and more poor in the system that remains or until employers drop coverage altogether. Frankly, I think this appears to be a handout to insurers. Several credible studies, including the Rand Corporation's, suggest a major reduction in employer health care coverage will follow as the likely outcome of this tax cut proposal because of adverse selection.

I don't understand this. This doesn't seem to be relevant to the purpose we are about in a $400 billion prescription drug benefit for seniors. Once again, I think this legislation in this area does more harm than good. It certainly does with respect to the U.S. Treasury because I think it has the capacity to go well beyond the $6 billion in cost over a period of time, particularly as it is more of a savings program than it is one that is going to help on health care.

That is the big picture for me. As you can tell, I don't think it is so good. But let me now illustrate the specifics, as least as I see them, in a cost-benefit analysis for New Jersey's seniors because that is what I care about. It is clear to me this is the analysis that is the most important from my perspective. It is the primary driver for how I came to my conclusion with respect to this bill.

This is not about insurers and HMOs. It is not about what the Democratic caucus would argue. It is not about what political scorekeepers think. It is not even about the pharmaceutical industry, which, by the way, in our country is most heavily concentrated in my State. It generates about 65,000 jobs and produces about $30 billion worth of business and revenues. It is really important to our State. But simply my analysis is about New Jersey's seniors and their role and participation in this program across this Nation. On that basis, I would like to talk about some of what we see.

First of all, I think from all of the independent analyses we see, approximately 94,000 New Jersey retirees will lose their employer-based prescription drug benefits. There are estimates of 2.1 to 2.7, whether it is CBO or some private estimates. The middle of the range number for New Jersey is about 94,000.

We have, in New Jersey, a substantial number of seniors, what people call dual eligible, who would receive this wraparound of their Medicaid benefits, various low-income folks, 152,000 of those who receive their benefits through Medicaid and, as we all know, will be paying copays and potentially have an accelerated rise in health costs. They certainly will be on formularies that may limit their choices of drugs. Those 152,000 seniors I think will find this difficult.

We also have 220,000 seniors who are currently enrolled in our State pharmaceutical plan. I first want to congratulate the conferees because they did provide for a wrap here around State programs. It is going to be cumbersome and anything but seamless to move from the program that has been in place for 25 years, created by a bipartisan set of Governors and legislators over that period of time, that have provided the State program. We are going to have to change it. We are going to have to have our seniors go into private programs, and then the State is going to have to fill in those gaps, to be able to make sure that our low-income seniors, who have terrific programs, probably the best in the country, are able to maintain the same coverage.

As I say, I think the facilitating language with regard to financial obligations has been very good. I am very

grateful for the work of the conferees with regard to this estimate. But the seamless element, the quality of coverage with regard to this element, this particular program, is going to be very hard to implement. Each of these seniors, the lowest income seniors in our State, is going to end up being faced with formularies and be experiencing changes each year with regard to who has maximum coverage, and it will be a major impact on how they look at it. Plus they are going to end up potentially paying copays and premiums that are slightly more than what they have in current benefits. So there is another 220,000.

Finally, there are about 52,000 seniors in New Jersey's program who pay more for Part 3 premiums due to the premium test—the means testing—that is coming out. Some can argue means testing is good. That is said where you have already very high income seniors.

Now $80,000 in New Jersey, which is where this means testing begins, is not exactly superrich. We happen to have the most wealthy average population in the country. We also have the most expensive cost of living of any place in the country. We pay more in taxes; we send more to Washington than anyplace else in the country. This means testing, which is going to affect about 52,000 of our seniors, is not going to Bill Gates-like folks or Warren Buffett; it is going to middle class New Jerseyans and I think is going to have a lot more bite. I would have liked to have seen it set higher. It was cut back. I frankly wonder if this is going to be good for the overall Medicare Program because we are ultimately going to start pulling out a lot of these high-income seniors. As people know, Part B is voluntary, and we could end up again providing another adverse selection element to the overall underlying traditional Medicare Program.

