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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. Today's prayer will be offered by our guest Chaplain, Rabbi Milton Balkany of the Congregation Bais Yaakov of Brooklyn, NY.

PRAYER

The guest Chaplain offered the following prayer:

Our Father in heaven!

I sing You a song for the blessed United States of America. I sing a hopeful song for the peace and tranquility that we seek. Every patriotic soul joins me and our voices blend in heartfelt harmony. Let our notes wend their way from the hot Mojave sands to the cool waters of the Great Lakes. Let our song echo in the footsteps of Lewis and Clark as they courageously unraveled the mysteries of this free land. Let our lyrical prayer soar up the peaks of Mount Hood and Mount McKinley until they reach the summit of Your glory and Your mercy.

Though our voices are many, though our accents and inflections are as different as the day is long, our song is one and our one song is plain and true and unchanging. We sing: peace. Peace. True Peace. Bring us back to the times of fearless skies and unbridled New York nerve, of tranquil school yards and cool back porch nights. Return these times to us, O G-D. And we will return to You—with a new song, a mighty, rapturous chorus of jubilation!

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 ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The acting majority leader is recognized.

SCHEDULE

Mr. MCCONNELL. Mr. President, we will shortly resume consideration of S. 1, the prescription drug benefits bill. We have been in discussion with the distinguished assistant Democratic leader about votes later this morning. We hope to be able to have an announcement shortly about when the votes will commence. Obviously we will stay on this bill all day today. We will be finishing it this week, hopefully Thursday night. We are going to press forward and encourage Members to continue to offer their amendments. We will try to get votes as rapidly as we can.

Mr. REID. Mr. President, the amendment I understand that has been the focus of so much the last few days is prepared and the two leaders are looking this over. We hope to be able to have a vote on that soon. In the meantime, I have a lot of amendments lined up that we can move on and I will work with my distinguished friend, the majority whip, in determining when we can do that. We hope in the next hour we will start a bunch of votes. We will work on that and the majority will make an announcement soon.

Mr. MCCONNELL. I yield the floor.

RESERVATION OF LEADER TIME

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

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The PRESIDENT pro tempore. Under the previous order, the hour of 9:30 having arrived, the Senate will proceed to 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:

Graham (FL) amendment No. 956, to provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill.

Kerry amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare program.

Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.

Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.

Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.

Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Baucus (for Harkin) amendment No. 967, to provide improved payment for certain mammography services.

Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare Prescription Drug plan, a MedicareAdvantage Organization offering a MedicareAdvantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

Rockefeller amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage.

Akaka amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid program and SCHIP to include citizens of the Freely Associated States.

Akaka amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Bingaman amendment No. 972, to provide reimbursement for Federally qualified health centers participating in medicare managed care.

Bingaman amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all Medicare part B services furnished by certain Indian hospitals and clinics.

Baucus (for Edwards) modified amendment No. 985, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.

Baucus (for Lautenberg) amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Murray amendment No. 990, to make improvements in the MedicareAdvantage benchmark determinations.

Harkin amendment No. 991, to establish a demonstration project under the Medicaid program to encourage the provision of community-based services to individuals with disabilities.

Dayton amendment No. 960, to require a streamlining of the Medicare regulations.

Dayton amendment No. 977, to require that benefits be made available under part D on January 1, 2004.

Baucus (for Stabenow) amendment No. 992, to clarify that the Medicaid statute does not prohibit a State from entering into drug rebate agreements in order to make outpatient prescription drugs accessible and affordable for residents of the State who are not otherwise eligible for medical assistance under the Medicaid program.

Baucus (for Dorgan) amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare program.

Grassley amendment No. 974, to enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs.

Durbin amendment No. 994, to deliver a meaningful benefit and lower prescription drug prices.

Smith/Bingaman amendment No. 962, to provide reimbursement for Federally qualified health centers participating in Medicare managed care.

Hutchison amendment No. 1004, to amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the Medicare program at 6.5 percent.

Sessions amendment No. 1011, to express the sense of the Senate that the Committee on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under Medicaid and SCHIP as part of the reauthorization of the temporary assistance for needy families program.

Sununu amendment No. 1010, to improve outpatient Vision services under part B of the Medicare program.

Conrad amendment No. 1019, to provide for coverage of self-injected biologicals under part B of the Medicare program until Medicare Prescription Drug plans are available.

Conrad amendment No. 1020, to permanently and fully equalize the standardized payment rate beginning in fiscal year 2004.

Conrad amendment No. 1021, to address Medicare payment inequities.

Clinton amendment No. 1000, to study the comparative effectiveness and safety of important Medicare covered drugs to ensure that consumers can make meaningful comparisons about the quality and efficacy.

Clinton amendment No. 999, to provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level.

Clinton amendment No. 953, to provide training to long-term care ombudsman.

Clinton amendment No. 954, to require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information.

Reid (for Boxer) amendment No. 1036, to eliminate the coverage gap for individuals with cancer.

Reid (for Corzine) amendment No. 1037, to permit Medicare beneficiaries to use Federally qualified health centers to fill their prescriptions.

Reid (for Jeffords) amendment No. 1038, to improve the critical access hospital program.

Reid (for Inouye) amendment No. 1039, to amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system.

AMENDMENT NO. 988

Mr. THOMAS. I ask unanimous consent to lay aside the pending amendments.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. THOMAS. I send an amendment to the desk.

The PRESIDENT pro tempore. The clerk will report.

The Senator from Wyoming [Mr. THOMAS], for himself and Mrs. LINCOLN, proposes an amendment numbered 988.

Mr. THOMAS. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for the coverage of marriage and family therapist services and mental health counselor services under part B of the medicare program, and for other purposes)

At the end of subtitle B of title IV, add the following:

SEC. ___. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking ''and'' after the semicolon at the end;

(B) in subparagraph (V)(iii), by inserting ''and'' after the semicolon at the end; and

(C) by adding at the end the following new subparagraph:

''(W) marriage and family therapist services (as defined in subsection (ww)(1)) and mental health counselor services (as defined in subsection (ww)(3));''.

(2) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor

''(ww)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

''(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(4) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree in mental health counseling or a related field;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

''(v) marriage and family therapist services and mental health counselor services;''.

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) (42 U.S.C. 1395*l*(a)(1)) is amended—

(A) by striking ''and (U)'' and inserting ''(U)''; and

(B) by inserting before the semicolon at the end the following: '', and (V) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(W), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)''.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING

FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended in section 301(a), is amended by inserting ''marriage and family therapist services (as defined in subsection (ww)(1)), mental health counselor services (as defined in section 1861(ww)(3)),'' after ''qualified psychologist services,''.

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

''(vii) A marriage and family therapist (as defined in section 1861(ww)(2)).

''(viii) A mental health counselor (as defined in section 1861(ww)(4)).''.

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (ww)(2)), or by a mental health counselor (as defined in subsection (ww)(4)),''.

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting ''or a marriage and family therapist (as defined in subsection (ww)(2))'' after ''social worker''.

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-HOSPITAL SERVICES.—Section 1861(ee)(2)(G) (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting ''marriage and family therapist (as defined in subsection (ww)(2)),'' after ''social worker,''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2004.

Mr. THOMAS. This extends the opportunity to directly pay medical health consultants. I will discuss it later. In the meantime, I will set it aside for later discussion.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The Senator from California.

Mrs. BOXER. Mr. President, I take a couple of minutes to explain an amendment we will be voting on later that was introduced on my behalf by Senator REID and to let my colleagues know I think it is a stunning situation when suddenly, after fighting back all the amendments that we had to try to improve the benefits, that we are giving our seniors—miraculously there is $12 billion found and it will start a whole new experiment, which may be very interesting and may be just fine. It will push some people out of Medicare and see if it works better in the private sector. I hate to say we have tried it and it hasn't worked but that is fine.

At the same time, we are going to allow Medicare to do more prevention and do more pharmaceutical benefit. We will see what that looks like when it comes to us.

The point I am making, yesterday the Senator from Pennsylvania was railing against some Members who wanted to make this plan better because there was no money. It was so expensive. But they found money to do some experiment.

Today I have an amendment to give people a chance to decide if they want to help people with cancer, if they want to help people who are diagnosed with cancer.

I don't know if you have ever had the experience of having cancer in your family, but surely we all know people who have had that experience. Life in that family comes to a halt. People are reeling from the diagnosis of cancer, whether it is breast cancer, lung cancer, prostate cancer, colon cancer, stomach cancer, blood cancer which is leukemia, lymphoma; millions of Americans are touched. And we have a drug benefit that stops at $4,500 and then $1,300 later you start getting help for your medication.

Yesterday, I gave the Senate a chance to close that benefit shutdown, close that coverage gap, and the Senate refused to do it, mostly on a party-line vote.

Today I offer an amendment to let people redeem themselves. What I say is, if you are diagnosed with cancer, you should never have your drug benefit shut down. You are reeling from this diagnosis. You are sick with this disease. And you should not have to worry about whether you can afford your medicine.

Later in the day we are going to have a chance to see if people are willing to have enough compassion in their heart to stop the benefit shutdown for families where there is a cancer diagnosis. Why do I choose cancer? I could have chosen a number of other diseases. I chose that one because it touches so many families. If it passes, I am going to offer one where there is an Alzheimer's diagnosis. If that passes, I will offer one where there is a Parkinson's diagnosis.

There are a couple of good things in this bill. It starts a prescription drug benefit. That is a plus. We are going to have to fix it. It is a mess. It is the only plan in the country I have found that has such a benefit shutdown. The premiums can go up at any time. HMOs and PPOs can drop out of the business and then you do not know what you are going to do. The fact there is a benefit is important. And it is generous to those who are very poor.

But I want it to be fair to those in the middle class and I want it to be fair to those who need their pharmaceutical products the most. So I am going to give my colleagues a chance to end the benefit shutdown for people who have cancer. If you want to vote no, vote no. If you want to tell people you had a chance to make sure they have those pharmaceutical products through a period of their lives when they are frightened, when they are fighting a disease, go ahead. Do it. Do it.

But I ask you to look inside your soul. You are about to vote on a new program of $12 billion. Don't walk away from the people with cancer just to give money to HMOs, because that vote will come back to haunt you. That is how I feel.

I was very disappointed yesterday that we had a straight party-line vote, pretty much, on my amendment to end the benefit shutdown. But around here you have to be held accountable for what you do. So I am going to give people a chance to come back and say, OK, in the case of cancer, people are not going to have their benefits shut down. Just imagine what it is like, going through chemotherapy, taking all kinds of risks so you can live, because chemotherapy, as you know, basically kills a lot of healthy cells, too.

And, if that is not enough, you are going to have to deal with the accountants with their eyeshades in the HMOs, who will say, What have you done? You really didn't get to $4,500. Why are you shutting down my benefit? You will be begging them not to shut you out because your doctor says if you miss this medicine you could reverse the progress you are making on this disease.

I am going to stop discussing this amendment. I think it is pretty clear. Senators will have a chance to help people with cancer. If you do not want to do it, then you have to live with that vote.

Mr. President, I yield the floor and I look forward to this vote on my amendment.

The PRESIDENT pro tempore. The Democratic leader.

Mr. DASCHLE. Mr. President, under the unanimous consent agreement we reached last night, there was scheduled an amendment to be voted upon, the so-called Grassley benchmark amendment, at 10 o'clock. We have not yet had the opportunity to review the amendment. As I understand it, it is still being negotiated. So we are not in a position, obviously, to agree to the amendment at 10 o'clock. We look forward to consulting with both managers of the bill. Certainly I will be talking to the majority leader as we continue to work to bring the amendment to the floor.

Given the fact we are not yet at a position to vote, it would not be my expectation that there would be a vote at 10 o'clock.

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

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

AMENDMENT NO. 972

Mr. BINGAMAN. Mr. President, I ask unanimous consent to call up amendment No. 972 on Medicare community health center payments.

The PRESIDING OFFICER. That amendment is pending before the Senate.

Mr. BINGAMAN. I ask unanimous consent to revise the list of sponsors of the amendment to read: Senators SNOWE, BINGAMAN, SMITH, HOLLINGS, and HATCH.

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

Mr. BINGAMAN. Mr. President, I thank the chairman and ranking member for agreeing to this very important amendment related to our Nation's community health centers. I also thank Senator SNOWE, with whom all who are now cosponsoring this amendment introduced S. 654, the Medicare Safety Net Access Act of 2003. Her leadership on the Nation's community health centers has been unwavering and has made it possible to get to the point where we can adopt this amendment.

I also thank Senator SMITH, Senator HOLLINGS, Senator HATCH, and Senator CONRAD for their longstanding advocacy support for community health centers. Senator SMITH and Senator HOLLINGS need to be thanked for their constant advocacy and push to see this amendment pass.

In addition, it should be noted that Senators HATCH and CONRAD spearheaded a very similar effort to protect community health centers in the Medicaid Program back in 1997.

As we proceed with the passage of S. 1, we need to be careful not to create potential unintended consequences as a result of our actions. This amendment corrects an important unintended consequence that this legislation could have had on our Nation's community health centers. Community health centers have broad bipartisan support. The President and the Congress have committed to doubling the funding for community health centers over a 5-year period. The health centers provide care for over 13 million people annually. Nearly one million of those are low-income Medicare beneficiaries. They receive section 330 Federal Public Health Service Act grant funds to support care for the uninsured and for low-income patients. To ensure those grant funds are used entirely for that purpose, Congress has specifically taken action to ensure that both Medicare and Medicaid are fully reimbursing health centers for the costs associated with the care provided for Medicare and Medicaid beneficiaries.

Simply put, the funding intended for low-income and uninsured people should not be diverted and instead used to subsidize Medicare underpayments. Therefore, health centers are reimbursed by Medicare under a cost-base system. This amendment would simply extend the same requirement to the new Medicare Advantage programs by ensuring that community health centers are provided with a wraparound or supplemental payment equal to the difference between the payments they now receive under Medicare generally and the payment they would receive from Medicare Advantage plans. This is not a new concept.

In 1997, Congress allowed States to dramatically increase the number of patients who were enrolled in Medicaid managed care. We recognized the potential adverse impact on community health centers, and to deal with that we required the Medicaid Program to provide a wraparound or supplemental payment for the difference between the managed care organizations payment and a health centers reasonable cost. Again, Senators HATCH and CONRAD were instrumental in that effort.

