Great relationships were established, and good constituent service. He won his last election by getting more African-American votes than any Republican in the South.

All I can say about Senator Thurmond is that we pray for his family, we mourn his loss, but we thank God that He provided us a great public servant.

Well done, Senator Thurmond.

Thank you, Mr. President.

Mr. NICKLES. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nomination on today's executive calendar:

Calendar No. 252, the nomination of Joshua Bolten to be Director of the Office of Management and Budget. I further ask unanimous consent that the nomination be confirmed, the motion to reconsider be laid upon the table, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

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

The nomination was considered and confirmed.

LEGISLATIVE SESSION

The PRESIDENT pro tempore. Under the previous order, the Senate will return to legislative session.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

Mr. BAUCUS. Mr. President, will the Chair state the regular order?

The PRESIDENT pro tempore. The pending amendment numbered 1060, as modified is the regular order.

Mr. BAUCUS. Mr. President, is that the Nickles-Feinstein amendment?

The PRESIDENT pro tempore. It is.

Mr. BAUCUS. Mr. President, I move to table the Nickles-Feinstein amendment, and I ask for the yeas and nays.

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Oklahoma (Mr. INHOFE) is necessarily absent.

Mr. REID. I announce that 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 PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 38, nays 59, as follows:

[Rollcall Vote No. 261 Leg.]

YEAS—38

Akaka	Edwards	Murray
Baucus	Grassley	Nelson (FL)
Bayh	Harkin	Nelson (NE)
Bingaman	Hollings	Pryor
Boxer	Inouye	Reed
Breaux	Johnson	Reid
Byrd	Kennedy	Rockefeller
Cantwell	Lautenberg	Sarbanes
Clinton	Leahy	Schumer
Corzine	Levin	Snowe
Daschle	Lincoln	Specter
Dorgan	Mikulski	Stabenow
Durbin	Miller	

NAYS—59

Alexander	Dayton	Landrieu
Allard	DeWine	Lott
Allen	Dodd	Lugar
Bennett	Dole	McCain
Biden	Domenici	McConnell
Bond	Ensign	Murkowski
Brownback	Enzi	Nickles
Bunning	Feingold	Roberts
Burns	Feinstein	Santorum
Campbell	Fitzgerald	Sessions
Carper	Frist	Shelby
Chafee	Graham (FL)	Smith
Chambliss	Graham (SC)	Stevens
Cochran	Gregg	Sununu
Coleman	Hagel	Talent
Collins	Hatch	Thomas
Conrad	Hutchison	Voinovich
Cornyn	Jeffords	Warner
Craig	Kohl	Wyden
Crapo	Kyl	

NOT VOTING—3

Inhofe	Kerry	Lieberman

The motion was rejected.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

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

Mr. GRASSLEY. Mr. President, what is the business before the Senate?

The PRESIDENT pro tempore. Amendment No. 1060, as modified.

Mr. GRASSLEY. I urge adoption of the amendment.

The PRESIDENT pro tempore. Is there further debate?

Mr. BAUCUS. Mr. President, will the Chair identify the sponsors of that amendment?

The PRESIDENT pro tempore. Senator BAUCUS for Senator FEINSTEIN, amendment No. 1060, Part B premium, subtitle (d).

Mr. BAUCUS. Mr. President, the Senate is ready to vote.

The PRESIDENT pro tempore. The question is on agreeing to the amendment.

The amendment (No. 1060), as modified, was rejected.

Mr. BAUCUS. I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

The PRESIDENT pro tempore. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I have a unanimous consent request to correct a previous unanimous consent request. In a previous unanimous consent request, I referred to amendment No. 990 when I meant to refer to the previously adopted Murray amendment No. 961.

I ask unanimous consent to make that change.

I referred to the Kyl amendment No. 1128 when I meant to refer to Kyl amendment No. 1121.

I also ask unanimous consent to make that change.

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

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

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

AMENDMENT NO. 1133

Mr. GRASSLEY. Mr. President, I send an amendment to the desk.

The PRESIDENT pro tempore. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY] proposes an amendment numbered 1133.

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

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

(The amendment, No. 1133, is printed in today's RECORD under ''Amendments Submitted.'')

Mr. GRASSLEY. Mr. President, is there no discussion necessary on the amendment?

The PRESIDENT pro tempore. Who seeks recognition?

The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I would just like to say that we have help for our teaching hospitals in the managers' amendment. It is not much. But I am working with all of the managers, the ranking member as well as the chairman, to try to increase funding for teaching hospitals.

I want to point out our teaching hospitals must have the support that is in this bill at a higher percentage if we are going to keep the young physicians trained and if our country will keep the greatest health care system in the world.

I thank the managers for helping me put that in the managers' amendment.

The PRESIDENT pro tempore. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I oppose the managers' amendment because of an amendment that is in the managers' amendment, the Corzine amendment which provides three States the opportunity to basically opt out of the Medicare Program for prescription drugs and have an entitlement flow of funding going to the States for the States to develop their own stand-alone drug benefit. As a result of that, States like mine and two others will not have the advantage of an integrated drug benefit which I fought very strongly for on this floor and which I believe will also lead potentially to this unlimited entitlement flow of funds to the States because of the way this language is drafted, the potential for lots of mischief in respect to double dipping, inter-government transfers, disproportionate share payments. We could be opening a virtual Pandora's box. Yes. For my States and two others. But I think, frankly, it is not good policy and does not do the kind of improvement of the overall Medicare program which my State should participate in as well as the other States represented here.

There is no Federal oversight by the Secretary of Health and Human Services for this plan.

There are a host of other problems with this amendment. It is my understanding that the managers gave a commitment that this amendment be included in the package. And so to honor the chairman's commitment, I will not object to this amendment nor call for a vote to strike the amendment. But I, unfortunately, will have to vote against this bill.

The PRESIDENT pro tempore. Is there further debate?

Mr. GRASSLEY. I ask unanimous consent that the amendment be agreed to.

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

The amendment (No. 1133) was agreed to.

AMENDMENTS EN BLOC WITHDRAWN

Mr. GRASSLEY. Mr. President, I ask unanimous consent to withdraw the pending amendments.

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

The amendments (Nos. 953, 958, 934, 964, 965, 980, 979, 973, 986, 990, 977, 993, 962, 1004, 1019, 1020, 1021, 999, 954, 1037, 1039, 1051, 1012, 1061, 1075, 1076, 1077, 1024, 1073, 1088, 1089, 1090, 1091, 1110, and 1041) were withdrawn.

ADULT DAY CARE

Mr. BUNNING. Mr. President, during consideration of this bill in the Finance Committee, I submitted language regarding adult day care which I and my staff were told by Finance Committee staff was acceptable and included in S. 1, the Prescription Drug and Medicare Improvement Act of 2003, as part of the base bill to be considered on the Senate floor. I was very thankful for your consideration and approval of my language, Chairman GRASSLEY.

Mr. GRASSLEY. Yes, Senator BUNNING, I remember your submitted language regarding Adult Day Care.

Mr. BUNNING. After we voted to pass S. 1 out of the Finance Committee, I have since learned that the adult day care language accepted and made part of the bill is not the language I submitted at all, but instead it is language based on a bill introduced by Senator SANTORUM related to the same issue.