We will come back to some other perspectives with regard to New Jersey. But by my calculations, it is 94,000 retirees with employer-based coverage. They are going to lose that coverage, at least that quality coverage relative to what they will get in a new prescription drug program in Medicare. There are 152,000 dual eligibles who will end up with payments that are different than what they would have had under the old program; 220,000 of our State beneficiaries will end up with a lower quality, less seamless program than what they have today, and 40,000—I talked about this earlier in my remarks—40,000 diagnosed with cancer every year are going to have a much harder time getting drug treatments that they previously had. It is going to cost about $50 million to the State over the 10-year period in payments with respect to these drugs. Those folks are going to be impacted.

Then there are the 52,000 subject to means testing. That is 558,000. I am not going to be so certain there are not some overlaps here, but we are talking in the neighborhood of about 500,000 folks who are going to be hurt. There are now only 300,000 New Jerseyans who are without drug coverage. I think that speaks for itself. There is a tough tally when you look at those who are harmed and those who are benefited. That, to me, is an important consideration.

That is an important consideration. Those are not the only considerations. With regard to New Jersey, we have certainly one that already meets the Medicare privatization approach that falls under the premium support program demonstration projects. Actually, it looks as if there will probably be two. I don't think our seniors are going to say they want that in their backyard. They like prescription drugs, but they also like traditional Medicare.

I think it is hard for me to go back to them and argue when they have had a chance—by the way, we have seen a lot of people dropping out of Medicare+Plus Choice because they haven't felt like the program is good. Plus a number of insurers dropped people who signed up for it. They thought it was going to be a good deal and it didn't turn out to be so. That is another one that a lot of folks talked about. There are approximately 1 million New Jersey Medicare beneficiaries who are going to see their Part B deductible rise at a faster rate than their Social Security benefit.

Some people will say that is not a part of this bill, that it is something else. But the fact is, we are building an escalator on Part B. It doesn't compare with what I think is going on with Social Security. At least when I go to townhall meetings, that is a real problem for me to try to deal with and explain to folks. That is the challenge.

Roughly 100,000 seniors will be negatively impacted and a lot of others will feel as if they were somehow not properly protected in it. Again, 300,000 don't now have drug coverage.

That system doesn't work. It is arithmetic. It is very straightforward. It seems to me that there is more harm than benefits. For me, the case is closed.

It would be remiss of me not to say that I have another objection that I believe is built into this package. If I could convince myself that New Jersey seniors were going to be benefitted, I would come around on this issue. But I think this package puts America on a pathway to privatization of Medicare. I suggest that is not the right direction. I think we ought to be enhancing and extending the traditional Medicare Program and have a prescription drug benefit. We ought to be using that $12 billion to $14 billion that is going to benefit the managed care industry and the insurance industry to cover up one of those donut holes that we are talking about. We ought to be putting that money to work to enhance traditional Medicare.

While others have spoken eloquently and extensively, maybe even politically about this, I think it is a very serious consideration for those of us who believe that traditional Medicare should be enhanced.

I looked at three steps that will put it on that pathway.

Fourteen-billion dollars in subsidies and protection against skyrocketing health care costs provided to health insurers in this bill doesn't seem to me to be the right place to put us into a comparative cost-benefit analysis with the private providers who I think have many incentives to cherry-pick the healthiest, the wealthiest, and the most able versus what is going to be left in the traditional Medicare program, which raises costs. I think that is step 1.

Step No. 2, this series of demonstration projects which is hardly a level playing field by comparison—and I think it is actually going to be difficult for us to make a real assessment if it—I have heard actually limits this program under 600,000 folks. I think it is also possible that it will be cherry-picked in the areas as opposed to the difficulty of looking at the wide diversity of populations that we have in the country. I am particularly troubled when I look at what I see with regard to what fits into New Jersey with regard to this program. It could be very difficult.