With this important amendment we are proposing today we would do the same in the Medicare Program. According to testimony Tom Scully gave at the Center for Medicare and Medicaid Services and testimony that the Congressional Budget Office gave on the 13th of June, their estimates for how many Medicare beneficiaries actually were enrolled in the private health plans ranged all over the board. It went from 9 percent in one estimate, the CBO estimate, to 43 percent, the estimate that Tom Scully's actuaries developed. It was a fivefold difference in those estimates.

In the words of Dr. Holtz-Eakin, the head of the CBO, these are honest differences in trying to read a very uncertain future.

We do have clearly ahead of us a very uncertain future as to how many people will choose to leave traditional Medicare and move into the private plans. Mr. Scully is correct that health centers will lose their guarantee of cost-base reimbursement to 43 percent of their Medicare patients. Potentially, this could result in centers having to dip into their Federal grant fund money intended to provide care to the uninsured, and they would have to dip into those Federal grant funds in order to make up for losses they were incurring trying to provide services to Medicare patients.

Our Nation's safety net is already fragile. We need to take this action to ensure we are not jeopardizing it through the passage of this legislation.

Again, both the President and Congress have committed to double the capacity of our Nation's health centers to deal with the growing number of uninsured in this country. In light of this, the amendment we are offering today would protect the vital role that health centers play. It would ensure that health centers are not forced to decide either between subsidizing the Medicare Program with their grant dollars or refusing to provide services to some of the 1 million low-income Medicare beneficiaries that currently depend upon them for services.

I thank the chairman and ranking member for agreeing to accept this amendment. I thank all the chief sponsors, Senator SNOWE, and all cosponsors for their hard work. I believe it is a very important amendment. I urge my colleagues to support it.

Ms. SNOWE. Mr. President, I rise today to speak on behalf of the amendment that I am offering today with Senator BINGAMAN, a longtime champion of community health centers and the original cosponsor of the legislation that we introduced, S. 654, the Medicare Safety Net Access Act, from which this provision has been taken. I also would like to thank my colleagues, Senators HATCH and SMITH for their help in moving this important policy change forward. Chairman GRASSLEY and Senator BAUCUS also should be recognized for their work on behalf of Community Health Centers. Their willingness to work with me has made adoption of this policy possible.

This amendment will help ensure that Community Health Centers remain a viable and integral part of the health care delivery system for Medicare beneficiaries and rural communities at large. Community Health Centers, also known as Federally qualified health centers, provide care to millions of medically underserved Medicare beneficiaries. In many cases, Community Health Centers are the only source of primary and preventive services to which these beneficiaries have access. This is especially true for people living in America's rural and inner-city medically underserved areas.

As many of you know, under the traditional fee-for-service program Community Health Centers currently are reimbursed by Medicare bases on the cost to deliver care. However, because managed care plans, such as those expected to be used under the new MedicareAdvantage program, use capitated rates, which are negotiated rates based on patient volume and often are lower than the fee-for-service cost-reimbursement rate, Community Health Centers would likely experience substantial reductions in payments.

If, as CMS predicts, over 40 percent of seniors enter the new MedicareAdvantage program, Community Health Centers would experience a substantial loss of revenue because their payment for almost half of their clients would be based on a capitated rate. If this happens, Community Health Centers would be unable to meet the growing demand of serving the Medicare population.

This amendment ensures that doesn't happen. Starting in 2006, if the capitated rate that a Community Health Center receives from a participating MedicareAdvantage plan is less than the fee-for-service cost reimbursement rate, the Medicare program will pay the difference in the amount. This is done presently under the Medicaid program and it should be no different under the Medicare program.

Community Health Centers are an invaluable component in the health care delivery system in rural communities and I am pleased that this amendment has been accepted into S. 1.

Mr. HATCH. Mr. President, I rise in strong support of the Bingaman-Snowe-Hatch amendment. This amendment addresses an important issue for both Medicare beneficiaries and community health centers by ensuring that

Medicare beneficiaries, regardless of their Medicare health coverage choice, would receive seamless coverage if they choose to receive services from a community health center. And, it provides the Community Health Centers the ability to give the Medicare beneficiaries that they serve seamless health coverage as well.

I have been a strong supporter of community health centers for many years. These health centers provide care to over 13 million people annually; nearly one million are low-income Medicare beneficiaries. These health centers receive funding under the Public Health Service Act in order to provide quality care to their uninsured and low-income patients. To ensure those dollars are used only to provide health care to health center patients, Congress has taken action to ensure that both the Medicare and Medicaid programs are reimbursing health centers for the costs associated with care to Medicare and Medicaid beneficiaries. Therefore, community health centers are reimbursed by Medicare and Medicaid under a cost-based system.

In 1997, Congress allowed States to increase greatly the number of patients enrolled in Medicaid managed care by requiring the Medicaid program to provide a ''wrap-around' payments for the difference between the managed care organization's payment and a health center's reasonable costs.

This amendment ensures that we do the same thing for Medicare beneficiaries in the MedicareAdvantage program. More specifically, the amendment ensures that community health centers are provided with a ''wrap-around'' or supplemental payment equal to the difference between the payments they now receive under Medicare through the cost-based system and the payment they would receive from MedicareAdvantage plans.

Officials at the Centers for Medicare and Medicaid Services and the Congressional Budget Office estimate that nine to 43 percent of Medicare beneficiaries will enroll in private health plans offered through the MedicareAdvantage program. If these estimates are accurate, then health centers will lose their guarantee of cost-based reimbursement for up to 43 percent of their Medicare patients. This could result in centers having to dip into their Federal funding received through the Public Health Service Act. This funding is intended to provide care to the uninsured—not to fill in the gaps for certain Medicare health center patients.

The Bingaman-Snowe-Hatch amendment would not only protect the vital role of health centers but would also ensure that these health centers would continue to provide seamless health coverage to one million low-income Medicare beneficiaries. I urge my colleagues to support this amendment.

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. Mr. President, I ask unanimous consent that at 11 o'clock today, the Senate proceed to a vote in relation to amendment No. 972 and that the amendment now be considered as being proposed by Senators SNOWE, BINGAMAN, and HATCH; further, that following that vote, there be 2 minutes equally divided for further debate prior to a vote in relation to the Edwards amendment, No. 985, to be followed by 2 minutes equally divided and a vote in relation to the Graham amendment, No. 956, with no second-degree amendments in order prior to the vote.

Finally, I ask unanimous consent that the time until the votes be equally divided between the two managers or their designees, and I further modify the request to allow 4 minutes equally divided prior to the Edwards vote.

The PRESIDING OFFICER. Is there objection?

AMENDMENT NO. 985, AS MODIFIED FURTHER

Mr. EDWARDS. Mr. President, reserving the right to object, I have a modification at the desk with additional modifications. I ask unanimous consent, first, that the modification be accepted.

The PRESIDING OFFICER. The amendment is further modified.

The amendment (No. 985), as modified further, is as follows:

At the end, add the following:

TITLE ____—DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. ___01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) NEW DRUG APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following ''(including, if the Secretary so requires, whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)''; and

(2) in subsection (d)(5)—

(A) by inserting ''(A)'' after ''will''; and

(B) by inserting after ''thereof'' the following: '' or (B) if the Secretary has required information related to comparative safety or effectiveness, offer a benefit with respect to safety or effectiveness (including effectiveness with respect to a subpopulation or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug''.

(b) MISBRANDING.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after ''effectiveness'' the following: ''(including effectiveness in comparison to similar drugs for substantially the same condition or conditions)''.

(c) REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including effectiveness in comparison to other drugs for substantially the same condition or conditions);

(ii) information relating to side effects and contraindications; and

(B) any advertisement present a fair balance, comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided that*, nothing in this section shall require explicit images or sounds depicting side effects and contraindication.

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. ___02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

''(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

''(A) the Secretary provides the person written notice of the violation; and

''(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

''(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

''(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

''(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

''(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).''.

SEC. ___03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n)

of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. ___04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, for the information of Senators, we are going to have this block of votes. Then there is going to be a period of time where the two leaders have agreed there would be no amendments voted on. At about 2:30 or quarter to 3, we are going to try to line up a batch of votes to take up time this afternoon.

So for the information of Senators, at 2:30 or quarter to 3, the two managers and leaders are going to try to line up a bunch of votes.

AMENDMENT NO. 985, AS MODIFIED FURTHER

Mr. EDWARDS. Mr. President, I rise today, together with my friend, Senator TOM HARKIN from Iowa, to introduce an amendment to bring down the cost of prescription drugs. As everyone knows, the cost of prescription drugs has been skyrocketing. We have to bring these costs under control, not only to lower the drug costs for seniors but also to lower drug costs for all Americans, including those who will not get a prescription drug benefit under the Medicare Program.

There are lots of reasons drug costs are rising, and I have offered several proposals to address that in the past. This amendment addresses two particular concerns. The first is what is called the ''me too'' drugs that provide minimal benefits for people but large profits for drug companies. The second is the massive growth in the direct-to-consumer advertising that does not genuinely educate consumers.

This amendment, from TOM HARKIN and me, would address these problems with two steps. First, we call on the Secretary of HHS to require drug manufacturers to prove that ''me too'' drugs actually provide benefits before they are approved. Second, we would impose new requirements for fairness and balance in drug advertising.

Drug companies provide a very important service to America and to the sick. They deserve to make a profit for that, all of us agree on that. But they should also fulfill their mission as businesses, to generate innovative drugs that reduce pain, alleviate suffering, and cure disease.

Unfortunately, many drug companies seem to be giving that mission short shrift. We know they spend far more on marketing, advertising, and administration than they spend on research and development. We also know that instead of focusing on truly innovative breakthroughs, drug companies are focusing on ''me-too'' drugs to compete against blockbuster treatments for chronic conditions like allergies and high cholesterol. I want to talk about that for a minute.

Me-too drugs can be good things. They can help a specific population, or they can be safer and more effective. Of course those are good things. But here is the problem. Companies should not be able to profit off of a me-too drug just by misleading consumers about the benefits compared to existing drugs. Consumers should know how exactly the new drug stacks up against the existing drug.

Senator CLINTON spoke of the same need last night, when she introduced her very sound amendment. Consumers need to be given the ability to make an informed choice about the best drug for them.

This amendment would give the Secretary of HHS the authority to require drug companies to test drugs against their competitors. And if the drug company is going to advertise its ''me-too'' drug, it should tell the consumer how that drug compares to what they may already be taking for that condition.

Now, I want to talk about the larger point, which is drug advertising.

Some drug advertising is a good thing. Drug ads can let people know about drugs about which they don't otherwise hear. The drug industry's major trade group, PhRMA, says the purpose of direct-to-consumer advertising is:

> . . . to educate consumers about diseases, about the symptoms that may help them identify diseases, and the available therapies developed to treat them.

Those are good. Those are good goals. Here is the problem. Does anyone think drug advertising today is genuinely about educating consumers, as PhRMA says, rather than marketing? Does anyone believe that?

Are drug companies educating consumers about allergy medicines by showing this picture of a woman running through a field? I think all of us know, when this kind of advertisement, as in this picture, is shown on television, it is clearly about selling and about marketing. This is not for the purpose of educating consumers, and the American people know that. They know that without anyone telling them that.

Are they educating consumers about arthritis with images of a couple dancing in their kitchen? If this were about education, would an announcement read: ''Health warnings: Headache, nausea,'' and so on, while the picture on the screen still shows happy pictures of a mom and her kids? Absolutely not. These ads are not about education; they are about marketing.

There is nothing wrong with marketing and persuasion in most contexts. If they are selling paper towels or shaving cream, companies should go ahead and market as aggressively as they can. But prescription drugs are different. There is nothing more important in our lives than our health, and there is nothing more important than drugs for our health. These are matters of life and death for families, for seniors, and for kids. Advertisements for these products should be held to a much higher standard. They should educate, not just market.

That is not what these ads do. You don't have to take my word for it; that is what Consumer Reports says, that is what doctors say, and, most importantly, it is what common sense says. These ads make promises they cannot keep. They overstate benefits and they understate risks. Let me give just a couple of examples from recent research.

This is from a study from the magazine Consumer Reports. They studied drug ads and they found:

> . . . a broad and disconcerting range of misleading messages: ads that minimize the product's risk, exaggerated its efficacy, made false claims of superiority over competing products; promoted unapproved uses for an approved drug; or promoted use of a drug still in the experimental stage.

In a recent FDA survey of 500 general practitioners, family doctors, 7 out of 10 said advertisements about drugs confused patients about the risks and benefits of medicines. In another study, 75 percent of doctors said their patients came away with the impression that the drugs they saw in advertisements work better than they actually do.

The Kaiser Family Foundation did a survey of nearly 2000 adults who saw drug advertisements; 7 out of 10 said they learned little or nothing about what the treated condition; 6 out of 10 said they learned little or nothing about the drug. Here are comments from Arnold Relman and Marcia Angell, two former editors-in-chief of the New England Journal of Medicine. They said:

> DTC ads mainly benefit the bottom line of the drug industry, not the public. They mislead consumers more than they inform them, and they pressure physicians to prescribe new, expensive, and often marginally helpful drugs, although a more conservative option might be better for the patient.

So this amendment is simple. It says that drug ads should be balanced. They should include information about other drugs that may address conditions better. And they should have a real balance between the images selling the drug and the images questioning the drug.

Now, the Bush administration sees it differently. They think see it as drug companies should be able to use whatever marketing gimmicks they want to sell their drugs.

The FDA is supposed to stop ads that are misleading. But last year the Bush administration's FDA instituted a new policy that slows down the FDA's efforts. As a result, the FDA issued two-thirds fewer warning letters last year

than the year before. The GAO looked into this and found that warning letters are often ''not issued until after the advertising campaign has run its course.''

This is a gift to the drug companies. Without the threat of a warning letter, they can basically air whatever kind of ad they want and just ask for forgiveness afterwards.

Take the case of an ad for the prescription drug Tamiflu that ran on the radio last year. It featured Eric Bergoust, the Olympic gold-medal skier, who said ''I felt better so soon that I didn't miss a single day of training.'' The FDA told the drug maker Hoffmann-La Roche to stop running the ad because Bergoust's words ''misleadingly overstated the drug's efficacy.'' But the FDA's request came nearly three months after the company had submitted the ad for review, a month after the flu season had ended, and well after the company stopped running the ad.

