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Senate

The Senate met at 9:30 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. The Reverend Charles V. Antonicelli, of St. Joseph's Roman Catholic Church in Washington, DC, is, once again, our guest Chaplain.

PRAYER

The guest Chaplain offered the following prayer:

Let us pray.

Almighty God, we give You thanks and praise at the start of this day. Help us to know Your will. In the words of the Psalmist we pray, ''Lord, make me know Your ways. Lord, teach me Your paths. Make me walk in Your truth, and teach me: for You are God my Savior.''

Help us Lord, to be as generous with each other as You are with us. Help us to respect and care for all people, even those who are different from us.

Bless and protect Your humble servants in this Senate. Watch over them, their families and their staffs. Keep them from harm and guide them in the ways of Your peace.

We ask this in Your Holy Name. Amen.

PLEDGE OF ALLEGIANCE

The President pro tempore led the Pledge of Allegiance, as follows:

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

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, the Senate will resume consideration of S. 1, the prescription drug benefits bill first thing this morning. There are two amendments currently pending to the bill: an Enzi amendment relating to pharmacies and mail-order prescriptions, and a Bingaman amendment regarding asset tests. These amendments are being reviewed, and we will have one of those votes some time early today. The other we will be voting on over the course of today. In addition, of course, we will be considering other amendments both today and tomorrow.

The chairman and ranking member will continue to work together to try to get Senators to come forth and offer their amendments, or to let them know what those amendments will be so we can establish a queue for those amendments to be considered today, tomorrow, and, indeed, into next week.

I do encourage, as I did yesterday morning, all Members to come forward and let the managers know what amendments they are considering offering. It is important to do so. For example, today we are waiting on one of the amendments to get an official scoring back from the Congressional Budget Office, so even after we hear about the amendments, it takes some time to process them. So it is absolutely critical that we hear from our colleagues in terms of what amendments they intend to offer.

We will have rollcall votes throughout today's session. We will be voting tomorrow as well.

(Ms. MURKOWSKI assumed the Chair.)

JUNETEENTH OBSERVANCE

Mr. FRIST. Madam President, I will comment very briefly on two issues, the first is on the Juneteenth observance.

Madam President, Juneteenth, which is also known as Freedom Day, is the date on which 250,000 slaves living in Texas finally learned of their emancipation. And that occurred nearly 3 years after President Lincoln's historic Emancipation Proclamation.

It was in 1865, on June 19, that Union General Gordon Granger led 2,000 troops into Galveston, TX, with news that the war had ended and that slavery had been abolished. He told the people of Texas:

[T]hat in accordance with a Proclamation from the Executive of the United States, all slaves are free. This involves an absolute equality of rights and rights of property between former masters and slaves, and the connection heretofore existing between them becomes that between employer and free laborer.

The celebrations that followed began a 140-year tradition. Today, all across the country, Americans of all races will celebrate with prayer, and picnics, food, family, and friends.

We join them, here on the Senate floor, to celebrate the struggle for freedom and to honor the profound contributions of African Americans to our Nation's culture and history.

MEDICARE REFORM

Mr. FRIST. Madam President, one last issue I wish to speak about now is one we will be talking about today and tomorrow on the floor of this Senate, and that is this whole issue of strengthening and improving Medicare.

Over the last several days, we have used terms such as ''actuarial value,'' and ''asset tests.'' We hear those terms again and again. We use acronyms so often. We talk about PPOs and HMOs and waiting on CBO for scoring. All these are important issues and vital issues, technical issues that are critical to our decisions that must be made, that we are obligated to make and should make to serve seniors in a better way with regard to their health care.

But I do want to step back, just for a second, to set the stage for today's debate, to talk to seniors who might be either watching on C–SPAN or listening on the radio, and try to describe

● This ''bullet'' symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

what, from a big picture, from sort of 30,000 feet, what this bill is all about.