Mr. GRASSLEY. Yes, this is true, and I apologize for the inaccurate information and misunderstanding provided to you and your staff from the Finance Committee on this issue. The language included in the base bill instead is based on Senator SANTORUM's bill.

Mr. BUNNING. While Senator SANTORUM's adult day care proposal and my adult day care language are different, they both share the same goal of providing services to those special and needy adults who require extra attention and care. However, I have some differences with Senator SANTORUM's proposal, and he has some differences with my proposed language.

Mr. SANTORUM. Yes, we do share the same goal on this adult day care issue, and we do have some fundamental differences with one another's proposals and language on the matter.

Mr. GRASSLEY. Yes, that is my understanding, as well.

Mr. BUNNING. I am hopeful that once this bill gets to conference, we and our staffs can work out our differences on this adult day care issue and find a solution that is amenable to all of us. It is also my understanding the current version of the House of Representative's prescription drug benefit bill includes the adult day care language which is identical to my language.

Mr. SANTORUM. I am willing to work on this matter further, and do agree that since the Senate's and House of Representative's versions on the adult day care language will be different, we will have to find a solution to our differences on this important issue.

Mr. GRASSLEY. I will be happy to work with both of you and our staffs to rectify this problem. Adult day care is an important issue, and being that the Senate and House of Representatives will have different language on this issue, it must be conferenced in a way to ensure that all with interests in this matter, including interested provider and senior organizations, are involved and approving of the final adult day care language. I am looking forward to further working with both of you on this matter.

Mr. BUNNING. Thank you, Mr. Chairman and Senator SANTORUM. I appreciate both your willingness to revisit this matter and your leadership on this important legislation for our seniors.

FEE FOR SERVICE

Mr. FRIST. Mr. President, I believe in assuring the ability of seniors who choose to do so to add their own funds on top of the government contribution in order to participate in private fee-for-service plans under Medicare. I also believe that private fee-for-service plans should be able to provide an unmanaged form of the subsidized prescription drug benefit.

Accordingly, I am committed to ensuring that the bill reported from the conference committee that will consider S. 1 and H.R. 1 incorporates the functional equivalent of those provisions in H.R. 1 that permit private fee-for-service plans to provide the subsidized prescription drug benefit as an unmanaged benefit whose premium amount, just like the premium amount such plans charge for the core Medicare benefit under current law, is not subject to governmental review or approval.

Mr. GRASSLEY. I agree.

REPEAL OF THERAPY CAPS

Mr. ENSIGN. Mr. President, I will withdraw my amendment to repeal the arbitrary beneficiary caps on therapy. However, I would urge my colleague from Iowa, the Chairman of the Finance Committee, to work in conference to find a way to delay this law. As you know, the beneficiary caps will have one of three results—beneficiaries will either: (1) pay 100 percent out-of-their own pocket once the caps are exceeded; (2) self-ration therapy care; or (3) forgo medically necessary care altogether. Mr. President, I recognize that the Chairman has been a voice to eliminate these caps and hope that a final Medicare bill further delays implementation of them.

Mrs. LINCOLN. Mr. President, I would like the opportunity to join my colleague from Nevada to speak in support of repealing the caps on outpatient physical therapy, occupational therapy, and speech-language pathology.

The current therapy cap discriminates against the most vulnerable of Medicare beneficiaries. While the majority of enrollees will not exceed an annual $1,590 limitation on rehabilitation services, approximately 13 percent of seniors and individuals with disabilities covered by Medicare will be forced to pay for medically necessary services out of pocket.

This is a particularly burdensome situation for beneficiaries living in rural communities. Most likely to be harmed are beneficiaries who have experienced a stroke or hip fracture or who have Parkinson's disease or other conditions that require extensive rehabilitation following injury or illness.

I urge the Chairman and Ranking Member of the Finance Committee to work with me and my colleague, the Senator from Nevada, on repealing this cap or at least suspending it for 1 or 2 years. My colleague and I have sponsored legislation (S. 569) to permanently repeal this cap. Our bill has

been cosponsored by 41 members of the Senate.

Again, I appreciate the opportunity to join my colleagues from Nevada today. It is my sincere hope, Mr. President, that we will be able to address the issue of the burdensome $1,590 cap on outpatient therapy services.

Mr. GRASSLEY. I thank both the Senator from Nevada and the Senator from Arkansas for their comments and for withdrawing the amendment. As you may know, I asked CMS Administrator Scully at the Finance Committee markup to further delay implementation of these beneficiary caps. Unfortunately, as a result of the Senate Budget Resolution constraints, I do not have Medicare dollars to repeal the beneficiary cap on therapy services. I agree that this arbitrary limit does not make sense and have sought to address this issue in the past. I will work in conference to enact a therapy cap moratorium and appreciate your hard work and passion on this issue.

Mr. ENSIGN. I appreciate the Chairman's leadership on this issue and I thank my colleague for agreeing, at a minimum, to work toward another moratorium on implementation of the therapy cap. I would also like to thank the Senator from Arkansas for her words of support. Mr. President, I yield the floor.

I ask unanimous consent that this full statement be included in the RECORD as if read.

Mr. HATCH. Mr. President, I strongly support Senator KYL's sense of the Senate resolution to S. 1. His resolution asks Congress to rectify problems with the formula that is used to update Medicare physician reimbursement.

Due to flaws in this formula, payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004. This cut in physician compensation would be the fifth since 1991 including a 5.4 percent decrease in 2002. According to Medicare's own conservative estimates, between the years 1991 and 2003, reductions for physicians and other health professionals resulted in Medicare physician reimbursement that equates to 14 percent below their actual practice costs. The 2004 reduction would decrease Utah physician income by $13 million which translates to $3003 per physician in 2004. And this is in addition to the $9 million decrease in reimbursement that Utah physicians received in 2002. Furthermore, unless we correct this formula, it is estimated that more cuts will occur in 2005, 2006, and 2007.

The Medicare Payment Advisory Commission, MedPAC, has stated that these reimbursement reductions are the result of a problem with the Sustained Growth Rate that is used as part of the calculation to adjust rates each year. The SGR expenditure target is linked to gross domestic product. Therefore, the formula may decrease Medicare reimbursement for physicians and other practitioners when health care volume increases outstrip increases in the gross domestic product. The problem is magnified when gross domestic product decreases. Essentially, the formula penalizes physicians for factors over which they have no control.

It is true that as the population of our country ages, the volume of Medicare health care services consumed increases. However, physicians have no control over this and our Medicare system penalizes them because of it. As a result, some physicians no longer take new Medicare patients, some decline to participate in the Medicare program altogether, and young people are considering other professions.

I would submit that as the baby-boomer generation ages and increasing numbers of Americans become Medicare beneficiaries, we need physicians and other health care providers more than ever. If anything, we should be rewarding our physicians, not penalizing them.

An additional problem with the Sustained Growth Rate calculation is that it does not account for many changes in health care that improve quality but increase physician work also. The federal government actively promotes new coverage decisions, quality improvement activities and other initiatives that benefit patients but are not taken into account by the Sustained Growth Rate calculation.

MedPAC's recommendation to Congress is that annual updates in physician payments should reflect increases in the Medicare Economic Index or MEI rather than the gross domestic product. Using the Medicare Economic Index would eliminate the penalty that physicians and other practitioners currently experience when the volume of health care services increases due to factors that they are unable to control.