Our amendment would make sure this kind of thing cannot happen. The FDA should speed up the review process and use their authority to have misleading ads pulled before millions of consumers have already seen them. And drug companies need to be held accountable when they repeatedly violate FDA regulations. In this amendment, Senator HARKIN and I call for stiff civil penalties for such offenders.

So, in short, this amendment would not bar all direct-to-consumer advertising. It would simply require the advertising to educate, rather than simply market. I urge my colleagues to support this amendment.

This amendment is for the purpose of doing something to control drug advertising, to make sure that it is, in fact, about education, and to make sure these ''me too'' drugs actually have a benefit before they are approved by the FDA.

Thank you, Mr. President.

VOTE ON AMENDMENT NO. 972

The PRESIDING OFFICER. The hour of 11 a.m. having arrived, the question is on agreeing to amendment No. 972, proposed by Senators Snowe, Bingaman, and Hatch.

Mr. EDWARDS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea.''

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 94, nays 1, as follows:

[Rollcall Vote No. 242 Leg.]

YEAS—94

Akaka	Dodd	Lugar
Alexander	Dole	McConnell
Allard	Domenici	Mikulski
Allen	Dorgan	Miller
Baucus	Durbin	Murkowski
Bayh	Edwards	Murray
Bennett	Ensign	Nelson (FL)
Biden	Enzi	Nelson (NE)
Bingaman	Feingold	Nickles
Bond	Feinstein	Pryor
Boxer	Fitzgerald	Reed
Breaux	Frist	Reid
Brownback	Graham (SC)	Roberts
Bunning	Grassley	Rockefeller
Burns	Hagel	Santorum
Byrd	Harkin	Sarbanes
Cantwell	Hatch	Schumer
Carper	Hollings	Sessions
Chafee	Hutchison	Shelby
Chambliss	Inhofe	Smith
Clinton	Inouye	Snowe
Cochran	Jeffords	Specter
Coleman	Johnson	Stabenow
Collins	Kennedy	Stevens
Conrad	Kohl	Sununu
Cornyn	Kyl	Talent
Corzine	Landrieu	Thomas
Craig	Lautenberg	Voinovich
Crapo	Leahy	Warner
Daschle	Levin	Wyden
Dayton	Lincoln	
DeWine	Lott	

NAYS—1

Gregg

NOT VOTING—5

Campbell	Kerry	McCain
Graham (FL)	Lieberman	

The amendment (No. 972) was agreed to.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

Mr. BROWNBACK. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the time for the next two votes be limited to 10 minutes.

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

AMENDMENT NO. 985, AS MODIFIED FURTHER

The PRESIDING OFFICER. There are 4 minutes equally divided on the Edwards amendment prior to a vote.

Who yields time?

The Senator from North Carolina.

Mr. EDWARDS. Mr. President, the purpose of this amendment is to do something about the skyrocketing costs of prescription drugs in this country. Whatever we do to provide a real prescription drug benefit for seniors under Medicare, both for the purpose of keeping the cost of that plan down and for the purpose of doing something for all Americans who have no prescription drug coverage, we have to bring the cost of prescription drugs under control.

There are two abuses at which this amendment is aimed: First, stopping the proliferation of ''me too'' drugs that have no meaningful benefit; second, stopping the abuses in advertising.

Everyone has seen the ads: Couples dancing in the kitchen; people running through fields. These are not for the purpose of education. They are for the purpose of marketing. We are trying to bring this under control by putting fairness, honesty, and accuracy in that advertising.

The purpose of the amendment is to help control both those activities and, in the process, bring down the cost of prescription drugs.

Mr. President, I ask my colleague, the coauthor of this amendment, Senator HARKIN from Iowa, what he believes we need to do to bring down the cost of prescription drugs. I yield to Senator HARKIN.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, parliamentary inquiry: What type of time agreement are we under now?

The PRESIDING OFFICER. Four minutes equally divided. The Senator has 31 seconds.

Mr. HARKIN. Mr. President, I thank my colleague from North Carolina for offering his amendment of which I am a cosponsor. Every time I go back to Iowa, I hear from consumers and others: Why do I get inundated with all these ads, and I cannot buy them unless I go to the doctor?

Right now, the drug companies are spending more on advertising every year than they are on research, and we wonder why the price of drugs keeps going up.

This all changed a few years ago. If my colleagues will remember, before 1997, we did not see all these ads. Now it is time to cut out this massive advertising of drugs that we cannot even buy in the marketplace.

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

Mr. GRASSLEY. Mr. President, I yield the 2 minutes on this side to the Senator from Wyoming.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I ask the body to vote no on the Edwards amendment to increase drug costs. This is a new drug approval. The amendment masquerades as a direct-to-consumer advertising amendment while sweeping away carefully calibrated FDA drug approval standards.

While the Edwards amendment masquerades as an amendment to ''strengthen protections against misleading direct-to-consumer advertising,'' the amendment drastically changes the requirements for drug approval in the United States.

We have a great system that is working. Under the current law, pharmaceuticals must demonstrate they are safe and effective to be approved by the Food and Drug Administration. Under the Edwards amendment, the Secretary of Health and Human Services would be authorized to vary this standard on a

drug-by-drug basis to create new hurdles to drug approvals.

These new hurdles include lengthy, costly comparative trials and a showing that the drug is safer or more effective for a subpopulation or condition than a previously approved drug.

These changes to fundamental, longstanding law could hurt patients by delaying, and possibly denying, the approval of new drugs that patients need; by dramatically adding to drug development costs, discouraging companies from developing additional drugs to treat the same conditions; and increasing drug spending by reducing brand-to-brand competition.

We know far more about pharmaceuticals than many other medical interventions since, unlike most other interventions, they must obtain approval under FDA's safe and effective standard before they can be used. We should reject this amendment as it would add another regulatory hurdle to the already long and costly drug development and approval process.

The PRESIDING OFFICER. All time has expired. The question is on agreeing to amendment No. 985, as modified further.

Mr. EDWARDS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second. The clerk will call the roll.

The bill clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea.''

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 26, nays 69, as follows:

[Rollcall Vote No. 243 Leg.]

YEAS—26

Akaka	Feingold	Miller
Boxer	Feinstein	Nelson (FL)
Byrd	Harkin	Pryor
Cantwell	Inouye	Reed
Clinton	Johnson	Reid
Daschle	Kohl	Rockefeller
Dayton	Leahy	Schumer
Durbin	Levin	Stabenow
Edwards	Lincoln	

NAYS—69

Alexander	Bond	Cochran
Allard	Breaux	Coleman
Allen	Brownback	Collins
Baucus	Bunning	Conrad
Bayh	Burns	Cornyn
Bennett	Carper	Corzine
Biden	Chafee	Craig
Bingaman	Chambliss	Crapo
DeWine	Hutchison	Roberts
Dodd	Inhofe	Santorum
Dole	Jeffords	Sarbanes
Domenici	Kennedy	Sessions
Dorgan	Kyl	Shelby
Ensign	Landrieu	Smith
Enzi	Lautenberg	Snowe
Fitzgerald	Lott	Specter
Frist	Lugar	Stevens
Graham (SC)	McConnell	Sununu
Grassley	Mikulski	Talent
Gregg	Murkowski	Thomas
Hagel	Murray	Voinovich
Hatch	Nelson (NE)	Warner
Hollings	Nickles	Wyden

NOT VOTING—5

Campbell	Kerry	McCain
Graham (FL)	Lieberman	

The amendment (No. 985), as modified further, was rejected.

Mr. REID. I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 956

The PRESIDING OFFICER (Ms. MURKOWSKI). The order of business is amendment numbered 956, the Graham of Florida amendment.

Mr. REID. Madam President, it is my understanding the next matter is the Graham amendment.

The PRESIDING OFFICER. That is correct.

Mr. REID. Madam President, on behalf of Senators GRAHAM, FEINSTEIN, MURKOWSKI, JOHNSON, and this Senator, this is a tremendous piece of work Senator GRAHAM has done. It is good legislation. At least 12 percent of our seniors would be subject to a gap in coverage under this bill. Standard coverage would require seniors to pay 100 percent of the cost of prescriptions between $4,500 and $5,812 in total spending. At the same time, they are paying 100 percent of each prescription, and they are still required to pay a monthly premium.

Collecting a premium while a senior is in the gap is equivalent to levying a tax on the sick. This amendment suspends the payment of premium once the beneficiary hits the gap in coverage. This amendment is endorsed by the National Committee to Preserve Social Security, the Alliance of Retired Americans, and the National Council on Aging.

The amendment is offset by clarification of the Medicare secondary payer provision. This noncontroversial offset, which yields $8.9 billion over 10 years, is fully supported by the Department of Justice and is in the House Republican drug bill.

Mr. GRASSLEY. Madam President, I have to ask my colleagues to vote against this amendment because it costs $200 billion. We are working within a $400 billion package. I wish we could eliminate the gap, as well. What we are trying to do is help the most people who have the most need with the money we have. Most seniors will not be affected by the gap in coverage. Most seniors will not have drug spending in a year that exceeds the benefit limit.

According to the CBO, about 88 percent of the seniors will not even have prescription drug spending that exceeds the $4,500 limit.

The Senator from Florida calls the benefit limit a ''sick tax'' because he believes that seniors should not pay a premium for coverage for catastrophic costs. This is as if to say you should not pay for fire insurance if your house is not going to be on fire. Of course, that is not how insurance works. People purchase insurance to protect them against an unfortunate accident.

The PRESIDING OFFICER. All time is expired.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea.''

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 56, as follows:

[Rollcall Vote No. 244 Leg.]

YEAS—39

Akaka	Dodd	Levin
Bayh	Dorgan	Lincoln
Biden	Durbin	Mikulski
Bingaman	Edwards	Murray
Boxer	Feingold	Nelson (FL)
Byrd	Feinstein	Pryor
Cantwell	Harkin	Reed
Carper	Hollings	Reid
Clinton	Inouye	Rockefeller
Conrad	Johnson	Sarbanes
Corzine	Kohl	Schumer
Daschle	Lautenberg	Stabenow
Dayton	Leahy	Wyden

NAYS—56

Alexander	Dole	McConnell
Allard	Domenici	Miller
Allen	Ensign	Murkowski
Baucus	Enzi	Nelson (NE)
Bennett	Fitzgerald	Nickles
Bond	Frist	Roberts
Breaux	Graham (SC)	Santorum
Brownback	Grassley	Sessions
Bunning	Gregg	Shelby
Burns	Hagel	Smith
Chafee	Hatch	Snowe
Chambliss	Hutchison	Specter
Cochran	Inhofe	Stevens
Coleman	Jeffords	Sununu
Collins	Kennedy	Talent
Cornyn	Kyl	Thomas
Craig	Landrieu	Voinovich
Crapo	Lott	Warner
DeWine	Lugar	

NOT VOTING—5

Campbell	Kerry	McCain
Graham (FL)	Lieberman	

The amendment (No. 956) was rejected.

Mr. REID. I move to reconsider the vote.

Mr. ENSIGN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, I ask unanimous consent that Senator EDWARDS be recognized to offer an amendment—and he will speak, if necessary, at a later time—and, following the offering of his amendment, Senator ENZI be recognized to offer two amendments; and following that, Senator DURBIN—we hope at 12:30 or 12:35—be recognized to offer his amendment; that following the offering and the speech by Senator DURBIN, we ask that Senator ENSIGN be recognized to offer an amendment—sometime around 1 o'clock this afternoon.

For the information of Senators, the two managers are working to get a list of at least four amendments to vote on starting at 3 o'clock this afternoon. I ask unanimous consent for what I asked previously except for the voting at 3 o'clock.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from North Carolina.

Mr. EDWARDS. Madam President, I ask unanimous consent to lay aside the pending amendments.

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

AMENDMENT NO. 1052

Mr. EDWARDS. Madam President, I have an amendment I send to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from North Carolina [Mr. EDWARDS], for himself and Mr. HARKIN, proposes an amendment numbered 1052.

Mr. EDWARDS. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To strengthen protections for consumers against misleading direct-to-consumer drug advertising)

At the end, add the following:

TITLE ___—DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. ___01. DIRECT-TO-CONSUMER ADVERTISING.

Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by inserting at the end of the following:

REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including, if available, effectiveness in comparison to other drugs for substantially the same condition or conditions); and

(ii) information relating to side effects and contraindications;

(B) any advertisement present a fair balance, comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided,* that nothing in this section shall require explicit images or sounds depicting side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. ___ 02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

''(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

''(A) the Secretary provides the person written notice of the violation; and

''(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

''(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

''(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

''(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

''(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).''.

SEC. ___03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. ___04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisement except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

Mr. EDWARDS. Madam President, I ask unanimous consent that the amendment be laid aside.

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

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

The PRESIDING OFFICER. Will the Senator withhold?

Mr. EDWARDS. Yes.

The PRESIDING OFFICER. The Senator from Wyoming.

AMENDMENT NO. 1051

Mr. ENZI. Madam President, I ask unanimous consent to set the pending amendments aside and call up amendment No. 1051.

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

The clerk will report.

The bill clerk read as follows:

The Senator from Wyoming [Mr. ENZI], for himself and Mrs. LINCOLN, proposes an amendment numbered 1051.

Mr. ENZI. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To ensure convenient access to pharmacies and prohibit the tying of contracts)

On page 37, between lines 20 and 21, insert the following:

(C) CONVENIENT ACCESS TO PHARMACIES.—In this section, the term 'convenient access' means access that is no less favorable to enrollees than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TriCare retail pharmacy program. Such rules shall include adequate emergency access for enrolled beneficiaries.

On page 48, between lines 4 and 5, insert the following:

(4) TYING OF CONTRACTS.—No eligible entity with a contract under this part, or its agent, may require a pharmacy to participate in a medicare prescription drug plan as a condition of participating in nonmedicare programs or networks, or require a pharmacy to participate in a nonmedicare program or network as a condition of participating in a medicare prescription drug plan.

Mr. ENZI. Madam President, I rise to offer an amendment that would build upon the protections for seniors and pharmacists that the Senate approved last week. I am pleased to be joined by my distinguished colleague from Arkansas, Senator LINCOLN, in offering this amendment.

This amendment would ensure that seniors have convenient access to local pharmacies. The amendment would accomplish this in two ways.

First, there is language in the Finance Committee's bill that requires

the Government to develop a standard for ensuring that seniors have convenient access to local pharmacies. This amendment would further define what we mean by ''convenient access.''

