

(3) those households often carry a higher energy burden than most United States households, spending up to 20 percent of their household income on home energy bills;

(4) States provided more than 4,000,000 households with LIHEAP assistance in 2002;

(5) LIHEAP is currently able to serve only 15 percent of the 30,000,000 households who are income-eligible for assistance under LIHEAP; and

(6) the Committee on Health, Education, Labor, and Pensions has jurisdiction over the Low-Income Home Energy Assistance Act of 1981, which provides authority for LIHEAP, and is working towards reauthorizing the Act prior to its expiration in 2004.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that, when the Committee on Health, Education, Labor, and Pensions reauthorizes the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8621 et seq.), the committee should consider increasing the authorization of appropriations under section 2602(b) of that Act (42 U.S.C. 8621(b)) to \$3,400,000,000, in order to better serve the needs of low-income and other eligible households.

Mr. DOMENICI. Mr. President, as I understand it, this is the second-degree amendment. Clearly, it will be debated tomorrow when Senator GREGG and Senator KENNEDY return. We will see what the wish of the Senate is. I join with my colleague, Senator BINGAMAN, in stating that I hope we will leave it in this bill. I think the House has done the same. I think it is important that we adopt the LIHEAP bill and that we do it now. Obviously, there is no need for the Senator from New Mexico to debate any further on this issue because the opponents have to be heard from and they won't be here until tomorrow.

I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. DOMENICI. 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 President, I ask unanimous consent that the order for the quorum call be rescinded.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. DOMENICI. Mr. President, for Senators again, let me repeat that we are awaiting the return of Senator GREGG to debate this issue; that is, the second-degree amendment which was just offered a few moments ago. In the meantime, the entire Energy bill is before us. Amendments would not be in order obviously. We will await their return and then begin the debate. After we finish the debate, we will vote on LIHEAP.

We will also debate the ethanol amendment. We are attempting to work with Senators who have serious issues with reference to ethanol to see if we can't line those up so that we will be ready to proceed in due course and with some degree of dispatch.

Having said that, I don't believe there is going to be any further significant business on this bill. I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. DOMENICI. Mr. President, I ask unanimous consent that there now be a period of morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

SCHEDULE FOR JUNE

Mr. FRIST. Mr. President, in opening the Senate this morning, I spoke generally of the schedule for the next month. There are a number of items that I outlined which we will be addressing.

The first is energy, and we will continue that debate, possibly later today but through tomorrow, the next day, the next day, the next day—through this week. It is a very important debate as we work toward that objective, increasing domestic production, decreasing our dependence on foreign sources, addressing issues such as renewable energy sources that we all know are so important, and accomplishing all that with a lot of attention and focus and care with regard to the environment as well as the economy of this great country.

I mentioned this morning that we have begun, weeks ago—in fact, months ago—addressing the issues surrounding the strengthening of our Medicare Program—strengthening it, preserving it, improving it—and at the same time addressing an issue that seniors feel strongly about, people in Medicare feel strongly about, but also soon-to-be-seniors and that younger generation, and that is to include a new benefit of prescription drugs as part of our health care for seniors program, our Medicare Program.

As I talked to a number of people over the last week, a lot of people said, Why now? There are a lot of reasons why now. The bigger question I have is why didn't we do it 6 months ago or a year ago or 2 years ago. Prescription drugs have become an integral part of health care delivery, of the tools, of the equipment, of the armamentarium

that a physician has, that a nurse has, that health care providers have, to give people security, health security, and especially to give seniors health care security. That is the purpose of our Medicare Program, to give seniors that health care security. Yet we have this very important benefit today—much more important today than 10 years ago or 20 years ago or 30 years ago when Medicare was started—these prescription drugs, which are vital to health care security for seniors.

We will be addressing, 2 weeks from today on the floor of the Senate, for a 2-week period, how to strengthen and improve Medicare. To answer that question, Why address the issue now? I think there are three reasons.

First, I think we have a unique opportunity because the political environment is right. When I say political environment, I mean the responsiveness that we demonstrate to what our constituents want and what they demand and, indeed, what they deserve. Indeed, in terms of the political environment, we have seen the call for prescription drugs, proposals to deliver prescription drugs, enter into a number of campaigns 6 months ago around the United States of America, in the campaign cycles from 2 years ago, and that is simply a reflection of the importance of the issue to the American people.