What we have before us is a flawed formula that is threatening the health of Americans and the future of our country. Congress has addressed this problem before, but it seems that we were only putting a bandage over the wound; we never cured the disease that caused it. The wound continues to fester and it will continue to do so until we cure the problem. And the cure, it seems, is to revise the formula.

I for one, am tired of applying bandages to this wound. I believe that it is time to address this problem directly and definitively. I urge my colleagues to join with me in supporting this resolution and in working to correct this problem.

Mr. FEINGOLD. Mr. President, I joined my colleague, the distinguished Senator from Oregon, Mr. SMITH, in offering an amendment to promote better care for frail elderly and disabled. This amendment will allow the Secretary of the Department of Health and Human Services to designate health plans that disproportionately serve special needs beneficiaries as specialized Medicare Advantage plans.

A number of States have successfully chosen to serve seniors and the disabled by combining Medicare and Medicaid services through a waiver approved by the Department of Health and Human Services that integrates services under Medicare and Medicaid capitated financing arrangements. These programs provide beneficiaries with a comprehensive benefit package that combines the services traditionally provided by Medicare, Medicaid, and home and community based waiver programs.

In my home State of Wisconsin, the Wisconsin Partnership Program is one such success, a community-based program that has improved the quality, access, and cost-effectiveness of the care delivered to its beneficiaries. Perhaps most important to the beneficiaries, these programs help the disabled and the frail elderly remain in their own community, and avoid institutionalized care. Wisconsin is lucky to have four such programs across our State: Elder Care and Community Living Alliance of Dane County, Community Care for the Elderly of Milwaukee County, and Community Health Partnership Eau Claire, Dunn, and Chippewa Counties.

In order to qualify for these programs, a person must be Medicaid-eligible, have physical disabilities or frailties of aging, and require a level of care provided by nursing homes. Through programs such as the Wisconsin Partnership Program, these frail elderly and disabled beneficiaries are able to receive quality preventive care upfront, which allows more beneficiaries to stay in their communities and reduces the rate of hospitalization.

In Wisconsin, about 26 percent of all Medicaid recipients age 65 or older are in nursing homes. This rate drops dramatically for those enrolled in the Wisconsin Partnership Program, where only 5.9 percent of recipients age 65 or older are in nursing homes.

While the Wisconsin Partnership Program is a success, we must ensure that the Federal Government continues to support these State-based solutions to our long-term care needs and other specialty managed care programs that focus on frail, chronically ill seniors. Last year I introduced the Frail Elderly Act of 2002, which promoted specialty managed care programs and helped those already in existence to continue to operate. This amendment will work to accomplish both goals by providing a population-based designation that allows plans to be recognized for specialization in services for special needs beneficiaries. By establishing this specialized designation, we hope to be able to more easily move specialized plans from demonstration status to mainstream provider status, helping to promote a more effective way of caring for the frail elderly and disabled.

Mr. President I also want to point out that this amendment does not change payments, does not change administrative rules, and therefore doe not have a fiscal effect.

Fundamental long-term care reform is vital to any health care reform that

Congress may consider. As part of these reforms, we must support State and local efforts to encourage care for the most vulnerable populations. We must provide our seniors and disabled with real choices. They are entitled to the opportunity to continue to live in the homes and communities that they helped build and sustain. I urge my colleagues to support this amendment that will help provide a measure of support for the most frail elderly and disabled to allow them to stay in their own homes.

Mr. President, I ask unanimous consent that two letters of support for this amendment, from the Community Health Partnership and Elder Care of Dane County be printed in the RECORD.

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

COMMUNITY
HEALTH PARTNERSHIP, INC.,
Eau Claire, WI, June 26, 2003.

Hon. RUSSELL FEINGOLD,
U.S. Senate,
Washington, DC.

DEAR SENATOR FEINGOLD: I am writing to express my support for the amendment you will be offering with Senator Gordon Smith to create a designation for Medicare Advantage plans that target special needs beneficiaries. Community Health Partnership, Inc. (CHP) is one of four Wisconsin Partnership Program demonstration sites that has developed innovative models of care specifically for frail seniors and people with physical disabilities that would benefit from a specialty designation.

The Wisconsin Partnership Program (WPP) is an integrated program of acute and long-term care services designed to improve access to needed care, reduce fragmentation of care across providers and settings, and help people remain independent in the community, while achieving cost savings. The target populations for WPP include both elderly and physically disabled individuals who meet nursing home level of care criteria. CHP serves both populations in a 3 county, rural area. Participants must be Medicaid eligible or dually eligible for Medicare and Medicaid services. A hallmark of this program is the use of an inter-disciplinary care team comprised of a physician, nurse practitioner and social worker that help coordinate beneficiaries' care across all health care settings. The WPP also participates in the Medicare/Medicaid Integration Program, a demonstration to test strategies for integrating Medicare and Medicaid services. The goal of this program is to create a seamless system of care for beneficiaries and to reduce costs related to duplication of services and administrative functions across programs.

Like a number of other specialty Medicare+Choice programs, the WPP currently operates under demonstration authority, which expires at the end of next year. And, like virtually all Medicare demonstration programs, there is no mechanism for transitioning from demonstration status into the mainstream of Medicare. I understand that The Medicare Prescription Drug and Reform Act of 2003 begins to address this problem by establishing a special designation for specialized Medicare Advantage plans that exclusively serve special needs beneficiaries. Your amendment would allow the Secretary also to designate as specialized Medicare Advantage plans those that disproportionately serve special needs beneficiaries.

The expansion of the specialized Medicare Advantage designation would provide CHP and other WPP members additional flexibility in expanding our unique program to other beneficiary groups such as those who are eligible for Medicare, but not Medicaid and ''pre-duals''—those who are at risk of spending down to Medicaid based on health status and/or income limitations. Targeting healthy beneficiaries before they become frail or disabled would reduce long-run Medicare and Medicaid costs by preventing or delaying health care decline and the need for costly medical or long-term care services. Your amendment also would offer CHP a mechanism to serve non-special needs beneficiaries as a strategy for expanding our membership under a mainstream model or reducing our risk through a more representative cross-section of Medicare beneficiaries in West Central Wisconsin.

Your compassion for seniors, disabled and other special needs beneficiaries has been evident since you served as the Chair of the Senate Aging Committee in the State of Wisconsin. The amendment you are offering to the Senate Medicare bill only provides further evidence that you continue to be hard at work on behalf of Wisconsin's most vulnerable populations. Thank you for all of your work on behalf of Wisconsin's seniors.

Sincerely,

KAREN A. BULLOCK,
CEO.

ELDER CARE OF DANE COUNTY,
Madison, WI, June 24, 2003.

Hon. RUSSELL FEINGOLD,
U.S. Senate,
Washington, DC

DEAR SENATOR FEINGOLD: I am writing to express my support for the amendment you will be offering with Senator Gordon Smith to create a designation for Medicare Advantage plans that target special needs beneficiaries. Elder Care of Dane County is one of four Wisconsin Partnership Program demonstration sites that has developed innovative models of care specifically for frail seniors and people with physical disabilities that would benefit from a specialty designation.