The amendment would ensure that access to retail pharmacies under Medicare is ''no less favorable to enrollees'' than the access standards under the TRICARE retail pharmacy program.

TRICARE is the health care program for active-duty and retired members of the uniformed services, their families, and survivors. TRICARE is a regionally managed program that offers eligible beneficiaries three choices for their health care.

First, there is TRICARE Prime, where military facilities such as Department of Defense hospitals are the principal source of health care services. There is also TRICARE Extra, a preferred provider option. Finally, there is a TRICARE Standard, the fee-for-service option that used to be known as CHAMPUS.

For all three options, TRICARE offers pharmacy benefits that include access to a retail pharmacy network. To win an award to manage TRICARE benefits for the military, a contractor must maintain a retail pharmacy network that ''minimizes the number of eligible beneficiaries who will have to change pharmacies'' to use the contractor's network.

There are three minimum beneficiary access standards for the TRICARE retail pharmacy network.

In urban areas, the contractor must have a network pharmacy within 2 miles of 90 percent of eligible beneficiaries. In suburban areas, the standard is a pharmacy within 5 miles of 90 percent of the beneficiaries. In rural areas, the standard is a pharmacy within 15 miles of 70 percent of the beneficiaries.

The Enzi-Lincoln amendment would not require Medicare drug plans to meet these exact standards. It would only require that a Medicare drug plan's network be ''no less favorable'' to seniors than the TRICARE program is for active-duty military and retirees, including those who participate in the new TRICARE Senior Pharmacy Program, provided by the 2001 National Defense Authorization Act. If the Administrator of the new Center for Medicare Choices or a Medicare drug plan had a better way of meeting or exceeding the TRICARE standard, they would not be restrained from doing so.

As I mentioned earlier, there is another way this amendment would ensure that seniors have convenient access to their local pharmacies. The amendment includes a provision that prohibits a Medicare drug plan operator from requiring pharmacies to accept non-Medicare business and reimbursement rates as a condition of participating in the plan's Medicare business, or vice versa.

I expect that health plans and pharmacy benefits managers that operate in the commercial insurance market will be the same companies that will compete to provide Medicare drug plans and Medicare Advantage preferred provider options to seniors. If a plan wins a bid to provide a Medicare drug benefit, they may offer reimbursement rates to retail pharmacies that are better or worse than the rates they offer in their private sector commercial business. That is fine with me.

What concerns me is the possibility of these large plans ''tying'' their Medicare and non-Medicare business together. A Medicare drug plan should not be able to require a community pharmacist to accept an unprofitable reimbursement rate for its private sector business as a condition of participating in its Medicare network. Likewise, a community pharmacist should not have to take a money-losing Medicare reimbursement rate in order to keep its non-Medicare business from the same large plan.

We should allow community pharmacists to refuse unprofitable private sector business from a health insurer or a pharmacy benefits manager yet participate in a Medicare drug plan run by the same entities. By doing so, we will further ensure that seniors have convenient access to local pharmacies based on fair reimbursement rates that should take into account the added costs pharmacies incur in providing counseling and advice to Medicare beneficiaries, especially since pharmacists are rarely reimbursed directly for the time and effort it takes to provide that counseling and advice.

I urge my colleagues to join with Senator LINCOLN and me in continuing to improve this Medicare bill by ensuring that seniors have convenient access to their local pharmacists.

I yield the floor to my colleague on this amendment.

The PRESIDING OFFICER. The Senator from Arkansas.

Mrs. LINCOLN. Madam President, I thank my colleague from Wyoming. I am extremely pleased to offer this amendment with him to help our seniors by ensuring that local pharmacists can continue providing their services under the new prescription drug program created under this bill. I compliment him on his leadership—as well as the hard work of his staff—in crafting a very plausible solution to many of our problems.

I was proud to have supported another amendment offered by my friend Senator ENZI and Senator REED of Rhode Island which sought to ensure that PBMs can't force seniors into mail order programs. For those of us, such as the Presiding Officer and others, who represent large tracts of rural areas in our States, it is important to know that all seniors across this great Nation are going to get a fair shake when it comes to a prescription drug package. We want to make sure that the package we design and the law we produce are going to ensure that every senior has the same quality of care, the same quality of product, and the same quality of access through this prescription drug package.

Many Arkansas pharmacists, including Gene Boeckmann, owner of Wynne Apothecary, have explained to me the many problems with mail order pharmacy operations. For one, it weakens the personal contact between customer and pharmacist, a vital connection when it comes to one's health and particularly when you live in a rural area where medical professionals may not be there full time. I know many of our communities—the one just mentioned—have medical facilities that are satellites of hospitals from larger communities. Consequently, many of their medical professionals are not full-time residents. Oftentimes the only medical professional they have happens to be the pharmacist, someone they can call on a weekend or late at night if they run into problems.

Mail order pharmacies that are owned by PBMs also take money out of local communities. In many small towns across Arkansas, pharmacists such as Mr. Boeckmann are the ones paying the taxes. They support the local community baseball and softball teams. They donate money so the school band can go to competitions. They are serving their communities. They have the right and responsibility to do that and, through this bill, we want them to continue. Our communities need leaders such as Mr. Boeckmann. It is for this reason I am proud to support the Enzi-Reed amendment.

As we began drafting the amendment, we attempted to include a provision to prevent conflicts of interest. I hope we will be able to address this issue in conference. Our original amendment would have prohibited a PBM from favoring a mail order contractor it owns. Regrettably, we could not work out language agreeable to everyone, but I do hope we can continue to address the conflict of interest issue in conference. I will be working diligently with others to see that we can.

The amendment seeks to build on that effort by ensuring that seniors have access to their community pharmacists. Over the many years of this debate, I have heard from countless seniors who have told me how important their community pharmacist is to their health care.

I have told them time and time again, they are preaching to the choir with me. I can look back in my own life to when my grandmother was diagnosed with cancer. She lived with us the last 2 years of her life in the back of the house in the room next to mine. I can remember when she would suffer from discomfort, she didn't want to talk to the doctor. She knew what her ailment was. She wanted to talk to the pharmacist.

She would call him. He would say: Mrs. Adne, you need to stop taking your blue pill and keep your yellow pill, but remember it is going to upset

your stomach if you don't take it with a glass of milk or a biscuit.

She found great relief in the knowledge that the pharmacist could provide her. There was nothing more the doctors could do for her. Yet the pharmacist could provide her that information.

I look back on the journey my family had with my own father when we traveled down almost 10 years of a road through the disease of Alzheimer's, recognizing very little could be done by the physicians. Yet the pharmacist was the one we could call in our small community who actually could tell us how we could provide relief, ways we could enhance the quality of life for my father as he lived out those last few years and then those last few days in his own home, in the very woods he grew up in as a little boy.

These are the qualities of life we are talking about for our families, for our loved ones in rural areas, to make it possible essentially for them to be able to do that. What we are talking about is really putting common sense into the bill and recognizing how important it is to maintain that contact in rural areas. Seniors like my late grandmother or my father don't need a mail order service with a 1–800 number and a recording. They need their local pharmacist to talk to.

This amendment seeks to guarantee seniors convenient access to pharmacists. ''Convenient access'' would be defined as access standards that are at least as favorable as the Department of Defense's TRICARE program, to which Senator ENZI referred. That should be the minimum level of access. The TRICARE program requires that at least 90 percent of beneficiaries in urban areas have access to a network pharmacy within 2 miles, 90 percent of beneficiaries in suburban areas have access to a network pharmacy within 5 miles, and 70 percent of beneficiaries in rural areas have access to a network pharmacy within 15 miles.

Second, our amendment seeks to prevent PBMs from tying one contract with a pharmacist to another contract. The practice of committing pharmacists with one contract to another simply ties their hands from being able to provide the kind of service they should be able to provide.

As several of my colleagues have mentioned, PBMs play a major role in the negotiating process between pharmacists and drug companies. Some PBMs have the market power to require a pharmacy provider to accept one contract rate as a condition of participating in a totally unrelated program. This ''tying,'' as it is termed, of one contract to another is an abuse of market power, and it should be prohibited in the Medicare Program. Our amendment would prohibit tying.

I encourage my colleagues to join us by supporting this important amendment that will make Medicare a better program for our seniors and for our pharmacists. Let's make this easier for the seniors and keep the pharmacists in the business.

As I urge my colleagues to support the amendment Senator ENZI and I have offered, I also encourage them to think back to a circumstance, perhaps, in which they found themselves or a story they have heard from one of their rural constituents who can best describe to them in their own words how vital it is to have these important health care providers remain in our communities.

I thank my colleague from Wyoming for his great leadership and the hard work of his staff. I am proud to join him in offering the amendment. I do encourage all of our colleagues to support it and to support rural America so that all seniors across the Nation will have a benefit that will be equal in terms of access and for the information they need in order to find quality of life through the prescription drug package we believe they can.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I thank the Senator from Arkansas for her diligent effort. I ask my colleagues to vote for it.

Ms. LINCOLN. I thank the Senator.

AMENDMENT NO. 1030

Mr. ENZI. Madam President, I ask unanimous consent to set aside the pending amendment and call up amendment No. 1030.

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

The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Wyoming [Mr. ENZI] proposes an amendment numbered 1030.

Mr. ENZI. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To encourage the availability of MedicareAdvantage benefits in medically underserved areas)

On page 356, strike lines 8 through 11, and insert the following:

(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting—

(i) the persons from whom enrollees under such plan may obtain covered benefits; or

(ii) the categories of licensed health professionals or providers from whom enrollees under such a plan may obtain covered benefits if the covered services are provided to enrollees in a State where 25 percent or more of the population resides in health professional shortage areas designated pursuant to section 332 of the Public Health Service Act.

Mr. ENZI. Madam President, this amendment would make the Medicare Advantage preferred provider organization option more attractive to people in areas of the country that have shortages of doctors and other health care providers.

The proposed amendment would ensure that Medicare Advantage plans pay for covered services provided by any properly licensed health professionals to seniors in ''medically underserved States.''

In other words, if a MedicareAdvantage plan covers a service, then the plan must pay for the service if it is provided by a licensed provider in a medically underserved State, regardless of other plan limitations on the types of health professionals that may provide the service.

I assure my colleagues that this is nothing new. The law that governs the Federal Employees Health Benefits Program provides special consideration for enrollees of preferred-provider plans who live in States with critical shortages of physicians and other health professionals. Such States are designated as ''medically underserved areas'' for purposes of the Federal employees program, and the law requires preferred provider organizations to pay for services provided by any qualified providers in these States.

As a result, in medically underserved areas, Federal employees' health plans must treat any licensed health professional as a ''covered provider'' for any covered services performed within the scope of that State's licensure laws.

This amendment simply would require the same treatment by MedicareAdvantage plans of seniors who live in medically underserved States. If the plan says that a physician must provide a service, but a nurse practitioner is permitted under State law to provide the service, a senior in a medically underserved State could get that service from his or her local nurse practitioner.

The amendment would define a ''medically underserved State'' in the same way it is defined for the Federal Employees Health Benefits Program. The Federal employees program law defines a ''medically underserved State'' as one in which 25 percent or more of the population lives in health professional shortage areas, as defined by the Secretary of Health and Human Services. This amendment would transfer that language to MedicareAdvantage.

In 2003, the following States were considered ''medically underserved'' for purposes of the Federal employees health plan: Alabama, Idaho, Kentucky, Louisiana, Maine, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, West Virginia and Wyoming.

By the way, Louisiana, Maine, and West Virginia were added to the list in 2003, which demonstrates that the list if flexible enough to recognize States that may not have shortages of health professionals right now, but may have a shortage in the future.

Here's an example of how this provision works in the Federal employees program. The Rural Letter Carrier Benefit Plan allows physical and occupational therapy services to be provided by qualified and licensed physical therapists, occupational therapists, and physicians. However, the Govern-

ment Employees Hospital Association Benefit Plan, or the G–E–H–A plan, does not generally allow qualified physicians to provide physical or occupational therapy services. As a result, physicians who may have special expertise in rehabilitation medicine, for example, cannot provide such services to members of the G–E–H–A plan.

However, in medically underserved States, the G–E–H–A plan must allow Federal employees to receive physical or occupational therapy services from any physician who is qualified to do so and whose State license permits him or her to do so.

As a result, Federal employees in medically underserved States who live 50 miles from the nearest physical or occupational therapist don't have to drive 50 miles to receive a service they could get from the local physician.

Here's another example. The Rural Letter Carriers plan allows chiropractors to perform manipulation of the spine and extremities, as well as related procedures such as ultrasound and cold-pack application. The G–E–H–A plan allows chiropractors to perform manipulation of the spine and certain X-rays to detect and determine nerve interferences, but it doesn't allow for chiropractors to perform ultrasound or other related procedures like the Rural Letter Carriers plan does. Both plans also reserve certain procedures for other types of health professionals.

However, in medically underserved States, both plans must permit chiropractors to perform any service that the plans cover—provided that the services are within the scope of the chiropractor's State license.

Now that I have explained what this amendment would accomplish, let me be clear about what this amendment would not do.

First, the amendment would not require MedicareAdvantage plans to pay for services that they would not ordinarily cover. It would only require that plans pay for covered services in medically underserved States without limiting the types of professionals who may provide the service. Again, this provision only applies to services that the plan has already decided to cover.

Second, this amendment is not an ''any willing provider'' amendment. A number of States have ''any willing provider'' laws that require health plans to permit all providers to participate in the network if they agree to accept the plan's contract terms, especially their payment rates.

This amendment, however, would not require MedicareAdvantage plans to allow any health care provider to participate in the plan's network just because he or she is willing to do so. Nor would this amendment provide that a MedicareAdvantage plan could not pay a non-network provider any less than whit it pays a network provider.

This amendment simply directs plans to pay either their in-network or out-of-network for covered services that are provided by any type of health professional who is licensed to provide the service in a medically underserved State.

Finally, this amendment is not intended to favor physicians versus physical therapists, nurse practitioners, or other health professionals, or for that matter, to favor those other health professionals versus physicians.

This amendment simply would recognize the reality of healthcare in rural and frontier America—there simply aren't enough healthcare providers to go around. In States like Wyoming, the problem is getting worse, not better. Many of our doctors and other health professionals are growing older and retiring, while others are leaving our State to move to places with better medical liability laws.