When I am back in Tennessee, traveling through the State talking to seniors, the questions that I receive are not about reform or private competition or a market-based approach, and how all that is going to work in the bill. It is not how many stand-alone drug provider plans will be on the table. It is not what we have to think about here, what the 10-year cost is, or even the 20-year cost of the benefits we are discussing. Those are critical issues, issues that we must address as we address this historic legislation at this very important time, given the demographics, given the fact that we are talking about a health care system that has not kept up with the great advances in the delivery system and the technology and the medical science that have occurred over the last 30 years.

What they ask in these town meetings or in drugstores or when I am walking along on a sidewalk is: How is this going to affect me? I am a senior. I am concerned about my future. I am concerned about if I get sick. I am concerned about the fact that if I have an illness now, how is it going to affect me?

Very quickly, the first thing that will happen is in about 6 months, maybe 7 months after the President signs this legislation and makes it law of the land, every senior and individual with a disability on Medicare—every senior—will have the opportunity to get a little card, a Medicare prescription drug card. Every senior will be able to benefit from this little Medicare prescription drug card.

When I am talking to a senior, I tell them: You will be able to use this card similar to the way you might have a card for discounts at the grocery store, which is becoming increasingly popular today. We estimate that by using that little card—a card you do not have today; you cannot have today because the law does not allow it, but in 6 or 7 months after this bill is signed into law, you will have a card that will give you a discount of somewhere between 10 and 20 percent, by using that card, compared to the way you are getting your drugs today.

That is important to the senior because the senior knows that, yes, this will benefit me. Yes, Government, in a bipartisan way, has addressed the fact that the burden before me is huge.

Why can we do that? Because by using the combined purchasing power of up to 40 million people—instead of an individual senior going into a retail store and paying retail dollars for that—all of a sudden that senior, by having that card, becomes part of a huge purchasing group of as many as 40 million people.

If you are living alone and your income is less than $12,000 or if you are married and you and your spouse bring in less than $16,000, on that little card will be $600 of value you can use each year right off the top. In other words, you not only get a drug discount, but you will get an additional subsidy to help offset the cost of those medicines.

A senior asks me, How am I going to benefit? You take care of the details up in Washington, and do it right. But how is it going to benefit me?

Second, beginning in the year 2006, all seniors and individuals with disabilities covered by Medicare will be offered comprehensive prescription drug coverage. They will have access to a plan that offers more comprehensive coverage, when they ask how it is going to benefit them in the future.

Third—and this is what I am most excited about in the entire bill—we have also taken steps to offer seniors and that next generation of seniors a strengthened and improved overall Medicare Program. Seniors will have new choices they don't have now to get better coverage that meets their individual needs. They will be able to choose the type of coverage that best suits their needs.

They get immediate help, and we do it in a way with a benefit they don't have access to today, and, in addition to that, we expand choice. They will have an opportunity to choose a plan that better meets their needs. This is an exciting improvement in the Medicare Program which really brings it up to a modern type of health care delivery similar to—not exactly but similar to—the options we have as Federal employees and that I have as a Member of the Congress.

It used to be ''Mediscare.'' The last time we tried, 2 or 3 years ago, it was ''Mediscare.'' They said, ''Don't change.'' People will try to force you into HMOs. Do not trust Government. They are going to strip things away from you.

Actually the President mentioned this in a bipartisan meeting with Senators yesterday. It is no longer ''Mediscare,'' thank goodness. It is Medicare. That is really what we are trying to do in a bipartisan way.

People say, You want to have your choice of doctors and not be forced into HMOs. That is simply not true. In this bill, if you want to—for seniors listening to me—you can keep exactly what you have today in terms of your traditional Medicare coverage. You don't have to do anything to take advantage of the best choices. You can keep exactly what you have today. If you stick with what you have, you can get the prescription drug benefit along with everybody else, if you want to. In other words, keep what you have but take advantage of only prescription drugs. But if you are dissatisfied with your coverage today—and you realize that Medicare really doesn't cover preventive care, it covers very little in the way of chronic disease and management, it does not today, except Medicare+Choice, an organized, coordinated way of getting your health care—you don't have to, but you will be able to choose the expanded, the more flexible, and the more coordinated kind of coverage that today we clearly have as Federal employees and which also most working people have today, that sort of coordinated care plan.