The Wisconsin Partnership Program (WWP) is an integrated program of acute and long-term care services designed to improve access to needed care, reduce fragmentation of care across providers and settings, and help people remain independent in the community, while achieving cost savings. The target populations for WWP include both elderly and physically disabled individuals who meet nursing home level of care criteria. Elder Care Partnership serves frail elderly beneficiaries. Participants must be Medicaid eligible or dually eligible for Medicare and Medicaid services. A hallmark of this program is the use of an inter-disciplinary care team comprised of a physician, nurse practitioner and social worker that help coordinate beneficiaries' care across all health care settings. The WWP also participates in the Medicare/Medicaid Integration Program, a demonstration to test strategies for integrating Medicare and Medicaid services. The goal of this program is to create a seamless system of care for beneficiaries and to reduce costs related to duplication of services and administrative functions across programs.

Like a number of other speciality Medicare+Choice programs, the WWP currently operates under demonstration authority, which expires at the end of next year. And, like virtually all Medicare demonstration programs, there is no mechanism for transitioning from demonstration status into the mainstream of Medicare. I understand that The Medicare Prescription Drug and Reform Act of 2003 begins to address this problem by establishing a special designation for specialized Medicare Advantage plans that exclusively serve special needs beneficiaries. Your amendment would allow the Secretary also to designate as specialized Medicare Advantage plans those that disproportionately serve special needs beneficiaries.

The expansion of the specialized Medicare Advantage designation would provide Elder Care and other WWP members additional flexibility in expanding our unique program to other beneficiary groups such as those who are eligible for Medicare, but not Medicaid and ''pre-duals''—those who are at risk of spending down to Medicaid based on health status and/or income limitations. Targeting healthy beneficiaries before they become frail or disabled would reduce long-run Medicare and Medicaid costs by preventing or delaying health care decline and the need for costly medical or long-term care services. Your amendment also would offer Elder Care a mechanism to serve non-special needs beneficiaries as a strategy for expanding our membership under a mainstream model or reducing our risk through a more representative cross-section of Medicare beneficiaries in Madison.

Your compassion for seniors, disabled and other special needs beneficiaries has been evident since you served as the Chair of the Senate Aging Committee in the State of Wisconsin. The amendment you are offering to the Senate Medicare bill only provides further evidence that you continue to be hard at work on behalf of Wisconsin's most vulnerable populations. Thank you for all of your work on behalf of Wisconsin's seniors.

Sincerely,

KAREN MUSSER,
CEO.

Mr. HATCH. Mr. President, I rise to speak on the Gregg-Schumer amendment which was adopted last week. This amendment was based on a piece of legislation, S. 1225, the Greater Access to Affordable Pharmaceuticals Act of 2003, reported by the HELP Committee on June 11th.

I want to take this opportunity to explain why I cast the lone vote against this amendment. It is my hope that when my colleagues consider my explanation that they may be open to making additional changes to this very important amendment as the process moves forward.

Let me start by commending Senators GREGG, SCHUMER, MCCAIN, and KENNEDY for their work in developing this provision which I believe is a significant improvement on legislation that was adopted by the Senate last Congress, S. 812.

The Gregg-Schumer amendment relates to a complex and often admittedly confusing law I coauthored with my friend, Representative HENRY WAXMAN of California in 1984 the Drug Price Competition and Patent Term Restoration Act.

I chaired a hearing of the Senate Judiciary Committee in May of 2001 that helped document some abuses that were occurring in the law. Since our last hearing on this issue, much has happened.

Both the Federal Trade Commission and the Food and Drug Administration played a constructive role in attempting to end several mechanisms by which some research-based and generic

drug firms were attempting to game the system put in place by the 1984 and subsequent court decisions to avoid competition in the marketplace.

The FTC succeeded in achieving several widely-publicized consent decrees with a variety of offending firms under the existing antitrust statutes.

In addition, the FTC conducted an exhaustive survey and study of how certain provisions of the 1984 Waxman-Hatch Act affected competition in the pharmaceutical industry.

The FTC study contained two major recommendations. The first addressed the use of the statutory 30-month stay granted by the 1984 law in situations where patents are challenged by generic competitors. The FTC recommended that the law:

> Permit only one automatic 30-month stay per drug product per ANDA to resolve patent infringement disputes over patent listed . . . prior to the filing date of the generic applicant's ANDA.

This was precisely the position that I suggested in testimony before the HELP Committee on May 8, 2002 and argued for last year during the Senate debate on the Edwards-Collins substitute amendment to the McCain-Schumer legislation.

I would note that the 30-month stay provision in the McCain-Schumer bill last year, S. 812, and in the Edwards-Collins substitute, were both at variance with this central recommendation of the FTC report.

The second major FTC recommendation responds to those situations in which R&D and generic firms were entering into agreements not to impede generic competition. The FTC recommended that Congress:

> Pass legislation to require brand-name and first generic companies applicants to provide copies of certain agreements to the Federal Trade Commission.

Senator LEAHY, working very closely with the FTC, developed legislation, the Drug Competition Act, S. 946, that squarely addressed this second recommendation.

During the 107th Congress, I worked with Senator LEAHY on refining that bill. I supported it in committee, and worked with him to pass it through the Senate late last year. I supported his efforts to have it attached to the Medicare vehicle earlier this week. I expect that the 108th Congress will adopt this measure.

The FTC study served an important purpose of cataloging the facts surrounding certain abuses of the 1984 act. In formulating public policy, the facts should matter and a legislative or regulatory response should be tailored to fit the problem.

Unfortunately, the timing of the issuance of FTC study did not allow the report to get the attention it deserved by the Senate. The FTC report was published only one day before the Senate adopted S. 812, the Greater Access to Affordable Pharmaceuticals Act of 2003, last July 31st.

The GAAP Act, developed by Senators MCCAIN and SCHUMER, was substantially altered by the Edwards-Collins substitute, with active involvement of Senator KENNEDY.

While there is no question my colleagues were motivated by their goal of making drugs more affordable for seniors and all Americans, and despite the fact that it garnered 78 votes in the Senate, there were significant shortcomings in the bill.

Let me briefly review a few of the most troublesome provisions of the Edwards-Collins substitute to S. 812. The proposed legislation would have created for the first time a private right of action in the Federal Food, Drug, and Cosmetic Act. The last thing the already overburdened FDA staff needs is a bunch of trial lawyers bringing the agency to a screeching halt by second-guessing its judgment calls.

The bill that passed last year would have resulted in the waiver of patent rights apparently against even third parties—if pioneer drug firms did not file its patents with the FDA and, if challenged by a generic drug applicant, pursue expensive litigation within tight time frames.

In sharp contrast to the FTC recommendation, S. 812 basically made any patents listed with the FDA after a month from the date the pioneer drug application was approved by the FDA ineligible for the 30-month stay. In most cases, this is at least four years earlier than what I and the FTC recommended—freezing the Orange Book to patents listed before a generic drug application was filed.

The American Intellectual Property Law Association opposed S. 812. The patent-dependent biotech industry worked against the bill. The Patent and Trademark Office found that ''S. 812 would forfeit unnecessarily the core right of patent holders—the right to exclude others from practicing the inventions for the entire patent term. After years of research and development and significant investment, the patent right is extinguished for the mere failure to satisfy an administrative task or respond in a timely manner.''