In States with dire shortages of doctors and other healthcare providers, seniors shouldn't have to get into the car in the heat of summer or the cold of winter to drive to the nearest city to get healthcare services that they could get in their own town, or the town next door.

Even going to the town next door can be a challenge in Wyoming, because the town next door may be many miles away!

I want seniors in Wyoming and other sparsely populated States to be able to choose a MedicareAdvantage plan if they want comprehensive health coverage. These plans will be competing to offer seniors an integrated medical and drug benefit, innovative services like disease management, and more complete preventive services to keep seniors healthier.

For seniors in rural States to choose MedicareAdvantage, they need to know that a plan's network provides real access. There's a big difference between a network of health care providers being available, and a network of health care providers being accessible.

This amendment would provide protection and peace-of-mind to seniors who might consider joining a MedicareAdvantage plan. It's the same safeguard enjoyed by other Federal employees, including the Members of this Body. I ask my colleagues to join me in passing this amendment to ensure that seniors in rural and frontier States receive the same protection and piece-of-mind that we have in our own Federal health plan.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Illinois is recognized.

Mr. DURBIN. I see my colleague from Nebraska. There as a unanimous consent that I was to be recognized. I know the Senator has come to the floor. I hope we can work out a time that the Senator from Nebraska might be able to speak.

Mr. HAGEL. Senator ENSIGN and I are teaming up on a couple of amendments. We will follow the distinguished Senator from Illinois.

Mr. DURBIN. I will finish at no later than 1 o'clock.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Madam President, understand what this debate is about. It is the first time Congress has seriously considered offering help to senior citizens to pay for prescription drugs. I have said to Senators GRASSLEY and BAUCUS, who bring S. 1, the bill that is before us, to the floor, that I congratulate them for their good efforts. It is not an easy achievement.

For the first time in American history, we will offer this kind of assistance to seniors. But I have to say, having conceded their valiant effort, this prescription drug plan they have brought to the floor still has major deficiencies and major problems. I think it is going to run into a firestorm of criticism, primarily from senior citizens and their families, once they understand the specifics of S. 1.

For example, a lot has been said about a $35 monthly premium. This bill, S. 1, doesn't guarantee a $35 monthly premium for prescription drug coverage. It is a suggestion. It is not even worth the paper it is printed on. What is guaranteed is a $275 deductible, which means you really don't get any drug coverage until you have spent at least $275. For some people, that is not a major outlay from their own personal budget. For others, it could be.

There also is no assurance in terms of the amount of money that will be paid for your prescription drugs by the Government. The goal is 50/50—that you would split it with the Government. There is no assurance that will happen.

There is also going to be a gap in coverage. In other words, if you sign up for this voluntary program, if you pay your monthly premium of $35 plus, and if you start receiving checks from the Government, you may find a time, perhaps during the end of the year, when the Government checks stop coming because there is a gap in coverage.

My friend, Senator BOXER of California, will offer an amendment later to say what are we going to do about cancer victims—people who take expensive drugs that are necessary to save their lives. Under the bill before us, there will come a point in time each year when the Government stops helping cancer victims pay for the prescription drugs they need to stay alive. That gap in coverage is troubling, and it should be.

Also, there is no allocation for money spent by employers on behalf of retirees, that that be counted for the employee's benefit to qualify for this plan, which means that some employers might be tempted not to provide coverage at all to their retirees, and others won't see the benefit of that coverage because it doesn't translate into help under S. 1.

Those who push this plan believe in competition, so long as the competition is limited to two HMOs that can offer private insurance coverage for prescription drugs. That is the only

competition they are interested in. The interesting thing is, when you go to the seniors of America and say what are you looking for in a prescription drug plan, it is an amazing response.

Over 600 seniors were asked in a survey of a week or so ago: Which should be a higher priority of Congress, passing prescription drug coverage for seniors under Medicare or passing a bill to control excessive prices for prescription drugs? The choice: S. 1, prescription drug coverage for seniors under Medicare or passing a bill to control the excessive, runaway, skyrocketing prices.

Look at what they said. Of all seniors—people over 55—25 percent want Medicare drug coverage; 53 percent said control drug prices. Then look as you go down here. That portion here, 55 to 64 years of age, said 25 percent want Medicare drug coverage; 57 percent said control drug prices. For seniors, 65 and older, 26 percent want Medicare drug coverage and 50 percent said control drug prices.

In each instance, by a margin of more than 2-to-1, seniors—people over the age of 55—have said to Congress: Don't miss the ball here. The object has to be controlling the excessive cost of drugs. You can offer a helping hand to us, and that is good—25 percent believe that is good—but it won't mean anything if you don't do something about the cost of prescription drugs.

I am sorry to report to you that S. 1—I always have to look to see how many pages this is—with 654 pages doesn't dedicate a paragraph or a page to bringing down the excessive cost of prescription drugs. So the No. 1 issue, by a margin of 2-to-1, for people over 55 in America is controlling excessive drug prices, and it is ignored by S. 1. So here we are with this historic opportunity, and we are completely missing what most seniors in America believe to be the highest priority.

I went to my staff and said: Let's start from the beginning. What kind of a prescription drug program would we create if we had a blank slate? I said to them: Here is what I would like to see us come up with. Let me give a comparison between what we are proposing as my substitute amendment and the underlying bill.

The Grassley-Baucus bill has a $275 deductible. I said: Let's eliminate that deductible, and we did. Under the MediSAVE amendment, there is no deductible.

The premium under Grassley-Baucus is estimated to be $35, which means it could be much higher. I said: Let's require that the premium for this volunteer prescription drug plan be $35 defined in statute.

Cost sharing, under the best of circumstances, is 50/50 under the Grassley-Baucus plan, and under the MediSAVE plan, which we propose, it is 70/30, a substantially greater benefit for every senior covered by this plan.

The coverage gap I mentioned earlier in Grassley-Baucus says if you reach a point where you had $4,500 in prescription drugs in a given year—not an outrageous possibility; that is a little more than $350, $400 a month; a lot of seniors face that—that at some point during the course of the year your benefits will stop. I said: Eliminate that gap. I want full coverage all the way up to the catastrophic level of $5,000 in prescription drugs, which then kicks in at 90-percent reimbursement. And we did.

Then we got to this issue: Will we have lower prescription drug prices? Under Grassley-Baucus, no. That is why the pharmaceutical companies love this bill. We have not heard a word from them. They think this is great. Uncle Sam is going to provide some assistance to seniors to pay for prescription drugs, and the drug companies can continue to hike the prices of the drugs every single year without any restraint in S. 1. But we know there is a better way, and the better way is not socialism, as some of my critics might say.

The better way is the Veterans' Administration of the United States of America. They look at their hospitals across America and the millions of veterans they serve and they go to the drug companies and say: If you want your drug used in our Veterans' Administration hospitals, you have to give us a discount, and they do. The drug companies give a 40- to 50-percent discount, and that should be part of this Medicare plan as well.

Probably the most important single element in this MediSAVE plan I am offering is we are going to have Health and Human Services negotiating group purchasing. Drug companies are not going to like this. Pharmaceutical companies do not like to see their profit margins come down. But these are the most profitable corporations in America. I do not believe it is the responsibility of the Senate to find ways to reward the special interest groups, the pharmaceutical companies, and the HMOs at the expense of senior citizens. That is exactly what this bill does.

As I mentioned earlier, more benefits would count toward out-of-pocket spending. Medicare would have a deliberate benefit available. That is what I think is equally important. We say: Fine, competition in choice. Private insurance companies can offer prescription drug benefits but allow Medicare, the Government agency, to have a prescription drug program available to every senior across the United States.

Why is that important? Medicare, as an agency, has no profit motive. Medicare, as an agency, has a lower administrative cost than health insurance companies across America, and Medicare, an agency speaking for tens of millions of seniors, can negotiate lower prices. They can do what the Veterans' Administration has done, and that is why many of the most conservative Members of this Chamber live in dread for fear that Medicare would be able to compete with private insurance companies. Put that competition in place. Give the seniors a choice. MediSAVE does it. Grassley-Baucus does not.

We have an option for private coverage. Of course, it is in both bills.

We have a fallback which says if a senior citizen wants to go to the Medicare plan, they can always go to it, whether there is a private insurance plan in their region.

The benefit begins, incidentally, under the Grassley-Baucus bill, conveniently after the next Presidential election. So the White House can go around crowing about S. 1, prescription drug coverage is on the way, we delivered for seniors of America, and it is going to show up a few days after the election. What is wrong with this picture?

Seniors need help right now. A discount card is nice, but let's put a prescription drug policy in place that helps seniors right now. So we call on the establishment of this program as soon as practicable.

How did we do this? How did we put together all these benefits, which are much more generous than Grassley-Baucus, and still have CBO score it at $400 billion? I learned a little trick from the Republican side of the aisle when it came to tax cuts. When they could not get enough money for tax cuts, they decided they would sunset them at some point and reauthorize them. We did the same thing.

Grassley-Baucus costs $400 billion scored through 2013. Our MediSAVE substitute costs $400 billion scored to sunset at 2010. At that point, Congress can take a look at it. If we reach the point where we want to reauthorize the program or change it, it is up to us. In the meantime, we offer seniors in America a quality program, something they want, something they can use, and something that will truly help them.

If we do not address the cost of prescription drugs as part of a prescription drug program, we are going to fail. There is nothing we can do offering a percentage helping hand to seniors that will keep up with the dramatic increase in the cost of prescription drugs, which happens every single year. This substitute I am offering will provide that kind of competition.

Before I yield to my friend from Minnesota, who is a cosponsor of this amendment, let me give a couple other items that I believe might be of interest to my colleagues.

The Durbin MediSAVE amendment is cosponsored by Senator DAYTON of Minnesota, who is here, Senator BOXER, Senator BYRD, Senator CORZINE, Senator HARKIN, Senator LANDRIEU, Senator STABENOW, and Senator JOHNSON. It also has been endorsed by the AFL–CIO, United Auto Workers, AFSME, Alliance for Retired Americans, the American Federation of Teachers, and the National Committee to Preserve and Protect Social Security.

At this point, I wish to yield, for the purpose of debate, to my colleague

from Minnesota, Senator DAYTON, without yielding the floor.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Minnesota.

Mr. DAYTON. I thank the Chair.

Madam President, I thank Senator DURBIN. I commend my distinguished colleague from Illinois, Senator DURBIN, who has spearheaded the development of this amendment, and for the leadership he has shown in this and so many other areas. I stand proudly with the Senator today.

The Durbin amendment is the essential test for this body. It is going to be the measure of our commitment to seniors and to other Medicare beneficiaries all over America. It is going to be a test of our sincerity of what we said we intend to do for those people who are either disabled, through no choice of their own and are required to be on Medicare at an early age, or senior citizens who have worked throughout this country who have served this country so well and now are in their retirement years, the largest users by age of prescription drug medicines. So they are the ones most dependent on the quality of coverage we provide for them.

I heard again today from colleagues on the other side of the aisle, as I have heard others say throughout this Chamber, and as I have said many times in Minnesota, that our senior citizens deserve prescription drug coverage that is as good as Members of Congress receive; that is as good as the Federal employees receive through the plan of which we are all part. Yes, we pay into that plan, but it is also very well covered—''subsidized'' would be the right word—by our employer, the Federal Government; the same in the case of Senator DURBIN's amendment, at a level of parity to our plan.

If we want to provide senior citizens and other Medicare beneficiaries with the same level of coverage that we get in Congress, then Senator DURBIN's amendment is the way to do that.

S. 1, by contrast, provides half of those benefits overall—one-half of what we get in Congress. That is not right, that is not fair, and that is contrary to what I have heard most of my colleagues rhetorically say over the last month, and even the last couple of years, about the intent.

We cannot have it both ways. It is either going to be only half as good under S. 1 for senior citizens as it is for Members of Congress or it is going to be as good as Members of Congress receive under the Durbin amendment.

Do we have the resources? Yes, we have the resources. We surely had plenty of resources when I came to the Senate 2½ years ago, surpluses for a decade, as far as the eye could see. Now that we have been shifted into deficit mode, suddenly we are talking about a bill that is inadequate.

It is not lack of money. It is a lack of priorities. It is a lack of the right priorities for people in this country, and Senator DURBIN's amendment would say we are going to go back to the drawing board and do what is right for seniors and Medicare, and then we are going to turn around and do what we must to balance that equation.

As the Senator from Illinois also pointed out so well, if we want to do anything to address the ravaging of budgets of people of all ages by these prescription drug prices, it has to be through the kind of structured program which the Senator has proposed; otherwise, it is just a continued license to steal for the pharmaceutical industry.

S. 1 does nothing except say taxpayers are going to pay the costs of these rapidly escalating drug prices. Seniors will have to pay for a part of it as well. And then all of the taxpayers who are not senior citizens who are paying for part of this program for seniors are going to have to go to the drugstores for their families and themselves and keep paying prices that go higher and higher.

I had a deck of cards made that I am handing out in Minnesota. They compare the prices of these drugs now in Canada and the United States. Aside from the exchange rates, they show a fair comparison of prices for the same medicine, same manufacturer, same packaging, everything exactly the same in Canada as the United States. The prices in Canada are sometimes as low as 10 percent of what they are in the United States, 20 percent quite common, a third—one can get the same medicine in Canada for one-third the price in the United States.

Why? Because the Canadian Government stands up for its citizens. The Canadian Government says: We are not going to allow you to charge these exorbitant prices and make these excessive profits out of the pockets of our people. Tragically, our Government does nothing of the sort. This bill would continue that policy: Hands off; pharmaceutical industry, take whatever you can get.

So I commend the Senator from Illinois. I am grateful to him for putting this amendment together. I am proud to cosponsor it. I commend it to my colleagues, and I ask the people of America to keep an eye on this vote because it is going to determine whether we mean what we say.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Madam President, I thank the Senator from Minnesota, and I think it really does come down to whether we are going to pass a prescription drug plan in name only or something that seniors truly want and can use and is fair for them.

The Senator from Minnesota led us yesterday in an amazing rollcall vote, 93 to 3. We, as Members of the Senate, said we would live by the prescription drug plan that is created by this bill. Well, stay tuned. See if that amendment survives the conference committee or ever comes back to us.

If it does not, if it is taken out, the Senator from Minnesota has made a point. As Members of Congress, we will have a benefit twice as generous as what we are now offering to seniors across America, and what we are offering is not that generous to the seniors.