Then the third step is this 45-percent trigger on general fund expenditures that will cause an overall review of traditional Medicare when the breach occurs. I think all of us realize with the changing demographics and the baby boomers going into retirement, and with 40 million seniors growing to 75 million or 77 million seniors over the next 10 to 15 years, we are going to have that happen. I think that is going to lead to pretty hard choices without the kind of triggers we have here.

I think that it is just one more step, one more nail in the box that is trying to change us and move us away from traditional Government-supported and underwritten Medicare to privatization. In my view, after an inadequate analysis of this 1,100-page bill, I really think that may be the most troubling piece.

I think it is very difficult to be certain about any of the conclusions that any of us are drawing with regard to this bill. The one thing that I do know for certain as it shows up both in the marketplace and in the phone calls that we are receiving is that there are great benefits for the insurance industry and the pharmaceutical industry built into this.

By the way, as I said, the pharmaceutical industry is right smack dab in the middle of my State. I like to see them do well. I like to see them press forward in their research. But I don't think that should come at the serious expense of many of America's seniors. I can say, at least based on what I understand by my analysis, that is not the case with regard to New Jersey seniors.

Frankly, I just do not understand this mad dash to get this done before

Thanksgiving. It obviously must reflect some other agenda than what seems sensible. I think we ought to slow down. We ought to be careful. We ought to be thoughtful. I know there are a lot of people who have spent a lot of time. We have heard about the 6 years of debate and discussion. But to come to a conclusion where we have to make a decision about something that is extraordinarily important to the lives of the people across this country—not only to our seniors but to the families, and the impact it has on the markets that we deal with with regard to prescription drugs—investing $400 billion is a very important issue. It ought to help our seniors as much as possible. It is a good thing. I think all of us want to be supportive. We should do our best with what we have to invest in this project. You have to think about it in the context of a very limited amount relative to how much seniors are going to spend over the next decade. I hear estimates that it may be as much as $1.8 trillion. What we are talking about here is about 20 percent of that.

We have to make tough choices. I appreciate the difficulty with which the Senator from Iowa had to work his way through these difficult areas. I think he made a lot of good choices, but there are some in here that are very difficult. I think we ought to be wise and reflect on this 1,100-page report.

I am convinced we can do better, at least in the cost-benefit analysis that I put together for my State.

As a consequence, I have to oppose this report. I hope we can slow it down and make some revisions and bring it to a positive conclusion which is not ideological and which is not political; that is, believing we are searching for the best interests of all of our seniors in America.

I yield the floor.

The PRESIDING OFFICER (Mr. ENZI). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, before the Senator from New Jersey leaves, I want to speak about a couple of words which he mentioned. And I don't say it to take exception with what he said or to quibble with his description of the legislation before us. But if the President of the United States saw Senator GRASSLEY speaking right after some words that the Senator from New Jersey used about legislation, the President would be offended because I found fault with the President using those very same words back on December 10 last year when I had my first meeting with the President on the Medicare issue.

The words that the Senator from New Jersey used about the legislation before the Senate is that it is cobbled up. As everyone in this body knows, for about a year and a half I worked with five Members of this body on what was then called the tripartisan plan. The President started his lecture to me last December, something along this line: We have to have a dramatic change of Medicare. We have to provide prescription drugs for the seniors. We have to change Medicare for the future. He says: We do not want something like that cobbled-up tripartisan plan.

Obviously, the President cannot know everything that goes on in the Congress of the United States about forming legislation, but if he knew the hours and hours, not only at the staff level but at the Member level, that went into the tripartisan plan that we unfolded here a year ago in July, the President would not use the words ''cobbled up.'' I never heard the President use the words ''cobble up'' after that because I tried to impress upon him there was a great deal of thought, a great deal of hard work, and most importantly, time, plus bill compromise that the word ''tripartisan'' implies to bring together where we were at that time.

If he had appreciated it, he would see we have to have the same sort of thought and hard work go into what he was thinking about. I never heard him say that again. I am reminded of that story now that the Senator from New Jersey said this legislation is cobbled together.