Here is what the July 18, 2002 Statement of Administration Policy said about the Edwards-Collins-McCain-Schumer legislation:

> . . . the Administration opposes S. 812 in its current form because it will not provide lower drug prices. S. 812 would unnecessarily encourage litigation around the initial approval of new drugs and would complicate the process of filing and protecting patents on new drugs. The resulting higher costs and delays in making new drugs available will reduce access to new breakthrough drugs. Moreover, the new cause of action is not necessary to address patent process abuses. Clearly, the bill would benefit from consideration by the Senate's experts on Hatch-Waxman law on the Judiciary Committee, the proper committee of jurisdiction for this bill.

While S. 812 passed by a very wide margin, it was certainly not without its critics.

Comes now S. 1225. This bill emerged from the HELP Committee. Once again, it is entitled the Greater Access to Affordable Pharmaceuticals Act. Once again, it is cosponsored by Senators MCCAIN, SCHUMER, and KENNEDY.

Due in large part to the leadership of Chairman GREGG, there are significant changes in the bill compared with last year's legislation.

While I have significant concerns over certain aspects of S. 1225 as adopted in its amended form on June 19, 2003, I must acknowledge Chairman GREGG and Majority Leader FRIST for their roles in working with the cosponsors of last year's bill to make substantial improvements in the legislation.

Likewise, I commend Senators SCHUMER, MCCAIN and KENNEDY for abandoning many of the troublesome features of a bill that garnered 78 votes last Congress.

I can only believe that the factual presentation, analysis, and recommendations contained in the FTC report and subsequent public notice and comment process surrounding the recently-issued FDA final rule on patent listings and the application of the statutory 30-month stay both played a constructive role in helping to form the basis of the Gregg-Schumer legislation.

It is appropriate to recognize the efforts of the Bush administration for tackling the problem of multiple, successive 30-months stays through rulemaking. Secretary Thompson, Commissioner McClellan, and FDA Chief Counsel Dan Troy, should be saluted for their roles in so promptly completing a rulemaking regarding patent listing that generally embraced the one-and-only-one 30-month stay policy recommended in the FTC Report. Chairman Muris and the FTC staff deserve credit for a report that helped shape a more carefully targeted policy response.

There can be no doubt that this year's vehicle, S. 1225, is superior to S. 812. This new Gregg-Schumer bill, S. 1225, embraces exactly the type of one-and-only-one 30-month stay policy that I suggested to the HELP Committee last May, argued for on the floor last July, and was ultimately recommended by the FTC.

The Gregg-Schumer legislation, S. 1225 in the form adopted by the Senate, also addresses some problems that the FDA rule perhaps did not resolve satisfactorily. As FDA Chief Counsel Dan Troy stated at the June 17th Judiciary Committee hearing:

> We tried as best we could to cut down on all opportunities for gaming. We did not succeed in cutting down all opportunities for gaming, because nothing, no legislation is so good, no rule could be so good as to cut down all opportunities for gaming, because there are unforeseen circumstances and unintended consequences.

I think Mr. Troy is correct about the nature of the inherent limitations of regulatory and legislative fixes for complex problems where there are powerful incentives to game the system to gain financial advantage. We need to

keep this in mind as we analyze further the amendment the Senate adopted last week.

As I stated at the June 17th hearing, it was unfortunate that the PTO was unable to present a witness. Admittedly, the invitation was issued on short notice. I have asked PTO for its formal comments on the Gregg-Schumer amendment. I would also be interested in the PTOs comments on whatever language the House adopts. We would also be wise to hear from the Office of the United States Trade Representative if USTR finds that the legislation raises any concerns for international trade and intellectual property under the TRIPS provisions.

It is my understanding that FDA and FTC staff provided a great deal of what is known as ''technical assistance'' on the Gregg-Schumer amendment, a good deal of it between the markup on June 11th and the time the amendment was offered on June 19th. I am not aware whether PTO or USTR were consulted.

PTO and USTR should understand that this is a fast moving train, so they should be prepared to give us any comments they may have in short order. President Bush and the congressional leadership have made it plain that they expect the conference report on the Medicare bill to be completed as soon as possible.

One special area of concern to me as Chairman of the Judiciary Committee is that one provision of the amendment overwhelmingly adopted by the Senate raises significant issues with respect to civil justice policy, including a constitutional concern. Specifically, proposed section 271(e)(5) of title 35, would make the failure of a patentee to file a patent infringement action within a specified time frame sufficient to establish ''an actual controversy'' for the purpose of establishing subject matter jurisdiction for a declaratory judgement action by a generic drug firm challenging a patent.

Whether the Congress can, or should, by statute grant subject matter jurisdiction for a declaratory judgment based on the failure to bring a suit raises some interesting questions, particularly in light of manner in which the U.S. Courts of Appeals, including the Federal Circuit, have developed and applied the ''reasonable apprehension'' test. At our June 17th hearing, DOJ did not present the Judiciary Committee with its final opinion on the matter but Mr. Sheldon Bradshaw, Deputy Assistant Attorney General, Office of Legal Counsel, noted, ''that the actual case of controversy requirement is constitutionally compelled rather than statutorily required. And as a result, Congress can't simply create a case or controversy by statute but the plaintiffs must establish the constitutional requirement for bringing the case.'' The committee has received a spirited correspondence that takes differing views on the case or controversy provision of the Gregg-Schumer amendment.

I have requested the Department of Justice for its formal views on this language. At this point, I think it premature to embrace this language. It is my understanding that the bill that the House will take up does not contain the controversial case or controversy language. I stand prepared to work with the sponsors of the amendment, DOJ and others on this important issue.

Yet another improvement of S. 1225 over the bill adopted by the Senate last year relates to the manner in which the 180-day rule is addressed. In short, I am pleased that the policy embraced last year, the rolling exclusivity policy, was replaced in favor of a ''use it or lose it'' approach. I have long stated a preference for the consumer friendlier ''use it or lose it'' rule over the too open-ended rolling exclusivity.

The Waxman-Hatch law provides an incentive for generic firms to challenge patents. To encourage generic competitors to pursue patent challenges in a vigorous fashion, the 1984 law provided 180 days of marketing exclusivity in situations where a generic drug firm could show the pioneer's patents were invalidated or not infringed. For many years it was thought, as intended, that this valuable 180-day period of exclusive marketing would be granted to the first generic firm to successfully invalidate or invent around the pioneer's patents.

FDA regulations issued in 1994 required that the first generic applicant had to defend successfully against a patent claim made by a brand name company to receive the 180-day exclusivity. In a 1998 D.C. Circuit case, Mova v. Shalala, the court construed the plain language of the statute to strike down the successful defense requirement. As a result FDA now makes 180-day exclusivity decisions by applying the literal words of the statute. This results in a system that rewards first filers, not necessarily successful challengers.

The Gregg-Schumer amendment retains the preference for first filers. I believe that re-instating the successful defense requirement may prove preferable than intentionally sanctioning a first filer regime.

Frankly, I am uncertain of the policy justification for S. 1225's retention of granting the 180-day reward to the first filer rather than the first successful defendant. I believe that there is a lot to be said for giving the reward to the actual winner in court or the first not to be sued, not just the first one to enter the Parklawn Building with an application.