Second, we have a unique opportunity because, I believe, the legislative stars are aligned at this point in time—unlike last year, unlike 3 years ago, and possibly unlike 2 or 3 years from now. By that I mean that we have a President of the United States who has spoken out boldly and forcefully that this is important to our domestic agenda. In fact, the President put out a framework several months ago demonstrating his commitment and the commitment of this administration to strengthening Medicare, to improving Medicare, and at the same time adding this new and important benefit of prescription drugs.

When I say the legislative stars are aligned, it starts in many ways there because it takes that bold leadership because this will be the single most significant and most expensive change in the history of Medicare, a new benefit at the same time we strengthen and modernize Medicare. But it also takes bold leadership in the House of Representatives and bold leadership on the floor of the Senate. As a physician, as majority leader of the Senate, I have made it very clear that this is a huge priority for the leadership of this body. Indeed, that reflects the leadership in the last Congress where Medicare reform and modernization and prescription drugs were discussed on the floor for 2 or even 3 weeks, but where we were not able to bring to it a conclusion.

Then we have a House of Representatives, as we look at these legislative stars. Indeed, it is lined up. This will be the third Congress, maybe the fourth

but the third Congress that I recall, that will have put forth and passed a bold, comprehensive plan.

So when you have bold leadership in the White House by the President of the United States, you have this body, which is committed—committed to giving our seniors what they deserve, you have a majority leader who happens to be a physician, who has taken care of, personally, tens of thousands of patients who would be beneficiaries of this type of program—and a House that is committed, we can do it.

The third reason we have this unique opportunity, and which is one that we have little control over, is the unprecedented aging of the population which was defined post-World War II and what we know today as the baby boomers. This unprecedented fertility curve that happened after World War II, this move in our population which begins to hit in about 6 or 7 years, resulted in a doubling of the number of seniors. From where we are today over the next 30 years, that doubling of the number of seniors is going to call for health care security. It is going to make it very expensive. Therefore, we need to look in whatever we do today to make sure we meet that fundamental criterion of having it be sustainable over time, and not to make promises that can't be sustained when we are going to have twice as many people demanding and deserving the services for that health care security.

That unprecedented tidal wave of the aging of our population is what we need to face as responsible legislators. What complicates that huge increase in demand for services is that in the pay-as-you-go system, the number of workers out there who are actually paying into the system is going to fall over time. About seven workers in 1970 would support one senior. I just told you that we are going to double the number of seniors. But no longer having seven workers support every senior, it is now down to about four workers for every senior. And it will go down to about 2.9 workers for every senior. For every one senior you have over here, you are going to have fewer people working harder to provide those services, and on top of that you have a doubling of the number of seniors receiving those services.

This underscores the need to approach this modernization, this strengthening, this reform, this improvement of Medicare, especially since we are adding on top of that system I just described the single largest addition of benefits in the history of Medicare.

Even with benefits as designed today which we have already promised, the system itself is difficult to sustain because of this doubling of seniors, and with almost a halving of the number of people paying in. On top of that, we have the challenge of adding a very expensive service.

It is estimated that seniors will spend about \$2 trillion in medicines

over the next 10 years. I would say that is a low estimate. If we were to promise all seniors all of their prescription drugs for the next 10 years, that would be \$2 trillion which we would be putting on the system. Today, for all health care, we spend about \$250 million a year. That simply can't be sustained long term. But that is the challenge which we have.

Let me say that as a physician and as someone who has been involved in delivering care to seniors, Medicare has been hugely successful. The Medicare Program, which is now a little over 35 or 38 years old, has been hugely successful. Seniors would have been driven to financial ruin. They would not have received the health care benefits because there would be too many barriers without this great program. The problem and the challenge is that the program itself has not changed very much over the last 30 years. We have changed it a little bit on the floor of the Senate, but at the same time health care delivery has changed dramatically. We know better how to deliver care in a continuous way that looks at quality, constant monitoring, and chronic disease, but none that have ever been incorporated into this great program, but a stagnant program that hasn't kept up with the times, with the great advances, such as difficult heart transplants—I was involved in putting in artificial hearts as a surgeon in that arena—with a little stint; and the angioplasty. None of that was done in 1965 when Medicare started—zero.

The system changes so little. And you can go through every specialty of health care. These rapid changes in health care simply are incorporated only very slowly with years of lag time, if they are incorporated at all. In Medicare, there is very little preventive medicine, for example. It has been a great program, a tremendous program, and a program we need to preserve. But we need to improve it and strengthen it over time.