But in Medicare today, you don't have that option. You will have the option to get things that are not currently covered by Medicare, such as preventive care.

I mentioned the programs of chronic disease management. There are also programs that promote wellness. Annual physical exams we know are so important. Again, whether it is annual or every 18 months, it probably doesn't matter that much. But right now, it is not covered under Medicare. That would be covered in the new program. You will be able to have a nurse call you or stay in touch with chronic disease management to remind you in case you have forgotten about who it is taking your weight or checking your blood pressure or looking for fluid retention and blood pressure, all of which are important. If you pick those up early, it keeps you from being hospitalized or getting sick. That heart is beating. If fluid is building up in your lungs, the heart beats harder and harder. You will have to be admitted to the hospital, and you will be trying to catch up. If they pick it up earlier and you stay healthy through appropriate management, you will not have to be hospitalized.

These are the kinds of coordinated benefits most working people have today and, as I mentioned, which Federal employees have today. It is the sort of benefit we want to make available—not forcing people but making it available to seniors as well.

Our goal in this bill is to allow you to have options so you can choose the kind of coverage and the kinds of doctors and hospitals that are most consistent with your needs. That is our goal, to make sure those choices are available for you.

In the days to come, we will have a lot of discussion and amendments as to how this plan will evolve. That is the whole purpose of having the debate and amendments.

As all of us know, the House of Representatives is going full steam ahead doing exactly the same thing we are doing and developing a plan, after which we will go to conference.

This bill represents the largest expansion of the Medicare Program in its history. We are going to be spending an additional $400 billion, which is a hefty sum, in providing this new benefit and strengthening the Medicare Program, and $400 billion is a lot. But the fact is that seniors over the next 10 years are going to be spending about $2 trillion on medicines and prescription drugs.

We are trying to target the resources of $400 billion in a way that makes the most sense so we can have appropriate benefits for seniors who are less well off and seniors who have very high drug costs so they get the most help.

I am looking forward to the debate. I want America's seniors to be able to come back to this picture I have just painted, and I want them to understand really these three things.

No. 1, if you want to, you can stick with what you have.

No. 2, you can, if you want to, stick with what you have but also get help with your prescription drugs.

And, No. 3, you will have for the first time in our Medicare Program the option, the opportunity of choosing a comprehensive, coordinated health care plan that keeps up with medical advances, with advances in technology and with advances in health care delivery systems.

When we finish this bill, and when we are successful, you will have a plan that offers real health security.

Madam President, I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of S. 1, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the Medicare Program, to provide prescription drug coverage under the Medicare Program, and for other purposes.

Pending:

Enzi/Reed Amendment No. 932, to improve disclosure requirements and to increase beneficiary choices.

Bingaman Amendment No. 933, to eliminate the application of an asset test for purposes of eligibility for premium and cost-sharing subsidies for low-income beneficiaries.

The PRESIDING OFFICER. The Senator from Maine.

AMENDMENT NO. 933

Ms. SNOWE. Madam President, I rise to address the pending Bingaman amendment because I believe it is important to provide some of the background as to how we arrived at the asset test that is included in the pending bill before the Senate regarding prescription drug coverage and the overall Medicare Program.

We learned a lot, as I said initially, from the debate and the tripartisan plan we had offered last year. We had included an asset test. That asset test did present a number of problems to colleagues on the other side of the political aisle. We attempted to work it out, but obviously it was not to their satisfaction. We had a number of meetings during the course of the debate last fall on the pending legislation, but we were not able to resolve the differences.

One of the key contentious issues was the fact that we had an asset test they believed was too encompassing, that it would deny many low-income individuals the ability to have access to the overall drug coverage and the type of subsidy we had included. So we learned from that debate, we learned from the discussions, and we took a far different approach this time in this legislation to incorporate the lessons that had been learned in developing an asset test.