The amendment places a high premium on being a first filer. At our hearing last week, FTC Chairman Muris characterized the rush to be a first filer as ''the shantytown problem of people in line to file.'' FDA Chief Counsel Troy described that ''. . . right now, there are sometimes limousines, sometimes vans, sometimes cars, sometimes even tents in the Metro North parking lot that come days, weeks, and in some cases even months in advance of a particular date. Why we should reward someone because they camp out longer in the parking lot is a good question?''

I am concerned that the language that passed the Senate could allow some unintended and, in fact, counterproductive, results. Changes in current law with respect to the court decision and commercial marketing triggering mechanisms for the 180-day exclusivity provision demand careful attention and analysis. The amendment does not appear to adopt all the FTC recommendations in this area.

Other questions should be raised. What if, for example, the generic applicant that successfully challenges the validity of the patent is not also a first filer? Why should such a non-first filing but successful invalidity challenger not be granted the 180 days exclusivity? Stated another way, why should the first filer—or in Chairman Muris' ''shantytown'' situation, a whole group of first-day, exclusivity-sharing, first-filers, gain while the actual successful challenger waits out the 180-days? I am not sure that such an outcome is fair or even rational. Moreover, such a system may not result in the most efficient or aggressive pursuit of patent challenges.

One thing is for sure: You can expect a lot more first filers to appear at the door of the FDA building on the first day that successful drugs become eligible for patent challenges. As I pointed out at the Judiciary Committee hearing, some have already suggested that the first to file system might result in an increase in willful infringement cases. In fact, there was a decision last month by a Federal court in Chicago that ruled against a generic firm which filed a generic drug challenge before obtaining the opinion of outside counsel on either non-infringement or invalidity.

Another type of potential problem could arise, and frankly I am not certain how it can be avoided, if a non-first filing generic drug challenger wins a court decision on grounds of non-infringement. Unless I am wrong in my understanding of the Gregg-Schumer amendment, a generic challenger that prevailed on a non-infringement theory would have to wait for the 180-days granted the first filer, or a group of first-day, first-filers, to expire before the non-infringing firm could enter the market. Such an outcome only hurts consumers by needlessly delaying introduction of the non-infringing generic product for 180 days.

Unlike a determination of patent invalidity, a finding of non-infringement does not accrue to third parties. It is important to understand that there are two ways for a generic firm patent challenger to be awarded the 180-day exclusivity under the law. First, the generic challenger can show that the pioneer's patent is invalid. And second, the generic challenger can demonstrate

that its product will not infringe a pioneer's patent.

These are two very different theories. Al Engelberg, a highly successful and highly respected attorney engaged by generic drug firms to attack pioneer patents, has made the following observation about the difference between invalidity and non-infringement challenges:

In cases involving an assertion of non-infringement, an adjudication in favor of one challenger is of no immediate benefit to any other challenger and does not lead to multi-source competition. Each case involving non-infringement is decided on the specific facts related to that challenger's product and provides no direct benefit to any other challenger. In contrast, a judgment of patent invalidity or enforceability creates an estoppel against any subsequent attempt to enforce the patent against any party. The drafters of the 180-day exclusivity provision failed to consider this important distinction.

As one of the drafters of the 1984 law, I must accept a measure of responsibility for this problem. It is not clear, however, that S. 1225 has addressed this issue in a satisfactory fashion. The language adopted in the Gregg-Schumer amendment does not appear to solve the problem created by the 1998 Mova decision that effectively eliminated the successful defense requirement.

Frankly, I think we need further thought on how best to address the implications of the distinction between invalidity and non-infringement claims in the context of Hatch-Waxman patent challenges and 180-day exclusivity awards. Specifically, I question the appropriateness of continuing to group together patent invalidity and patent non-infringement challenges, particularly in light of the fact that the latter may in practice extend longer than the purported 180-day award. From what I know now, there are strong arguments to prefer the reinstatement of the successful defense requirement over the establishment of a new system based on first filing.

Let me close by once again commending Senators GREGG, SCHUMER, MCCAIN, and KENNEDY for all their hard work in reaching the compromise amendment that was so overwhelmingly adopted by the Senate. The Gregg-Schumer amendment represents significant improvement over the legislation passed by the Senate last year. I am pleased that the amendment adopts the one-and-only-one 30-month stay policy that I, and the FTC, advocated last year.

I am also pleased that the Senate has adopted Senator LEAHY's Drug Competition Act, which also addressed a major recommendation of the FTC. I have worked with Senator LEAHY to perfect and pass this measure.

As a co-author of the 1984 Drug Price Competition and Patent Term Restoration Act, I support efforts to bring affordable and innovative drugs to the American public. While I support the spirit and much of the letter of the Gregg-Schumer amendment, for the reasons I have set forth, I was unable to fully support this measure at this time.

Mr. BUNNING. Mr. President, during consideration of S. 1, an amendment was introduced by Senators SANTORUM and SCHUMER dealing with payments to the Medicare+Choice program. This amendment would have increased payments to the M+C plans over the next 2 years, to make sure they are still viable when the MedicareAdvantage program takes effect in 2006.

I realize the amendment was withdrawn because of the lack of funding in the Senate bill, but it is still an important issue I would like to lend my support to.

The Medicare+Choice program already provides a good prescription drug benefit to many seniors across the county, and gives these seniors another option to the Medicare fee-for-service program.

Unfortunately, many Medicare+Choice plans are pulling out of the program because their reimbursement levels are too low. This is leaving many seniors scrambling for a new Medicare+Choice plan or having to go back into fee-for-service Medicare which doesn't offer them the same types of benefits as their old M+C plan.

In fact, it seems like every year, more and more Medicare+Choice plans leave the market.

I am concerned if we do not provide these plans with enough funding over the next two years while the MedicareAdvantage program is being implemented, these M+C plans will continue to leave the program and more seniors will be left in the lurch.

This isn't fair to our seniors.

I had hoped we could provide some additional funding for the Medicare+Choice plans over the next 2 years so the plans currently in the program will remain and we might actually attract new plans to other areas that have not been served.

In Kentucky, we have a limited number of Medicare+Choice plans. In fact, only seniors in certain counties in Northern Kentucky and around Louisville have access to these plans. With higher payments to Medicare+Choice plans, we might actually get some more plans to come into our state and cover more counties.

We shouldn't give up on the Medicare+Choice plans, or the seniors enrolled in them. I hope this is an issue we can resolve during the conference with the House, and I commend Senators SANTORUM and SCHUMER for bringing this issue before the Senate.

Mr. LEAHY. Mr. President, I am pleased that late last night the Senate again supported lowering drug prices and maintaining a fair generic drug approval process by adding the Drug Competition Act of the Prescription Drug and Medicare Improvement Act of 2003, S. 1. Last November, the Drug Competition Act passed the Senate by unanimous consent. On Monday, Senator GRASSLEY and I, along with Senators CANTWELL, DURBIN, FEINGOLD, KOHL, and SCHUMER, offered our bill as an amendment to the larger Medicare bill. I hope that in this Congress it is actually enacted into law as part of the larger effort to improve the health care of millions of Americans. Prescription drug prices are rapidly increasing, and they are a source of considerable concern to many Americans, especially senior citizens and families. Generic drug prices can be as much as 80 percent lower than the comparable brand-name versions.