Our challenge is that a lot of the seniors listening to me are thinking their Medicare is OK. You politicians up there in Washington, DC may have been a doctor in the past and now may be a U.S. Senator, but just do not touch what I have. I may be 80 years old, or 85. I don't want any politician tinkering with my health care that I think is OK.

That is going to be a challenge as well because a lot of people are going to say don't touch it at all.

I would argue that seniors deserve for us to touch it. Don't take anything away from seniors. If they want to keep what they have today, they can keep exactly what they have. But at the same time we have an obligation to let seniors and soon-to-be seniors know the program is not as good as health care which can be delivered today, and which is delivered today in the private sector. They need to know that.

For example, Medicare doesn't cover catastrophes. That simply means if you

are very sick, with Medicare there is no limit of \$1,000, \$10,000, \$50,000, or \$100,000 that you are going to pay in. You are always going to be paying out-of-pocket a certain percentage. For example, with physicians, you might be paying 15 or 20 percent of whatever that physician charges. But for the rest of your life—no matter if you have a catastrophe, if you had \$100,000 in bills, there is no cap in Medicare. That is not true in the private sector. There is a catastrophe cap for most health care plans.

Second, Medicare today does not offer very much in the way of preventive care. We know that if we catch the disease early and we manage it well before you require hospitalization, before you require surgery, and before you require radiation therapy, you are going to have huge cost savings. But, more importantly, you will have a better quality of life for the rest of your life.

That takes prevention—catching those cancers when they are tiny, before they have spread throughout the body, or catching that heart disease before it has manifested itself in shortness of breath, or congestive heart failure and not being able to get out of bed. We do it all the time today. Yet annual physical exams are not covered in Medicare.

I would tell seniors who say they are getting good coverage today to ask whether there should be some prevention involved. Right now Medicare has very little.

Second, wouldn't you like to have a plan that limits your out-of-pocket expenditures?

Third, Medicare today—as great a program as it has been—does not cover prescription drugs. If you talk to seniors today and ask somebody who is 80 or 85 years of age, Are you on prescription drugs, they will say, No, hopefully, but in all likelihood they will say Yes, for my diabetes, or for my congestive heart failure, or for my obstructive pulmonary disease, for my arthritis. Really, you can pick any one as you go through.

Thus, I would argue, if you are saying you deserve health care security, you deserve some health with your prescription drugs, yet you don't get it today at all in Medicare, there are things which we can do to strengthen it. The value of the benefit package is inferior to what is in the private sector today—inferior to what I would argue seniors deserve today.

I list these things because it is important for people to realize that as good as Medicare is, it simply does not provide what is available and what seniors deserve. If you are a senior, look at your total expenditures for health care. Medicare only pays about half of them. That means you have to figure out some way to pay for the other half. You might do it by buying other supplementary insurance policies, or by getting discounts, or whatever you have to do. In some way or another you have to figure out how to pay for it.

That is certainly not true for people in this body, or for the 9 million Federal employees who are not responsible for 50 percent of their health care today under their insurance program.

We need to change Medicare so it gives a better value and so our seniors will be able to get the health care they need without being unfairly punished by having to pay so much out of pocket—so much more than, say, Federal employees. The list goes on.

As we debate, we will talk more at length about these issues.

I want to mention one other problem with Medicare that we need to debate on this floor; that is, the fragmentation of the system.

In 1965, through compromise at the time, there was a Part A for physicians and a Part B for hospitals. It has been fragmented into two separate categories.

Today, health care needs to be continuous. There needs to be a continuum. You want ongoing, continuous quality management, and you don't need different financing systems or different record keeping or different deductibles or different copayments set up. It is just not an efficient and effective way to deliver health care today.

In short, the Medicare system—again, as good as it is—does not live up to the standard we have set in the private sector. It is now time to address that gap, which we will be doing on the floor of the Senate.

Medicare today is still set up the way it was in the 1960s and in the 1970s to respond to acute episodic care. People get sick and go to the hospital. You treat them, and they go home.

That is not the way health care is delivered today in the private sector where you want to keep people out of the hospital, where it is not just acute care, where you are not just responding to a heart attack. The idea today is to prevent the heart attack in the first place. Now we have the expertise to do it, we have the medicines to do it, but seniors are not getting it today.