To some extent, I suppose every political compromise, for every piece of legislation, one could use those words to describe it. I know the Senator from New Jersey participates in a lot of very difficult legislation in the committees he serves on and knows what it takes to put a bill together. However, I look at this piece of legislation, the compromise it takes, the hard work it takes, all the long hours it takes, as not a perfect piece of legislation but surely not a cobbled-together piece of legislation.

From that point of view I will respond not to the Senator from New Jersey any further but to speak about some of the aspects of this legislation as we get ready to vote on it tomorrow.

Mr. CORZINE. Will the Senator from Iowa yield for just a question and a comment?

Mr. GRASSLEY. I would be glad to yield for a short question or short comment and reserve my right to the floor.

Mr. CORZINE. I appreciate the comment with regard to cobbling. It is great to be put in the same company of criticism with regard to the use of the term. I do not want to leave the impression that I don't think there was great thought and effort in putting together this extraordinary piece of legislation. It is actually a tremendous tribute to the Senator from Iowa for the ability to put together all the various interests in common and come up with something that is pretty doggone close for all Members to be able to consider.

My concern is that it is very hard to know from this Senator's point of view all the details. I wish I could say I was absolutely certain that I had analyzed this exactly the right way for those seniors in my State. But this is an incredibly complex issue, not only for the seniors themselves to be facing but also for those who are trying to decide how we are investing $400 billion.

I congratulate the Senator for his efforts. Unfortunately, as I look at it, I come out with a different perspective, but I don't think it is for lack of good intentions, hard work, and great compromise on the Senator's part.

Mr. GRASSLEY. I surely appreciate the good nature in which the Senator from New Jersey just stated his feelings about this legislation. I wanted to give equal treatment to the President, as I did the Senator from New Jersey and vice versa.

One of the aspects of this legislation that is misunderstood is the issue of health savings accounts, which is a new name for what people hear Congressmen talk about as medical savings accounts, only different in name, particularly, as it relates to people in my State, the benefit to farmers and small business people.

This bipartisan agreement includes these provisions establishing health savings accounts. I will refer to them as HSAs.

HSAs are tax-advantaged savings accounts that can be used to pay for medical expenses incurred by individuals, their spouse, or dependents. HSAs are similar to medical savings accounts. However, medical savings account eligibility has been restricted to employees of small businesses and the self-employed. HSAs are open to everyone with a high deductible health insurance plan. The only limitation on the health plan is that the annual deductible must be at least $1,000 for individual coverage, and $2,000 for family coverage. Contributions to the HSA by an employer are not included in the individual's taxable income. Contributions to an individual are tax deductible.

Total yearly contributions to an HSA can be as large as the individual's health insurance plan deductible, between $1,000 and $5,000 for self-coverage, and $2,000 and $10,000 for family coverage.

The interest in investment earnings generated by this account is also not taxable while in the health savings account. Amounts distributed are not taxable as long as they are used to pay for qualified medical expenses such as prescriptions, over-the-counter drugs, and long-term care services, as well as the purchase of continued health care coverage for the unemployed individual. That is legislation we passed a long time ago called COBRA.

Amounts distributed which are not used to pay for qualified medical expenses will be taxable, plus an additional 10-percent tax being applied in order to prevent the use of HSAs for nonmedical purposes. These accounts are portable, so an individual is not dependent on a particular employer to enjoy the advantages of having an HSA, low-income individual retirement account. The HSA is owned by the individual, not by the employer, and if the

individual changes jobs, the HSA goes with the individual.

In addition, individuals over age 55 may contribute extra contributions to their accounts and still enjoy the same tax advantage.

In 2004, an additional $500 can be added to the HSA. By the year 2009, an additional $1,000 can be added to the HSA.

In regard to this legislation before the Senate beyond the health savings accounts, I point out what a great prescription drug benefit structure we have. First and foremost, it is important to point out that this is a voluntary program. If you currently have drug coverage and you like it, you can keep it or, if you do not have drug coverage and do not want it, you do not have to take it. If you are covered by Medicare fee for service today, and you are satisfied with it, you can stay right where you are.