We understand Senator BINGAMAN's desire to do more for low-income beneficiaries, but we have to keep in mind that we have crafted the legislation within the $400 billion parameter included in the budget resolution. We have come a long way in terms of how much we are providing for a prescription drug benefit. Can we do more? Absolutely. But obviously we have to live within the confines of our ability to finance this and so many other obligations.

Just 5 years ago we started at $28 billion with then-President Clinton's proposal. We increased it to $40 billion, to $300 billion, to $370 billion. Now we are up to $400 billion as proposed by President Bush. That is almost $200 billion more than he had originally proposed last year. We have come a long way in this debate.

How do we design the best, most effective, fairest low-income subsidy assistance? We decided it would be important to provide a universal benefit in the Medicare Program when it came to prescription drug coverage. But also we wanted to ensure that we targeted those who were most in need. That was one of the other principles that was so essential in developing the program. That is why we decided to use various low-income Medicare and Medicaid beneficiary programs that are already enacted and have been part of law, consistent across the board with respect to formulas, and have been used by senior citizens so it is something familiar to them.

We used the qualified Medicare beneficiaries program, otherwise known as QMBs, the select low-income immediate beneficiaries, SLIMBs, and qualified individuals, the QI–1 program, to send the highest level of assistance with cost premiums, deductibles, and copayments to those most in need. As it exists in current law, we target the assistance to beneficiaries based on both their income and asset level to make sure we are capturing those who truly have the most need.

We drop the asset test that was included in the previous tripartisan legislation that would have prevented 40 percent of low-income beneficiaries from receiving coverage. We really address some of the inequities and the problems with our previous asset test by including, this time, in this legislation, programs that have already worked for seniors who have a very limited asset test.

For those in the lowest income categories, we are talking $2,000 for individuals, $3,000 for couples. For those from 73 percent to 100 percent, we are talking about asset tests between $4,000 for individuals and $6,000 for couples. The same is true for those between 100 and 135 percent of the poverty level; then for those between 135 percent and 160 percent of poverty level, assets again at $4,000 and $6,000 for a couple.

We think that by establishing consistency with other programs that have worked, we are able to design a fairer approach to the issue in terms of eligibility for the low-income subsidy. Also, we are utilizing existing government infrastructure so that we do not divert scarce dollars away from beneficiaries to create new Federal or State bureaucracies.

In developing S. 1, we did look to the lessons we learned from last summer's debate and the negotiations that progressed into the fall. We realized that in constructing the tripartisan plan, we were excluding millions of seniors and disabled Americans from eligibility for the low-income assistance subsidy because their income or assets did not meet the strict guidelines. Obviously, we did that because we were then living within the confines of $370 billion.

So we created the new categories for low-income assistance. It goes up to 160 percent of poverty level. Again, that is also a change from the tripartisan plan where we put the maximum subsidies up to 150 percent of poverty level. So we increased it from 150 to 160 percent of poverty level. For an individual that means $15,472 and for a couple that is $20,881, regardless of an individual's assets. We are not even using an asset test for another category below 160 percent of poverty level so that we are ensured we are capturing everybody who comes within those poverty guidelines in order to ensure they get the maximum subsidy possible.

This new category that we are capturing under the 160 percent and not requiring an asset test will include 8.5 million additional Medicare beneficiaries in 2006 and provide them with very generous assistance. They will not be subject as well to the gap in coverage where they are responsible for 100 percent of the cost of the prescription drugs.

This new benefit only requires a $15 deductible compared to the $275 for those above 160 percent of poverty. They have a much more generous cost sharing starting at 10 percent, from $51 to the benefit cap of $4,500; and from $4,500 until they spend $3,700, they pay a 20 percent copayment. Once they reach the catastrophic cap, the Government will pay 90 percent of the cost.

We clearly did design a program that provides the most assistance to those in most need. I know we always could do more, but obviously we had to stay within the parameters of the $400 billion in designing this program. There are those on my side of the political aisle who believe we have gone too far in providing the types of subsidies we do. But we have copayments that obviously do help to reduce utilization and