Look at what it is. We estimate over the next 10 years the cost of prescription drugs for seniors in America will be $1.8 trillion. In that period of time, we are going to spend $400 billion in this prescription drug benefit. So that is less than one-fourth of the total cost of prescription drugs.

How can that one-fourth, $400 billion, go further? If the overall costs are reduced down from $1.8 trillion.

Let me give an idea of how that works. The Veterans' Administration has cut drug prices for veterans by as much as 50 percent by negotiating with drug companies. There is no provision in S. 1 that requires the Federal Government or Medicare or anyone to negotiate with the drug companies on behalf of senior citizens—none. At best, we hope some private insurance companies will work out a formulary that gives them an opportunity for a profit by reducing the cost of drugs. That is as good as it gets. That is as close as this Senate will come to saying to the drug companies that they have to do better.

When it came to our veterans, we stood up as a government and said: We are going to stand behind them. When it comes to this situation for prescription drugs for seniors, we do not.

Health and Human Services has a similar formulary of drugs available across America for community health centers and the like. They bargain down prices. But when it comes to seniors, the largest unprotected group of prescription drug users across America, this bill is silent; it does nothing. The alternative which I am proposing will do something.

Medicare has 25 times the number of people as the Veterans' Administration. It has bargaining power. It can reduce the cost of drugs. At this point, we know the inspector general of HHS compared a list of 24 drugs covered by both Medicare and VA and found that VA spent 52 percent less for the same drugs. The inspector general estimated that Medicare would have saved $760 million in 1 year on those 24 drugs alone.

Let me say parenthetically, when we went to the Congressional Budget Office to score this, incredibly, they refused to even concede that we could get a discount on drugs. Now, I like the Congressional Budget Office. I am sure they are the greatest people in the world. But to whom are they listening? They are ignoring the reality of the Veterans' Administration. There is real cost savings that we can anticipate.

Let me tell my colleagues what the savings are for seniors when we move from the 50/50 split that is proposed by this bill to a 70/30 split, 70 percent paid by the Government for prescription

drugs, assuming a $35 monthly premium.

Take a look at it. If a senior in 1 year spent $1,000 for prescription drugs, they would end up spending out of pocket $720 under our proposal—that is under MediSAVE—but under the Grassley-Baucus bill, they would actually spend over $1,000.

How is that possible? A thousand dollars of prescription drugs and it costs more than $1,000? Do not forget the monthly premium. The monthly premium has to be added in. That has to be paid. So if a senior signs up for this voluntary prescription drug benefit under this plan, for the first $1,000 in drugs they have spent, they are not going to get anything back; they are still going to be out of pocket.

Now let's look at what happens with $2,300, which is the average that seniors pay for prescription drugs. Under our MediSAVE plan, it says a senior will spend out of pocket $1,110—that counts your monthly premium. Under the Grassley-Baucus bill, it is $1,708. We are going to save them about $600 if they are the average senior with the average annual cost for prescription drugs of $2,300. Our bill will save seniors $600 over the Grassley-Baucus plan.

As we go up to $4,000, $1,620 is what a senior would pay out of the $4,000 prescription drug bill under our plan, $2,558 under the Grassley-Baucus plan. For the $5,000 plan, the situation is a senior would pay $1,920 under MediSAVE, $3,307 under the Grassley-Baucus bill. And then for $10,000, here is a situation where a senior would have out of pocket $2,420 for a $10,000 bill—and prescription drugs can reach that cost; ask people on cancer therapies—$4,539 if they took the Grassley-Baucus plan.

So by every single measure at every single stop along the road, the plan I am proposing is going to offer much better and real savings for seniors.

Some I have talked to on the Republican side of the aisle say: DURBIN, there you go again; this would be a price control. Well, the Veterans' Administration bargains with drug companies. We do not call it price control. When Canada stands up for its citizens to the same American drug companies, I think they are standing up for a national value and a family value. It is not a matter of corrupting the marketplace. The marketplace now is being driven by a handful of prescription drug companies that have little or no competition.

So unless and until some force such as the Government or the Veterans' Administration or the Department of Health and Human Services steps in, the average family, the average senior, does not have a fighting chance.

Incidentally, we brought this other chart out so people can see that even under this administration, we have had efforts by the Secretary of Health and Human Services to bargain down the cost of drugs.

Remember the anthrax scare? They said perhaps everybody should be prepared to buy Cipro. They took a look at Cipro market prices, and it was $4.67 per tablet. People said: If we have an anthrax problem across America, how will we afford this?

The Secretary of Health and Human Services, Tommy Thompson, went in and bargained it down to 95 cents and ultimately to 75 cents a pill from $4.67, and they made a profit at 75 cents. Do you want to know what the markup is on your prescription drugs? Look at what he achieved.

I will quote Secretary Thompson, who achieved this, and I commend him for it:

> Everyone said I wouldn't be able to reduce the price of Cipro. I'm a tough negotiator.

He obviously was, but when it comes to tough negotiations, this bill is silent. S. 1, the bill before us, is silent when it comes to these negotiations. We need to have someone who will stand up for seniors, families, and against the excessive prices charged by drug companies. The reason the drug companies want this bill is that no one is standing against them.

The bill I am offering, the MediSAVE substitute, will have exactly the opposite impact. We will bring down the excessive costs of prescription drugs. We will guarantee a $35 monthly premium, no deductible. We will make certain there is no gap in coverage so the private insurance companies cannot yank the chains of seniors across America. We will always give you a Medicare option so, as a senior, you can turn back to that agency and you can have a not-for-private low administrative overhead cost formulary that is discounted always available to you.

That is what seniors want. That is what they need. That is why so many organizations endorsed this bill. This is the bill we should be passing. We should send this to the House and say: What you are offering is a pale alternative to the real thing; MediSAVE is the real thing.

I commend it to my colleagues. I hope they join in voting for passage of this amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. Madam President, I ask unanimous consent the pending unanimous consent be modified so I be allowed to offer an amendment in the slot allocated to the Senator from Nevada, since we are cosponsor, and I ask unanimous consent I be allowed to offer two amendments.

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

AMENDMENT NO. 1012

(Purpose: To provide medicare beneficiaries with an additional choice of Medicare Prescription Drug plans under part D that consists of a drug discount card and protection against high out-of-pocket drug costs)

Mr. HAGEL. Madam President, I ask unanimous consent that the pending amendment be laid aside and the Senate proceed to the consideration of amendment No. 1012.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

> The Senator from Nebraska [Mr. HAGEL], for himself and Mr. ENSIGN, proposes an amendment numbered 1012.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

AMENDMENT NO. 1026

(Purpose: To provide medicare beneficiaries with a discount card that ensures access to privately-negotiated discounts on drugs and protection against high out-of-pocket drug costs)

Mr. HAGEL. Madam President, I ask unanimous consent that the pending amendment be laid aside and the Senate proceed to the consideration of amendment 1026.

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

The clerk will report.

The assistant legislative clerk read as follows:

> The Senator from Nebraska [Mr. HAGEL], for himself, Mr. ENSIGN, Mr. LOTT, and Mr. INHOFE, proposes amendment numbered 1026.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. HAGEL. Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

AMENDMENT NO. 1012

Mr. ENSIGN. Madam President, I will speak on the pending amendment that Senator HAGEL and I have offered. This amendment is similar to the bill we offered in last year's Medicare prescription drug debate. We offered it as a complete substitute last year. I will describe this legislation.

What we are proposing to do is substitute our piece of legislation for the prescription drug portion of the pending legislation. It is very important to have a prescription drug benefit for those seniors, especially those who are low or middle income, who have serious diseases and sometimes have to choose between prescription drugs and rent or prescription drugs and maybe even the type of food they eat.

I have heard story after story around my State of seniors who literally sometimes do not take their medications or maybe take half a dose because they cannot afford the prescriptions their doctor has recommended.

The Hagel-Ensign amendment has several advantages over the current portion of the committee bill. First, it takes effect one full year earlier than the committee bill. Second, we do not have monthly premiums for our prescription drug benefit. Under the committee's mark, seniors pay $35 a month; under ours, it is a one-time annual fee of $25, that is all. They pay that once a year, unless they are low-income, and then we waive that annual fee. Under the committee's mark, it is $35 a month.

We have several other differences in the bill. In the committee's mark, low-

income seniors have a very generous benefit for those above Medicaid income but who are below 160 percent of poverty. We recognize it is very generous. As a matter of fact, I submit it is overly generous and we will see an overutilization by those senior citizens because they do not have anything at stake. One to two dollar co-pays when you are paying 97.5 percent of their out-of-pocket expenses is not enough to discourage overutilization. We are going to see an explosion of utilization of drugs, especially in the low-income market.

Let me explain the amendment. We offer a prescription drug benefit with the seniors paying up to a certain percent depending on income, up to a certain dollar figure, and after that the Government will pick up 90 percent of the cost. For people who are below 200 percent of poverty, which is around $18,000 a year for an individual or $24,000 for a couple, they would be capped at an out-of-pocket expense of $1,500, and after that the Government picks up 90 percent. Between 200 and 400 percent of poverty, incomes for an individual up to nearly $36,000, and for a couple a little over $45,000, they would be capped at an out-of-pocket expense once again of $3,500 a year, and the Government pays 90 percent above that. Between 400 and 600 percent they are capped at $5,500 out-of-pocket a year. For people above that, the wealthier seniors, 20 percent of their income is their deductible under this plan.

All of these people get a prescription drug discount card. That prescription drug discount card can provide a discount of 25 to 40 percent on the drugs they purchase. Before these ever kick in they have already saved money for every senior. This is a completely voluntary plan. If seniors like the coverage they have today, they can stay in the coverage they have today. If they want to try something guaranteed to cap their out-of-pocket expenses, this is the plan for them.

We have several real-life examples to compare with the committee mark. First, James Johnson is 68 years old with an income of around $16,000. He is above 160 percent of poverty. He is being treated for diabetes. These are typical medications of someone being treated for diabetes: glucophage, glyburide, neurontin, lescol, zoloft. This totals $5,736 a year that this person pays for prescription drugs.

Let's compare under the committee mark versus the Hagel-Ensign approach. Under the committee mark, this person would have a total out-of-pocket expense of $4,000. Under the Hagel-Ensign, this person would have about $1,900. This person would do a little over $2,000 better under Hagel-Ensign than under the committee mark. For those low-to-middle income seniors who have a serious disease, they do better under our approach.

Everyone wants to help the most those who need it the most. Under our approach that is exactly what happens. Those people who are sick, who need the most help, get the most help under our plan.

Here is another real life example. Doris Jones is 75 years old with an income of around $17,000 per year and is being treated for diabetes, hypertension, and high cholesterol. She takes lipitor, glucophage, insulin, coumadin, with total drug costs around $3,600. To compare the committee mark, the bill before us compared to Hagel-Ensign would spend around $2,380 a year under the committee bill; under the Hagel-Ensign approach she spends about $1,700. Although she did not have as much out-of-pocket drug costs for the year, she saves almost $700 a year under the Hagel-Ensign approach.

And the last real-life example, Betty Smith is 66 years old. She has an income of around a little over $15,000 per year and is being treated for breast cancer. She is still receiving low-dose radiation therapy with nolvadex. Her medication profile is as follows: morphine, paxil, dexamethasone, aciphex, and nolvadex, with total costs for drugs around $8,000 a year. To compare Betty's costs between the Hagel-Ensign approach and the committee mark: her total out-of-pocket expenses will be $4,340 with the committee mark; under our bill, she will spend around $2,100, which would be a savings to her of almost $2,200 a year.

Once again, comparing the two approaches, those middle- to low-income seniors who have serious diseases are going to get much more help under the Hagel-Ensign plan.

Our bill actually costs less money than the committee approach and because of that we are going to be offering an amendment, which subsidizes the costs for people with incomes 160 percent of poverty and under; I will talk about that in just a minute. But the reason our bill comes in at less money is because the seniors are paying the first dollars out of pocket. After that, the Government kicks in to subsidize their costs. So, by them paying the first dollars out of pocket, we encourage people to be accountable in the system. The person who is receiving the drugs is responsible for paying those first dollars. Guess what: that causes them to go out and shop. They call the various pharmacies and find out what the best price is. They ask their doctor, Is there a generic drug available that is just as effective? If it is something maybe not life-threatening and they want to take the generic version of the drug, the doctor can say, Yes, I have had good experience with patients with this. They can take the generic drug, saving themselves money and saving the whole system money.

That is why our bill overall would cost less money. What Senator HAGEL and I have decided to do is, because there is $400 billion available to spend under the budget, we have taken around $60 billion, spread over 10 years, to put toward those people who are truly poor, below 160 percent of poverty. Our plan would give them, in a pharmaceutical benefit account, $700 to spend on prescription drugs. If they do not use it, it rolls over to the next year. By the way, if it rolls over 2 years in a row, and the third year they get another $700, at the end of the year they get to keep anything above $1,500. So there is an incentive; they have something at stake, so they will still shop around for the best price for their drugs. So it keeps market forces at play within our Medicare prescription drug system. That is one of the strong points, we feel, about our plan.

There are several other advantages that we think are in our bill that are not included in the committee mark. I asked this question yesterday; I asked the administration, I asked Secretary Thompson, and I asked the director who oversees Medicare, What will happen under the committee's mark to the State plans? My State of Nevada and many other States, New York, Massachusetts, West Virginia—have State plans that help senior citizens with prescription drugs. What will happen to those state low-income plans—above Medicaid level but below around 160 percent of poverty—if the committee mark is enacted?

The simple answer is: all of those plans will go away because, for those seniors under this plan, there is no reason for the States to pick them up anymore. The committee mark will pick them up completely.

Our plan works with the States, instead of substituting for the States. Those plans in the States that are already working, and working well, will continue. As a matter of fact, each State can learn from the other. If they want to be a little more generous, a little less generous, they can do that. But it doesn't supplant the States, like the committee mark does.

The other big problem I have heard articulated with the committee's prescription drug benefit is that private companies that currently have plans are going to start dropping their plans left and right. Under our bill, because we offer a higher deductible than most of the plans offer, there is not going to be the incentive for them to drop their plans. So it is not going to be a transfer from the private sector onto the public sector. And when I say public sector, I mean the taxpayer—younger people paying the taxes for older citizens.

There are many benefits to our plan, we think, over the committee mark. Let me just quickly repeat those.

First, we help those seniors, especially in the middle- to low-income, much more than the committee mark does, those who have serious diseases.