This drug benefit also offered through Medicare will be a comprehensive benefit that will provide real relief for our seniors. Seniors that now pay full retail price could see a 25-percent reduction in their prescription spending. Additionally, these seniors' overall out-of-pocket drug spending could fall by as much as 77 percent. This is real relief for real people, not some hypothetical.

To provide relief to all seniors, the drug benefit is based upon income level. It is quite simple. Those who need more help because they are low income will receive more help under this program.

We divide this up according to the levels of poverty under the official poverty indexes of the Federal Government.

For those individuals and couples who are above 150 percent of the Federal poverty level, they can expect to see a monthly premium of $35, an annual deductible amounting to $250, a 75–25 percent cost-sharing up to a payment of $2,250, and a true out-of-pocket catastrophic cap at $3,600.

Additional benefits, including help with both the premium and initial cost-sharing, are targeted to seniors with income levels below 150 percent of the Federal poverty level. These subsidies will be available at increasing levels for those between 135 and 150 percent of the poverty index, and those between 100 and 135 percent. And then there is still another category of greater help for those below 100 percent of poverty.

I will explain how this differs for each of these categories. First, for individuals who are 135 to 150 percent of poverty, this group would have a $50 deductible, sliding-scale premium assistance, and 15 percent cost-sharing up to the benefit limit of $2,250, and $2 or $5 cost-sharing above the catastrophic level—$2 meaning for generic, $5 for brand-name drugs.

For individuals who are below 135 percent of the poverty index, they would have no deductibles, no premiums, $2 and $5 cost-sharing up to the catastrophic limit, and no cost-sharing after the catastrophic level has been reached.

Now, we go to the neediest of our seniors, the dual eligibles, those who are presently low income and getting help not only from Medicare but from the State Medicaid Program. They currently have their drug costs paid for by the Medicare Program that differs a little bit from State to State based upon the laws of those States.

Our conference report calls for Medicare to pick up the cost of their prescription drugs. Most of this population will have a $1 and $3 cost-sharing up to the cost-sharing limit, and then, after that, no cost-sharing on the catastrophic. Now, that $1 and $3, again, is generic for the $1, and $3 for the brand-name drugs.

By providing coverage to all seniors based on income levels, you can see that the number of individuals with no prescription drug coverage will fall from 24 percent in the year 2002 to 2 percent in the year 2009.

Now let's make it clear. About over half of individuals today have some prescription drug coverage—some very good, some not so good—and then 25 percent, maybe 30 percent have nothing. Now, we expect this to go down under this program to just 2 percent of our population, after 3 years of phase in.

Mr. President, 98 percent of the seniors receiving prescription drug coverage in 2009 will receive it from privately insured plans. Moreover, 33 percent of the beneficiaries will get their prescription drug coverage from integrated private plans, three times the rate in 2002.

Additionally, seniors will see immediate benefits with discount drug cards. These are going to be available in the middle of next year, and through all of the year 2005. Then, after the year 2005, the new program, in its entirety, kicks in. So the discount drug card is for an interim period of time while it takes the Department of HHS a period of time to set up what we are going to pass tomorrow. These discount drug cards will pass on between 15 and 25 percent of savings on seniors' current drug prices.

It is clear to see that the conference agreement has come a long way since we passed this bill in this body the first time in June. Many of my colleagues wanted a lower deductible. We have a lower deductible. Other colleagues were more concerned with getting the dual eligibles' drug costs out of the Medicaid Program and covering everybody by Medicare. We have done that as well.

So this is a good, solid drug benefit that will provide real relief to all seniors. Not only is this a good bill, with a good benefit, this bill provides an incentive for employers not to drop their retiree coverage.

Because there has been so much misinformation about corporations dropping employees, and since we have gone to such great strides in the conference report to overcome that problem and reduce that possibility, I want to spend some time on that and make clear that what we did in this respect—I think it is fair for me to say that the conference report, the compromise between the House bill and the Senate bill, is very much better than either the Senate bill, when it passed in June, or the House bill, when it passed the other body in June. So I would make these comments about whether or not employers are going to drop coverage of their retirees.