So what are we going to see play out here in the next month? We will begin to hear—probably starting tomorrow—a lot of discussion of the various plans that have been both proposed in the past and that the Finance Committee is thinking about. The Senate Finance Committee now is developing a balanced plan, a balanced proposal that draws upon a lot of the legislation that has come to this body, legislation that, in the last Congress, was the tripartisan plan, and a plan from several years ago that JOHN BREAUX and I worked on, and a House-passed plan from last Congress and the Congress before, and the framework put forth by the President of the United States.

I hope and pray but I am committed to see that we develop a bipartisan plan, bringing the best out of this body, from Democrats and Republicans, to address some of the needs—hopefully all of the needs—that I outlined a few minutes ago that make

Medicare today less than what seniors deserve.

Over the next 2 weeks there will be a lot of discussion on this issue. Two weeks from now, on the floor of the Senate, we will be debating the legislation for 2 weeks. I am hopeful we can pass a plan out of the Senate before July 1 that responds to these needs.

I mention it has to be balanced and it has to be bipartisan. I say that for lots of reasons. In large part, it is because this is a huge challenge. We are going to have to take the very best of the Republican ideas, the very best of the Democrat ideas, the very best of the President's ideas, and the very best of the House's ideas and put them together. This will be the single largest expansion of Medicare in the history of the Medicare Program. As I said, it is going to be about \$2 trillion that seniors are going to be spending over the next 10 years. We need to debate, as we go forward, how we can lower that barrier so seniors can get those prescription drugs.

I will close by saying that reform, modernization, strengthening has to be linked to prescription drugs, and prescription drugs have to be linked to strengthening and improving Medicare. It does not make sense in a fragmented system that doesn't have very much in preventive care that was built on a 1960s model. It does not make sense to superimpose a brand new benefit without taking advantage of putting all that in a single system that gives continuity, quality assurance, a systems approach where you can reduce medical errors that we know occur today.

There are five key principles that will guide our legislative efforts.

I think, first and foremost, we need to stress that whatever we do needs to be patient-centered. We need to think of that senior, what we can do to give him or her health care security, building whatever changes are needed around that.

Second, our seniors deserve the opportunity to voluntarily choose the health care plan, the health care coverage that best meets their individual needs. It is revolutionary in many ways but to look at a senior and say: You will have the opportunity, A, to keep exactly what you have now, what you have under current law, or, B, you can choose a type of coverage that better meets your individual needs, which may focus on your chronic disease of heart failure, which may involve disease management of your diabetes, and which will include preventive care, so whatever your status is when that progresses, we will pick it up early. Seniors will be able to voluntarily choose the type of health coverage and drug benefit that best meets their individual needs.

Third, seniors also deserve coverage where they have continuous quality management and safety improvements, and that requires a systems approach. You hear about these medical errors being made in hospitals, confusing pre-

scriptions and medicines that interact with each other. I think that is the sort of thing we can avoid if we incorporate it in the legislation. I know we can do it in the legislation that evolves over the next several weeks.

Fourth, as I look at these principles, seniors deserve to be able to capture innovation. If we figure out a newer, better way to do something that will improve health care, that innovation should be captured. You should not have to wait 4 years to have access to innovation. It was 4, maybe even 5 years after heart transplants were widely available that they were made available in the Medicare Program. Seniors should not have to wait that long, if it is crystal clear, if the data is there, that this type of therapy is effective.

The fifth principle I would add is that seniors deserve coverage that is less bureaucratic, that has less paperwork, that is more flexible, so it can, indeed, adapt to the times.

We have a huge task ahead of us. A lot of people say they don't know if it can be done over the course of the next month. I am confident it can be done, in large part because much of the work was done in the last Congress, and it is being done both on the floor of the Senate and in the House of Representatives. We have made tremendous progress. We are building on a lot of the work that has been done in the past.

I am confident it can be done because the American people want it to be done. I am confident it can be done because people in this body—Democrat and Republican—want to do what is best for seniors, what is best for individuals with disabilities. I think we are going to see that responsiveness of this body play out over the next 4 weeks. I am excited about it.

The House of Representatives will likely be considering strengthening Medicare, addressing prescription drugs over the course of this month as well. If we can both accomplish that—which we are going to work very hard to do—within 6 months, 8 months, or less than a year from now, seniors will have a benefit as they reach out to obtain and use those prescription drugs as part of their health care.

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

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

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

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

MEDICARE REFORM

Mr. DASCHLE. Mr. President, I welcome our colleagues back. We are looking forward to a very productive few weeks. We know we have a lot of work to do in a relatively short time. In particular, work on the Energy bill is