While the Drug Competition Act is small in terms of length, it is large in terms of impact. It will ensure that law enforcement agencies can take quick and decisive action against companies that are driven more by greed than by good sense. It gives the Federal Trade Commission and the Justice Department access to information about secret deals between drug companies that keep generic drugs off the market. This is practice that hurts American families, particularly senior citizens, by denying them access to low-cost generic drugs, and further inflating medical costs.

Last July, the Federal Trade Commission released to comprehensive report on barriers to the entry of generic drugs into the pharmaceutical marketplace. The FTC had two recommendations to improve the current situation and to close the loopholes in the law that allow drug manufacturers to manipulate the timing of generics' introduction to the market. One of those recommendations was simply to enact our bill, as the most effective solution to the problem of ''sweetheart'' deals between brand name and generic drug manufactures that keep generic drugs off the market, thus depriving consumers of the benefits of quality drugs at lower prices. Indeed, at a hearing just yesterday in the Judiciary Committee, Chairman Timothy Muris of the FTC praised the Drug Competition Act in his testimony and urged its passage. In short, this bill enjoys the unqualified endorsement of the current FTC, which follows on the support by the Clinton administration's FTC during the initial stages of our formulation of this bill. We can all have every confidence in the commonsense approach that our bill takes to ensuring that our law enforcement agencies have the information they need to take quick action, if necessary to protect consumers from drug companies that abuse the law.

Under current law, the first generic manufacturer that gets permission to sell a generic drug before the patent on the brand-name drug expires, enjoys protection from competition for 180 days—a head start on other generic companies. That was a good idea, but the unfortunate loophole exploited by a few is that secret deals can be made that allow the manufacturer of the generic drug to claim the 180-day grace period to block other generic drugs from entering the market, while at the same time, getting paid by the brand-

name manufacturer not to sell the generic drug.

Our legislation closes this loophole for those who want to cheat the public but keeps the system the same for companies engaged in true competition. I think it is important for Congress not to overreact and throw out the good with the bad. Most generic companies want to take advantage of this 180-day provision and deliver quality generic drugs at much lower cost for consumers. We should not eliminate the incentive for them. Instead, we should let the FTC and Justice look at every deal that could lead to abuse, so that only the deals that are consistent with the intent of that law will be allowed to stand. The Drug Competition Act accomplishes precisely that goal, and helps ensure effective and timely access to generic pharmaceuticals that can lower the cost of prescription drugs for seniors, for families, and for all of us.

The effects of this amendment will only benefit the effort to bring quality health care at lower costs to more of our citizens. The Drug Competition Act enjoyed the unqualified support of the Senate last year, and I am pleased that my colleagues have recognized that it fits well within the framework of the Prescription Drug and Medicare Improvement Act of 2003. It is a good complement to the larger bill and does nothing to disrupt the bill's balance. I sincerely hope that this commonsense legislation is a part of any final agreement with the House on the larger Medicare prescription drug bill.

(At the request of Mr. DASCHLE, the following statement was ordered to be printed in the RECORD.)

● Mr. KERRY. Mr. President, I wish to express my enthusiastic support for the amendment Senators SCHUMER and SANTORUM offered to increase funding for the Medicare+Choice Program in 2004 and 2005. This amendment addresses a critically important issue that has far-reaching implications affecting the health care benefits of millions of low-income and minority seniors. I am pleased to be a cosponsor of this amendment to ensure that this urgently needed funding increase is included in the Medicare bill.

I believe we must take bold action to address the fact that Congress has not provided adequate funding for the health care of Medicare beneficiaries who select HMOs and other private sector health plans. In many parts of Massachusetts, and in other parts of the country, funding for Medicare+Choice plans has been limited to annual increases of only 2 percent in most years since 1998. These increase are inadequate at a time when health care costs are rising by 8 to 10 percent annually. This level of inadequate funding is unfair to the 170,000 Medicare beneficiaries in Massachusetts who have selected private health plan options. I am a strong supporter of the wonderful health plans we have in Massachusetts—Harvard, Tufts, Blue Cross/Blue Shield, and Fallon Community Health Plan. We must step up to the plate to help these plans—nonprofit plans in my State—in their time of need.

The Schumer-Santorum-Kerry amendment takes important steps to address this problem. By providing funding now to stabilize existing private health plan options for Medicare beneficiaries, we can help ensure that the proposed Medicare Advantage Program will be successful in the future. Our amendment lays the groundwork for successful long-term efforts to provide beneficiaries with high-quality health care choices.

As the Senate continues to debate changes in Medicare, it is important for us to remember that, for more than 4.5 million Medicare beneficiaries across America, Medicare+Choice is an essential program that provides high-quality, comprehensive, affordable coverage that is not always available, or affordable under the Medicare fee-for-service program. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because they recognize the value they offer.

Seniors in Massachusetts have come to rely on the high-quality health care they receive through their Medicare+Choice plans. Prescription drugs coverage, disease management services, physician exams, vision benefits, and hearing aids are examples of the additional benefits that are routinely offered by their Medicare+Choice plans.

These additional benefits are valued by all seniors, but they are particularly important to low-income seniors who cannot afford other Medicare supplementary plans that might provide them such benefits but at a greater cost.

As the Medicare debate moves forward, it is important for Congress to remember that Medicare+Choice serves as a vital safety net for many of our Nation's most vulnerable seniors. For millions of beneficiaries who cannot afford to purchase a Medigap policy, Medicare+Choice is their only hope for obtaining comprehensive health coverage.

The Schumer-Santorum-Kerry amendment focuses on protecting this important option for seniors who have nowhere else to turn for the quality health coverage they need. I urge my colleagues to support the additional funding that is urgently needed to strengthen the Medicare+Choice Program for seniors. This should be among our highest priorities in this year's Medicare debate.●

Mr. CARPER. Mr. President, when I ran for the U.S. Senate, I promised Delawareans that I would work in a bipartisan fashion to provide a Medicare prescription drug benefit for our Nation's seniors. I pledged that I would seek consensus around what is right with competing Republican and Democratic plans. Along with my Democratic colleagues, I would support voluntary coverage that is available and affordable for all seniors. Along with my Republican colleagues, I would support choice and competition to constrain costs. And to the extent we found ourselves constrained by limited resources, I would seek to provide the greatest assistance to those with the greatest needs.

The bill before us today achieves some of that vision. It is bipartisan. It will provide a benefit available to all seniors on a voluntary basis. It will harness market forces to strengthen the integrity of the Medicare Program for the future. And it will provide comprehensive health security to our most vulnerable, low-income seniors.

Still, the bill we have before us today is not everything I would have hoped for. The overriding priority of the current majority here in Congress has been to make dramatic reductions in Federal revenues without corresponding reductions in Federal spending. As a result, there is insufficient money in the budget under which we are currently operating to provide the kind of comprehensive coverage that all seniors—not just low-income seniors—truly deserve. This is an unfortunate choice of priorities, I think, but it is the choice that this President and this Congress have made.

Unfortunately, the consequences of the majority's misguided priorities are evident in this legislation. When Medicare was created, the idea was to provide seniors with health coverage that was similar to the coverage available to most working Americans through their employers. This is what seniors expect when we say that we are providing them with a Medicare prescription drug benefit. However, the majority has only set aside for this bill about half of what it would take, according to the Congressional Budget Office, to provide seniors a benefit comparable to standard employer-provided coverage. Thus, there is a very noticeable gap in this bill's coverage, reflective of a substantial hole in our Nation's budget.