Now, we have heard a lot from opponents of this historic bipartisan effort alleging that this bill will cause employers to drop their retiree health coverage. But one thing these opponents do not do is tell the people the whole story.

So as Paul Harvey says, the rest of the story and the reality is that employers have been dropping retiree coverage for years.

As you can see from this chart, there has been a gradual decline in the number of corporations providing coverage for their retirees. Since 1991, the number of larger employers offering health coverage to their retirees has dropped by nearly 20 percent, from 80 percent down to 61 percent.

This chart shows what we have been seeing in our States and hearing from our constituents. So employers have been dropping coverage for their retirees, and this has already been going on for more than a decade.

We know these days employers are finding it harder and harder to continue voluntarily providing health insurance coverage for their retirees.

That is why we in the Medicare conference worked diligently—put resources behind it—to help employers continue providing coverage for retirees, not just to be nice to the retirees but to be nice to the taxpayers because it is a heck of a lot cheaper to keep these retirees in their corporate plans than have them go on our plan.

That is our goal. Let me make it very clear; we have done a very good job of accomplishing that goal.

So let me tell you the three important ways we have done it.

First, the bill provides a 28-percent subsidy for the prescription drug costs for retirees so they will continue providing this coverage. That is about $750 per retiree, but that is just on average because every corporation has a different plan.

Second, we exclude this retiree subsidy from the Federal corporate tax. This dramatically increases the value of this subsidy for retiree coverage and helps the employer continue offering this coverage.

Third, the bill provides additional flexibility for employers to structure plans that complement Medicare's new drug benefit.

Overall, the conferees agreed to put $89 billion in this bill to protect retiree health coverage.

This funding makes it more likely—obviously not less likely—that employers will continue their retiree benefits. I think I ought to emphasize what $89 billion happens to be. That is 20 percent of all the money we are putting in this bill for prescription drugs for seniors. Now the Congressional Budget Office estimates that 17 percent of the retirees will not receive supplemental drug coverage from their employers beyond what is offered by Medicare in this bill. We have a different estimate from the Employee Benefits Research Institute that is outside of our government. It is a nationally respected organization that studies retiree benefits. They estimate that that number is going to be much smaller: 2 to 9 percent of the retirees might not receive supplemental coverage from their employer in the future if Congress passes the Medicare benefit.

According to the Employee Benefits Research Institute, if Congress creates a Medicare drug benefit of any kind, some employers will want their retirees to take advantage of that new benefit. This is an important part of the rest of the story. The only way to prevent employers from putting their retirees in the Medicare drug program is if we don't pass legislation such as this, if we say we don't give a darn about the 25 to 30 percent of the people who don't now have prescription drugs and we don't care if they ever have it. That is not the attitude of Congress. That is why this legislation is before us, because we do care about people who can't afford or don't have available a plan for prescription drugs.

For those people, particularly on this side of the aisle, who have been complaining about not doing enough or that passing this bill might cause some corporations to change their health benefits and prescription drugs for their seniors, do they think we should do nothing? No, they don't think so. They are crying because we aren't doing enough. I tell you honestly, we could put $400 billion, all of this bill, into just those 30 percent of the people in this country who retire from corporations that have a pretty good prescription drug program, probably better than most people have, and I couldn't guarantee anybody in this country that some corporation, big or little, wouldn't dump their programs, just dump them, as they have been doing for 20 years.

Let me be clear, these retirees will not be left without drug coverage. Retirees are not going to lose drug coverage. Why? Because of this bipartisan bill before us. These retirees will still be better off than today, because today when their employer drops coverage, they are left with nothing—no coverage whatsoever. Because of this bill, these retirees will be getting drug coverage from Medicare, and their former employer will likely pay the monthly premium for them. They will still be better off than they would be today where there is no Medicare drug benefit to back them up.