Second, we have no monthly premiums. The committee mark has a $35-a-month monthly premium.

Third, our plan does not replace State plans, it works with State plans.

Fourth, our plan also does not encourage the replacement of private

plans that companies have set up for their retirees.

Fifth, I believe our bill will control drug costs into the future. I applaud the committee. They have gotten together in a bipartisan way, trying to come up with a fix to a serious problem. But the problem I see is that it is right now scored by the Congressional Budget Office at around $400 billion. I think there is going to be so much overutilization in that, that it is going to end up being more like $800 billion or a $1 trillion plan. Young people are going to have to pay that.

That is just how much it is going to cost in the next 8 to 10 years. When you start extending that out into the 10 years beyond that, you start doubling and tripling those costs as we get the new, more expensive drugs into the marketplace.

So I think we should do the responsible thing. That is why we are encouraging our colleagues to take a look at this. We had the same bill voted on last year. We got a bipartisan vote. We had 51 Senators vote for this plan. If we got that for this amendment, this amendment would be adopted as part of the bill.

I know there have been deals made: Let's just defeat all amendments. I encourage people to say, If we can improve this bill, let's improve this bill. Let's make it responsible to the next generation. But let's also do what we say we all want to do, and that is to help those seniors who truly need the help. Let's help those who are the sickest and those who are in the lower-income categories, who end up having to make those decisions I talked about: choosing between prescription drugs and rent, between prescription drugs and food, or maybe only taking one of their prescriptions or a half dose of their prescription because they cannot afford the full dose.

In conclusion, I plead with my colleagues to study this issue. I know this bill is being rushed through, so people have not had a chance to take a look at all the options. This is so serious. This is the biggest entitlement program that any Senator who is currently serving will ever vote on. This has incredible implications for generations to come. We'd better do it right the first time because coming back for a fix a couple of years from now—we have seen how difficult it was to get to this point—is going to be virtually impossible.

So we'd better do it right the first time—at least get as close to right as we can. That is why we are encouraging our colleagues to take a serious look at the Hagel-Ensign amendment and do something right for the country.

I yield the floor.

The PRESIDING OFFICER (Mr. HAGEL). The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside.

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

AMENDMENT NO. 1060

(Purpose: To provide for an income-related increase in the part B premium for individuals with income in excess of $75,000 and married couples with income in excess of $150,000)

Mr. BAUCUS. Mr. President, on behalf of Senators FEINSTEIN and NICKLES, I send an amendment to the desk regarding an income-related increase in Part B premiums and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mrs. FEINSTEIN, for herself, Mr. NICKLES, Mr. CHAFEE, and Mr. GRAHAM of South Carolina, proposes an amendment numbered 1060.

Mr. BAUCUS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. BAUCUS. Mr. President, I ask unanimous consent that all pending amendments be set aside.

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

AMENDMENT NO. 1061

Mr. BAUCUS. Mr. President, on behalf of Senator AKAKA, I send an amendment to the desk regarding the treatment of Hawaii as a low-DSH State and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. AKAKA, proposes an amendment numbered 1061.

Mr. BAUCUS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To provide for treatment of Hawaii as a low-DSH State for purposes of determining a medicaid DSH allotment for the State for fiscal years 2004 and 2005)

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

''(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).''.

Mr. AKAKA. Mr. President, I rise in support of my amendment to restore a Medicaid disproportionate share hospital, DSH, allotment for Hawaii. Medicaid DSH payments are designed to provide additional support to hospitals that treat large numbers of Medicaid and uninsured patients.

The Balanced Budget Act of 1997, BBA, created specific DSH allotments for each State based on each their actual DSH expenditures for fiscal year 1995. In 1994, the State of Hawaii implemented the QUEST demonstration program that was designed to reduce the number of uninsured and improve access to health care. The prior Medicaid DSH program was incorporated into QUEST. As a result of the demonstration program, Hawaii did not have DSH expenditures in 1995 and was not provided a DSH allotment.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 made further changes to the DSH program, which included the establishment of a flood for DSH allotments. However, States without allotments were again left out. Other States that have obtained waivers similar to Hawaii's have retained their DSH allotments. Only two States, Hawaii and Tennessee, do not have DSH allotments.

As currently drafted, S. 1 provides that States without DSH allotments could obtain an allotment if their waiver was terminated or removed. It is my understanding that while this language would permit an allotment for Tennessee, it would prevent Hawaii from obtaining its DSH allotment as long as the QUEST program remains in place.

My amendment would provide a DSH allotment to Hawaii and allow for my home State to participate in the Medicaid DSH program. This amendment is needed because many of our hospitals in Hawaii are struggling to meet the elevated demands placed upon them by the increasing number of uninsured people. DSH payments will help Hawaii hospitals meet the rising health care needs of our communities and reinforce our health care safety net. All 50 States need to have access to Medicaid DSH support.

My amendment is similar to language included in the Senate passed version of S. 2, the Jobs and Growth Tax Act of 2003, that would have provided assistance to low DSH States and would have provided an allotment for Hawaii. Unfortunately, the DSH provisions were not retained in the conference report. A Hawaii specific provision is necessary as we attempt to provide additional support for hospitals in low DSH States in this legislation.

I appreciate all of the work done by my colleague from New Mexico, Senator BINGAMAN, to provide additional support for low DSH States. I urge that my colleagues support this amendment to allow the State of Hawaii to be treated like other extremely low DSH States and finally receive a Medicaid DSH allotment.

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

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

AMENDMENT NO. 1062 TO AMENDMENT NO. 974

Mr. REID. Mr. President, I call for the regular order with respect to Grassley amendment No. 974 and send an amendment to the desk on behalf of Senator BOXER.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mrs. BOXER, proposes an amendment numbered 1062 to amendment No. 974.

Mr. REID. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To eliminate the coverage gap for individuals with cancer)

At the end of the amendment add the following:

SEC. ___. NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.—

''(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

''(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

''(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D–19(a).

''(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D–16 that are necessary because of the rules under subparagraph (A).

Mr. REID. Mr. President, we on this side have been as cooperative as we could be. We have done everything we can to move this legislation along. And I have said publicly that I appreciate how Senator FRIST has handled legislation since he has become the Republican leader. He has not tried to shut off debate. He has rarely filed cloture, and that is commendable. And I have said, on more than one occasion, I appreciate that.

But we are in a situation now where, as part of the regular process of doing business here, we have a difficult amendment. It is a tough vote for a lot of people. It is a Boxer amendment. In effect, it would allow coverage—without exception—for prescription drugs for people who are diagnosed as having cancer.

We have been told by various people on the side of the majority that we are not going to have a vote on this. Well, my response to that is, we are going to do nothing else on the bill. This is now the regular order. And until there is an agreement made that we are going to vote on this, we are going to do nothing else. This is it. We have a lot of tough votes here, and this is one of them.

Now, Mr. President, we could have, if we had been mischievous, done other things. Some said: Why don't we have Alzheimer's? Why don't we have diabetes? Why not have juvenile diabetes? Why not have Parkinson's? The Senator from California, acting in good faith, recognizing the need to move this legislation, said she would limit her amendment to cancer. And that is what has happened.

So, Mr. President, we are now at a point where there is going to have to be a decision made by the majority when we are going to vote. We want a vote. That is all we want. We want a vote. We will do it at any time, but until there is an agreement, there will be an agreement on nothing on this bill.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I would like to speak about the underlying bill.

Mr. President, I think one of the greatest achievements of the Medicare bill that has been reported out by the Senate Finance Committee is the compromise Senator GRASSLEY and I worked out on the issue of private prescription drug plans.

Over the course of this 4-year debate over prescription drugs—and I might add, it has been very frustrating for a lot of Senators. We have been trying to find a way to get prescription drug benefits passed for seniors but have been at loggerheads the last 4 years. Both sides wanted their view and neither was willing to compromise. But I think, finally, it is clear we have reached an agreement.

I commend the chairman of the committee, Senator GRASSLEY, and all those who helped to work to make this possible. Frankly, a lot of people are to be complimented—everybody from Senator BREAUX to Senator KENNEDY. And the list is just endless. Senator SNOWE, for example, has been a great advocate, tirelessly trying to get a compromise agreement over the years.

We finally agreed private entities should administer a Medicare prescription drug program. I know that is something that many, particularly on the Republican side of the aisle, are very interested in.

Both sides of the aisle envision these entities might include pharmacy benefit managers, so-called PBMs. They could include insurance companies, chain store pharmacies, or partnerships among these entities. Any one of those groups would contract with HHS and be the private entity or the contracting company that would contract out the prescription drug benefits to beneficiaries.

The main disagreement was whether these private plans should be required to bear insurance risk for the prescription drug benefit. Without being too arcane, there is a question of performance risk and insurance risk. Performance risk has traditionally been borne by the pharmacy benefits manager. But the performance risk means the administrative risk and the cost of doing a good job just administratively; that is, without addressing the question of insurance risk as to whether people are going to buy these prescription drugs and how much the subsidy is or is not.

Now, some argue if plans are required to bear insurance risk in addition to the performance risk, they will be more efficient and prudent managers of prescription drug costs, the argument clearly being if you are a company or a PBM, and you have to bear the entire cost, the entire risk, including not only performance risk but insurance risk, you are probably going to be more efficient and probably a more prudent manager than you otherwise might be.

Plans will have stronger incentives, if they have that risk, to negotiate better prices and implement cost-containment strategies to minimize unnecessary utilization, the argument goes, if these plans bear at least some level of insurance risk.

Now, there have been critics of this model. Those critics argue if plans are required to bear insurance risk, they would structure their benefit design to discourage high-cost patients from enrolling in their plans; that is, they would cherry pick. We would be in the unfortunate world of adverse selection, where some plans would model their program they would offer to seniors in a way to discourage high-cost patients and encourage lower cost patients, and they therefore would be more profitable, leaving some of the higher cost patients, that is, those who really need drugs, out in the cold.

The health insurance industry has not been exactly rushing to the table to offer these benefits. The insurance industry does not seem willing to offer prescription drug benefits to seniors, even with the subsidies they would get if they are required to bear all of the risk.

Without a strong commitment from the health insurance industry, many fear that the insurance risk structure would lead to an unstable benefit. There would be a lot more instability because we don't know whether companies would be participating by offering plans. After all, this is something that is new. Plans would come in and out at will, forcing seniors to switch plans and possibly their medication.

In writing this bill, one of the greatest challenges Senator GRASSLEY and I faced was how to find the right balance between efficiency and plan stability. There have been several major prescription drug benefit bills and approaches. One we hear a lot about is the tripartisan bill of last year. Another one which explains this phenomenon was the so-called Graham or Kennedy bill of last year. The tripartisan model, in trying to resolve the dilemma between efficiency and stability, tilted more toward efficiency and away from stability. It had many more competitive components in it to

allow companies to be more efficient and cut costs and be more likely to participate. On the other hand, it was more unstable from the point of view of beneficiaries, probably more unstable from the point of view of the company as well, and that was a problem that many on the Democratic side had with that benefit design, particularly that model.

On the other hand, last year a major bill that was considered by the Senate was the so-called Graham-Kennedy bill. That bill tilted much more toward stability at the expense of efficiency. It was more expensive. More than $400 billion had been allocated over 10 years, and seniors would have had more predictability. They would know what they were getting because there was more money for companies. On the other hand, companies would not be able to compete among themselves, and there was much less competition and, therefore, under that model, much less efficiency.

One of the main merits of this bill is that it is in the middle. It is between the so-called tripartisan bill and the Graham bill. In trying to find the right balance between efficiency and stability, we are pretty much in the middle. We have found that balance. We both agreed that we needed to create strong incentives to keep prescription drug prices low. We also agreed that we needed stronger assurances that private plans would be ready and willing to enroll beneficiaries come January 1, 2006, when the benefit begins.

We have found that balance in this bill. This bill was passed out of the Finance Committee by a large bipartisan margin, which is some indication that we found the balance.

There are several important elements of this compromise I would like to highlight. First, our proposal would phase in insurance risk carefully over time through the use of reinsurance payments and risk corridors. Those are pretty big terms. What do they mean? Plans would receive Federal reinsurance payments for 80 percent of their enrollees' costs above the stop-loss level. These payments are intended to ensure that plans have strong incentives to enroll high-cost beneficiaries. That is, Federal reinsurance payments would cover 80 percent of the enrollees' costs above the stop-loss levels contained in the bill.

In addition, our proposal added another component to moderate risk through the use of what we call risk corridors. What in the world is a risk corridor? Simply put, it would limit a plan's loss if the plan sustained substantial financial losses. And by the same token, risk corridors would limit a plan's gains if it earned potential profits. We phase in risk over the first couple of years so that the private plans would have a little cushion, a little better opportunity to know how well their plan is working, and that errs a little bit more on stability at the expense of efficiency. But after a couple years, the tilt is a little more toward efficiency, having gained a couple years of experience, hopefully, of more stability.

During the first couple years the bill would establish a narrow corridor of risk. Over time the risk corridor would be expanded, thereby shifting a greater share of the risk on to the health plan. By phasing in risk over time, this bill addresses one of the biggest concerns plans had in considering whether to participate in the new program. That is, the uncertainty during the first couple years of the benefit.

This uncertainty takes many forms. For example, who will sign up for the benefit? That is a big question. Very few people know. Second, will drug costs increase faster than Congressional Budget Office projections? That is a big question. Moreover, will beneficiaries consume more prescription drugs once the benefit has been implemented?

That is another big question. It is hard to know. That is why we believe it is important to phase in risk rather than just cold turkey, 100 percent insurance risk the first day of the first year.

So during this period of uncertainty, we will ask the plans to bear a minimal level of insurance risk. As plans develop more experience, we will require them to assume more risk.

I am more confident than I was last year that private drug plans will provide a stable delivery system for Medicare beneficiaries under this new plan both in urban and rural areas. I remain concerned that not all seniors will have a choice of two or more prescription drug plans in the region. Plans may simply, given all the provisions we have added to this bill to help give them a little bit of reassurance, not be willing to participate in some parts of the country. After all, it is their choice whether plans want to participate.

This concern is why I insisted that any private plan delivery system must offer all beneficiaries the choice of at least two private plans, and if any part of the country does not have at least two choices, the Secretary would be required to contract with a plan that is a Federal fallback or a backup plan that would offer the standard benefit at the national average premium. Some might argue this delivery model does not provide enough efficiency and cost management. Others might argue that this will prove to be too unstable, too much efficiency, too much instability, despite the changes we have made. Plans may come and go. Worse, they may not even appear and seniors will be confused. That is a concern, and it is a legitimate concern, believe me.