It is also important to recognize that keeping employers in the game lowers the Federal cost of the drug benefit. That is why we are concerned about the taxpayer as well as the corporate retiree. Obviously, if it is dumped, it is going to cost the plan more than if they stay on the corporate plan. So providing this 28 percent subsidy actually lowers the cost of the Medicare benefit. This generous 28 percent subsidy for retiree coverage is good policy. And because it is good policy, it is good politics. This bipartisan bill protects retiree benefits. That has been our goal, and we have accomplished it.

Mr. GRASSLEY. Mr. President, Medicare contractor reform will not succeed if contractors are subject to unlimited civil liability in carrying out the payments, provider services, and beneficiary services functions expected of them. The conference agreement would therefore continue the past policy of limiting the liability of certifying and disbursing officers, and the Medicare administrative contractors for whom those officers serve, with respect to certain payments.

In addition, the language contained in section 911 of the conference agreement clarifies that Medicare administrative contractors are not liable for inadvertent billing errors but, as in the past, are liable for all damages resulting from reckless disregard or intent to defraud the United States. Importantly, the reckless disregard standard is the same as the standard the standard under the False Claims Act. This standard balances the practical need to shelter Medicare administrative contractors from frivolous civil litigation by disgruntled providers or beneficiaries with the Medicare program's interest in protecting itself from contractor fraud.

The False Claims Act, 31 U.S.C. §§3729–3733, applies to Medicare fiscal intermediaries and carriers under current law. This legislation makes it clear that the False Claims Act continues, as in the past, to remain available as a remedy for fraud against Medicare by certifying officers, disbursing officers, and Medicare administrative contractors alike and that, among other things, the remedy subjects Medicare contractors to administrative, as well as trust fund, damages.

ORDERS FOR MONDAY, NOVEMBER 24, 2003

Mr. GRASSLEY. Mr. President, for the leader, I would like to give what is referred to daily as the closing script, if I may.

I ask unanimous consent that when the Senate completes its business today, it adjourn until 9 a.m., Monday, November 24. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of the conference report to accompany H.R. 1, the Medicare modernization bill, provided that the time until 12:30 p.m. be equally divided between the chairman of the Finance Committee or his designee and the minority leader or his designee. I further ask unanimous consent that the cloture vote on the conference report begin at 12:30 p.m. Finally, I ask that the last 10 minutes prior to the vote be allocated to the Democratic leader for 5 minutes, to be followed by the majority leader for 5 minutes.

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

PROGRAM

Mr. GRASSLEY. Mr. President, tomorrow morning we will resume debate on the Medicare modernization conference report. Under the previous order, there will be approximately 3½ hours of debate prior to the cloture vote on the conference report which is locked in to occur at 12:30 p.m. The cloture vote on the conference report will be the first vote of the day. It is my hope and expectation that cloture will be successful. This issue deserves an up-or-down vote. I urge my colleagues on the other side of the aisle to allow this process to move forward.

MORNING BUSINESS

THE FLORIDA CITRUS INDUSTRY

Mr. NELSON of Florida. Mr. President, this week, leaders from thirty-four countries around the Western Hemisphere gathered in Miami for the Free Trade Area of the Americas (FTAA) Ministerial and Americas Business Forum for the purposes of expanding free trade within the Western Hemisphere.

The negotiations at this and future Ministerial meetings will greatly impact my State of Florida.

This event drew large headlines in the papers across the hemisphere as leaders converged upon Miami and anti-globalization protesters gathered outside to voice opposition. In this context, I feel it appropriate to commend Miami-Dade County, the City of Miami, and all the local and Federal law enforcement officers who helped keep the peace during a tense week of negotiations, and everyone who made it a success.

But in light of these talks, I want to share my own concerns regarding the FTAA negotiations, and the path ahead.

These talks did generate positive movement forward, towards greater economic integration in the hemisphere. Trade Ministers agreed to a baseline of minimum standards for a full and comprehensive agreement that takes into account differing levels of development among nations. This framework is a step forward that gives nations flexibility.