Nevertheless, I believe that given the competing forces of efficiency on the one hand—competition and cost containment—and stability on the other—making sure that seniors have the prescription drugs they want—we have found a balance between these two fairly legitimate concerns.

I am not here to say it is the perfect balance. Clearly, others have better ideas how to address the question of where the balance is. I do believe the provisions of this bill are pretty close to it.

As we implement this benefit, we will have to carefully monitor the new delivery system very closely to ensure that, in fact, it is fair to our seniors and also fair to our taxpayers and to our private sector partners.

There are a lot of concerns here. One surely is making sure the senior citizens get the prescription drug benefit. But then equally important is that the American taxpayers' concerns are respected, and that we get savings, where we can honestly get savings, not at the expense of beneficiaries. That is why I believe an inclusion of private competition is important. It is very important.

Health care in our country is evolving, as you know, very quickly, and into areas we can hardly even imagine. I believe that in the next 10 to 20 years, when we are also faced with the problem of the baby boomers, there are going to be dramatic changes. What are the three areas going to be?

First of all, with the massive computational power that is developing, nanotechnology, married with the biotechnology, we will be able to, in not too many years from now—10, 12, 15 years—predict, with the human genome project, the interaction of systems in our bodies and the effect of DNA and predict what maladies or illnesses people are going to have in the future. We will develop machines that will detect things at a molecular level, with thousands of tests, that will be able to predict what will happen to each individual, or whether some of us are more inclined to get cancer or to have coronary disease—you name it. We are going to be able to predict very precisely in not too many years from now.

In addition, we will then be able to take actions to prevent illnesses with much greater certainty than we can today. We will be able to prevent it, since we know better what will happen to each of us with respect to our health, by deciding whether to take this pill or that pill or that new medicine that addresses a potential coronary disease that may occur with absolute certainty, or near certainty, 30 years later, or a cancer disease that may, with almost near certainty, occur 20 years later. That is where we will be in Medicare. It is changing so much.

Then, basically, health care will change from remedial care to personal wellness care. That is, doctors and people in the health care industry will be working with individuals to determine what illnesses they may or may not get and things they can do right now to prevent those illnesses from occurring. It will be a big shift from remedial care, which is about 90 percent of today's health care, to wellness and preventive care.

What else will happen? Seniors are going to live a lot longer. The quality

of our lives will be a lot better. It will change the demographics of the country and the health care in our country. The main point is that there are going to be a lot of changes in health care in the not-too-distant future.

What we are passing today on prescription drug benefits will also change. It is almost impossible for us to predict what the legislation should be in the years 2009, 2014, as this bill does. Yet we are doing the very best we can.

My point is that, given where we are today, in June 2003, I think this is a very good and aggressive attempt to try to find the right balance given all the different considerations we face. We can be very sure—and the chairman and I will give it utmost vigilance and oversight to make sure—that this delivers what is being promised to all our Medicare beneficiaries, the seniors of our country.

I respectfully urge my colleagues to closely evaluate the provisions and the merits of this compromise proposal. I have mentioned components that I think some Senators haven't had time to look at yet. I am talking about the balance between efficiency and stability. I am talking about phasing in risks, the risk corridors, as a good-faith effort to try to help make competition work—if it does work. If it does not work, we will know after a period of time. If it does not work, the bill provides a safety backup plan so that seniors are protected.

As I said, with all of the health care changes and the changes in the medical care that will happen over the years, we will probably revisit this in the not-too-distant future to address current conditions and the provisions of this bill.

As Senators study it more closely, they will realize there is a little more good in this bill than a lot of Senators originally thought. A lot of people have just not had an opportunity to focus on this.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

AMENDMENT NO. 1062 WITHDRAWN

Mr. REID. Mr. President, we have had conversations while the manager has been speaking. We have been assured by the majority that we will have a vote on the Boxer amendment in the next 24 hours. Having said that, I withdraw the Boxer amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

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

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

Mr. BAUCUS. Mr. President, I address an issue that many of my colleagues have asked me about over the past 2 weeks. It is an issue of great concern to many, particularly on my side of the aisle. That is, if this bill is enacted, how much will premiums vary and what will the actual effect of premium variation be for seniors?

Now, we have had a couple of votes already on this subject. I have not had a chance to address it directly and I would like to do so at this point. The issue again is the extent to which benefits and premiums may vary under this new Medicare drug benefit.

My Democratic colleagues are concerned that if benefits and premiums for participating drug plans are allowed to vary seniors will be confused and they will be unable to make informed choices, that is, the premiums seniors would pay, the monthly amounts they would pay for prescription drug coverage, should they volunteer to participate—that is, if they volunteer to participate, because it is an entirely voluntary program. It is not mandatory like the old catastrophic coverage bill was—in 1989 I think it was. This is voluntary. Seniors have a choice of whether they want to sign up for this new prescription drug benefit plan. If they do sign up, they pay a monthly premium of $35 a month for participating in the prescription drug plan.

Then the question is: How much can premiums vary and how much confusion might that cause among people trying to figure out the various merits of the various plans?

I might say they will not be able to make an apples-to-apples comparison between plans that are available in their own area. That is their concern; they just will not be able to compare fairly. As I said, these concerns are legitimate.

Certainly, those who believe in competition believe choice should be based on price and on quality. It should not be based on a plan's effort to select the healthiest beneficiaries and jettison the sickest. It should also not be based on distortions in the market. That is, we want fairness. We want equity. We do not want so-called cherry picking. We do not want to have certain plans pick the healthiest seniors, adjust premiums to get the healthiest, and leave out other seniors who require more prescription drugs that are not as healthy. That would just not be fair.

At the same time, we want to have some competition, and this bill does provide for private plans to provide a drug delivery benefit. The reason for relying on the competitive delivery system rather than the Government-based program is to allow for innovation and benefit design, to let companies look to try to find a better way of doing things, that is, of containing costs, and be more efficient, without sacrificing quality and stability to our seniors.

I think most of us believe that kind of innovation will lead to efficiency. The attempt is to design it in a way that does not lead to a risk in selection because that would be very unfair. So the question is: How can we ensure that choice is in fact based on the right factors, that is on price and on quality? How can we make sure there is enough flexibility so plans can adapt to changing needs and to a marketplace innovation, without providing so much flexibility that seniors have a difficult time choosing among plans? That is the challenge. That is what we are trying to resolve in this bill.

I think the proposal before us, the legislation reported out of the Finance Committee that has come to the floor, does a pretty good job of constructing that balance, and I will explain why I believe that is true.

First, on benefit variation—that is different benefits seniors may get because of different plans—the Grassley-Baucus bill limits benefits variation at several levels. First, the $275 deductible and the $3,700 out-of-pocket limit are fixed in the statute. Those two figures cannot vary. So plans are permitted to improve the benefit, but they cannot go higher than the deductible outlined in the law, and they cannot raise the stop loss beyond the level specified in the law. So that is one check. It does leave some potential variation on the premium and copay, but at least two components—deductible and stop loss—are fixed in the law.

All plans, whatever the benefit design is, whatever they offer, have to have those two provisions as prescribed in the statute.

Now, a benefit variation is also constrained through various limitations in what the Congressional Budget Office calls actuarial value or expected cost of the benefit. In plain English, that means the value of the benefit must be roughly equal to the standard benefit package outlined in the legislation.

We have all heard about the standard benefit package, the deductible, the stop loss, the premium, and what the copays are, so that the value of the benefit of any plan any company offers must be roughly equal to the standard benefit package outlined in the legislation.

As I understand from actuaries who spend their time thinking about these things, the practical effect of these provisions combined is there will not be significant variation in benefit packages. There just cannot be. All companies are going to know pretty much what they can charge. The actuaries do not predict much variation.

The bill also, however, attempts to minimize premium variation. How? Well, the bill includes various provisions that are intended to control variation in the premiums so beneficiaries will not be faced with widely varying premiums within their own region or across different parts of the country.

For example, if my mother learned her friends in Florida were paying far less in monthly premiums than she was paying in Montana, I believe I would get an earful. I would hear from my

mother. She would wonder whether the system we created is fair. And she would be right; it probably would not be fair.

What do we try to do about this? It is not perfect, but I think it is a major effort, and I think it is a good effort.

First, all Medicare beneficiaries who are enrolled in the new drug program will be combined for purposes of calculating premiums and payments to plans, regardless of whether those beneficiaries are in fee for service, enrolled in a drug-only plan, or whether they are enrolled in a private PPO or HMO. All senior citizens who are enrolled in Medicare will be combined for the purposes of calculating premiums and payments to plans, regardless.

Mr. ALLEN. Mr. President, will my good colleague from the State of Montana please yield for the purpose of an introduction of an esteemed guest? I know this is very important, but I ask if he will yield for a moment.

Mr. BAUCUS. Mr. President, I yield 1 minute to the Senator from Virginia.

The PRESIDING OFFICER. The Senator from Virginia.

VISIT TO THE SENATE BY THE HONORABLE PATRICK COX, PRESIDENT OF THE EUROPEAN PARLIAMENT

Mr. ALLEN. I thank the Senator because I know he is talking about a very important issue to all the people of America.

I do have the honor of presenting to my Senate colleagues the Honorable Patrick Cox, who is the President of the European Parliament. As my colleagues know, the European Parliament is the only directly elected body in the European Union and the only popularly elected international assembly in the entire world.

Every 5 years, Europe's 375 million citizens have the chance to vote for 626 representatives. President Cox's position is the equivalent of the Speaker of the House and the President of the Senate combined. So he is TED STEVENS and DENNY HASTERT together.

I appreciate the indulgence of the Senator from Montana, and I request my colleagues to take a moment to introduce themselves to President Cox because we do have so many transatlantic bonds, not only philosophically but also economically for jobs.

I yield the floor.

Mr. BAUCUS. We are very honored to have our guest. I don't know how long he wants to stay. There are so many transatlantic issues we can address.

I see my very good colleague from Iowa in the Chamber, and we have lots of agricultural issues. We would also like to learn from Europe about European health care systems. I am sure there are provisions in Europe we could look at and adopt. No country has a monopoly on good ideas and no region of the country has a monopoly on good ideas.

I urge our guest to stay as long as he possibly can and hopefully have time to converse over some of these issues so we can get a better idea of how we can resolve some of these huge issues, including agricultural and other trade issues. We all know the more we work together, the better we will be on both sides of the Atlantic.

Mr. ALLEN. Thank you, Mr. President.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—CONTINUED

Mr. BAUCUS. I have been explaining various provisions in the bill that I think largely address concerns that some on the Democrat side have and I suppose on the Republican side of the aisle, too; namely, potential premium variation. Premiums that seniors pay might vary. Much confusion might occur for seniors and anyone else involved in prescription drug benefits that would be distributed under this legislation.

As I mentioned, the actuaries say there should not be much change. Also, the risk pool will include all Medicare beneficiaries, ensuring an adequate number of low-drug-cost beneficiaries will be able to subsidize the few beneficiaries with the high drug costs. Already, there is a huge risk pool. There is kind of a cross subsidization. Those with very low drug costs will help pay for those much higher costs of other seniors. The larger risk pool will prevent premium variation because we use the whole pool.

In addition, the bill will calculate Federal contributions toward plan premiums based on the national average of all plan bids. This contribution is then adjusted geographically for differences in prices. This is a so-called geographic adjustor. We want to make sure one part of the country is not discriminated against compared to another part of the country or vice versa, and we included the geographic adjustment on prices.

We have not included so far, because it is difficult to calculate, geographic adjustment based on utilization. As we know, in some parts of the country there is more utilization. That is a fancy term for saying there is a lot more care given to people than in other parts of the country. More care, the greater utilization, tends to be in parts of the country with more hospitals, more specialty health care providers.

There is an interesting study I urge my colleagues to read by Dr. Wennberg. I have not found anyone who refutes it. Looking at the country as a whole, there are parts of the country where utilization is twice as high and more than twice as high as other parts of the country. People, because of where they live, get twice as much health care in some parts of the country than in other parts of the country. This is adjusted for age, for race, for gender. It is adjusted for all the factors that can possibly be thought of.

The more interesting part of this study, even though some parts of the country get twice as much health care as other parts of the country—and it is because there are twice as many doctors or hospitals in some parts of the country as in others—the interesting part of the study is, the actual care given is no better, and in fact in some cases it is worse. That is, if you get twice as much health care, that is, twice as many visits to the doctor or the hospital, particularly for chronic diseases, you will not be twice as healthy; you will not be any healthier, on average, than you will be in parts of the country where there is less utilization.

The point is that we are trying to adjust, as I mentioned earlier, and have a geographic adjustment based on the costs. We have not yet figured out a way to adjust for different utilization mainly because, when it comes to prescription drug benefits for seniors, there is virtually no data because we have not had prescription drug benefits for seniors yet. Obviously, it is hard to get the data if we have not had the program.

There are other provisions in the bill that enable us to get more data, so fairly quickly we can get better utilization data and therefore have a geographic adjustment based not only on price but also on utilization. That will go a long way to address some of the concerns people have about potential premium variation and complexity. When we get that data, as I said, we will have a lot more information, but there is enough information already to have the effect of minimizing concern about premium variations.

There is another provision in the bill to help address this potential problem. That is, we have included in this bill a provision based on the Federal Employees Health Benefits Program—otherwise known as FEHBP—that prohibits plans from changing premiums that are unreasonably higher than the costs of the benefits provider. In other words, plans are prohibited from price gouging. That standard currently is in the law with respect to the FEHBP plan. That is in the law. There is a provision in current law that prohibits the FEHBP plans from charging premiums that are unreasonably higher than the cost that has been provided. I believe that same provision as applied to prescription drug pricing is an additional guarantee against gouging and certainly against unconscionable premium variation.

Finally, this bill allows the Secretary to refuse to contract with the plan. That is in the bill. Maybe a plan leans toward enrolling healthier beneficiaries. Maybe the Secretary determines that this plan is not a good actor; this plan is price gouging; this plan is engaging in cherrypicking; it is engaging in adverse selection at the expense of an American; or maybe it seems less committed to staying in the program; maybe there is a shady operation; who knows, maybe it seems more likely to drop out fairly quickly