When seniors reach $4,500 in prescription drug costs, the coverage in this bill gives out. It does not kick back in until total spending reaches $5,800. It is widely acknowledged that this makes no sense. It makes no sense from an insurance perspective. It certainly is not reflective of the standard either in private employer-provided coverage or in the coverage provided to those of us who are fortunate enough to serve as Members of Congress. Nobody likes this gap in coverage. Nobody, so far as I can tell, defends it. However, because the root of problem is the majority's failure to set aside sufficient resources for this program, efforts to deal with the problem have only created new and potentially more serious difficulties.

For example, the authors of this legislation have attempted to narrow the coverage gap by not allowing employer contributions to count towards the calculation of seniors' out-of-pocket

spending in the gap. To see how this works, we need to understand how the coverage gap works. Once seniors reach $4,500 in total drug costs, they fall into the coverage gap. They then have to spend a certain amount of their own money—in the final bill reported out of the Finance Committee it is $1,300—before their coverage resumes, or they get out of the coverage gap.

The effect of not allowing seniors to count payments made by their retiree health plans toward this out-of-pocket requirement is to ensure that seniors will remain in the gap longer and fewer will get out of it. This allows the level of spending at which the gap ends to be set at a lower level than would otherwise be possible for the same budgetary cost. The problem with this, however, is that it also provides an unintended incentive for employers to drop or scale back their retiree drug coverage.

Thankfully, contributions from State prescription drug plans, like our Delaware Pharmacy Assistance Program, count toward the out-of-pocket requirement, which should encourage States to ''stay in the game.'' Employers, though, are effectively barred from wrapping their coverage around Medicare in the way that would be most beneficial for their retirees, which would be by filing Medicare's coverage gap.

In the course of our consideration of this legislation here on the floor of the Senate, I have urged my colleagues to address these shortcomings in the bill, even if that means reconsidering the majority's budget plan and the resource allocation for this program. I supported an amendment by Senator BOXER to eliminate the gap in coverage. And I cosponsored an amendment offered by Senator ROCKEFELLER to allow employer-provided coverage to wrap around the Medicare benefit and thus to eliminate the incentive for employers to drop coverage for their retirees.

The majority has made clear, however, that they are unwilling to reorder their priorities or to emplore the possibility of finding the necessary resources elsewhere in the budget to fix what they acknowledge are shortcomings in this legislation. Thus, the rest of us are left to choose between a prescription drug benefit that provides some, but not all, of the assistance that seniors deserve, or no prescription drug benefit at all.

Congress has been debating this issue for more than a decade. In many ways, it has been debating the issue since Medicare was first created back in 1965. I ran for the Senate in part because I was frustrated at the inability or unwillingness of the parties in Washington to come together to do what they could to solve problems and get things done. I am unwilling to walk away from the table this year with nothing for Delaware's seniors. They have waited too long and the need is too great.

In light of the budgetary priorities of the Republican majority, I am also very concerned about our future prospects. Should we let the present opportunity pass us by? I am concerned that if we do not act to get started with prescription drug coverage this year, even the limited resources that now remain may go out the door for other purposes—most likely another round of top-heavy, upper bracket tax cuts.

This is a first step. It is a downpayment. Just as I pledged when I ran for the Senate to work in a bipartisan fashion to get results, I pledge today to continue to work to build on these results. I continue to believe that we should provide our seniors with quality coverage without caps or gaps. I will work to ensure that filling the gap of coverage that exists in the present bill is given greater priority in future budgets than it was in this year's Republican budget. I also believe that it is a mistake to shun rather than welcome employer efforts to wrap around the new Medicare benefit, and I will work to rectify that mistake as we move toward implementation of this program over the next few years.

Mr. President, it is often said that politics is the art of the possible. The bounds of the possible are a bit narrower now than they need, thanks to our Republican friends. But, as the ranking member of the Budget Committee has said, this may be the best bill that could be written under the constraints of the Republican budget. For that reason, I commend the authors of this legislation—Chairman GRASSLEY and Senator BAUCUS, among others—for their work. I urge my colleagues to support this compromise as an important, if limited, first step toward addressing what clearly is a pressing priority, not just for our elderly population, but for our Nation as a whole.

Mr. JEFFORDS. Mr. President, as we debate the Prescription Drug and Medicare Improvement Plan of 2003, I would like to take a few minutes today to speak in support of the overall bill, but I would also like to highlight several provisions in the bill that are of particular importance to me and my State of Vermont.

Over the last several days, we have focused much of our discussion on the aspects of this bill related to prescription drugs and the Medicare Advantage Program. These are clearly among the most important provisions of this bill and these issues warrant the attention and debate they are receiving. I especially appreciate the close relationship this bill has to last year's tripartisan effort—which effectively is the parent of the current bill Last year, my friends—Senators GRASSLEY, SNOWE, HATCH, and BREAUX—and I set out to design a bill that provided a prescription drug benefit along with other improvements, what we called ''enhancements,'' to the basic operations of the Medicare Program. The tripartisan bill was good legislation—something all of its original cosponsors were very proud to work on together.

This year, I am pleased to say that the Grassley-Baucus bill is even better than our effort from last year, and I commend Chairman GRASSLEY and Ranking Member BAUCUS for their leadership and initiative in bringing it to the Senate floor.

One of the most important reasons that the Prescription Drug and Medicare Improvement Act is stronger than the tripartisan plan from last year is because it includes provisions that begin to resolve longstanding inequities in payments to rural doctors, hospitals, and other provisions. This problem can be stated simply. Rural health care providers are paid less than providers in more densely populated areas for the same exact services. Earlier this year, I joined with my colleagues, Senators HATCH, GRASSLEY, LINCOLN, and BINGAMAN, in introducing the legislation that addressed geographic inequities for physician services by changes to the physician reimbursement formulas.

As many of our colleagues are aware, Senator GRASSLEY fought to include these rural provisions in the recent tax bill that was signed by the President. And although I strongly disagreed with enacting further tax cuts, I was doubly disappointed to see the rural health provisions stripped out in the conference with the House. These unfair geographic differences in reimbursement rates have gone on far too long, and I am especially pleased to see reimbursement issues for rural providers getting the attention they deserve—including the commitment from the President to my friend from Iowa pledging his support for rural health relief as part of the effort we have underway. I am, therefore, very pleased to see that these provisions are included in the chairman's mark and are now part of this bill.

I am also glad that Chairman GRASSLEY and Ranking Member BAUCUS have worked with me to address another inequity in the system. Critical access hospitals provide care in the most remote regions of my State of Vermont and all other rural States. These hospitals are small, yet serve as critical resources to their communities. The managers have agreed to include a provision in their amendment that will make a technical correction to current law, allowing hospitals like the Mt. Ascutney Hospital in Windsor, VT, to expand access to psychiatric and rehabilitative services to the most vulnerable citizens in that community.

I would also like to speak today in support of a provision in this bill that establishes Medicare demonstration programs to improve health care quality. I heard my friend from Montana speak yesterday about quality and geographic disparities, and I know how committed he is to improving the quality of services delivered under Medicare. Earlier in this Congress, I was pleased that Senators FRIST, BEAUX, and GREGG joined me in introducing S. 1148, the Medicare Quality Improvement Act. I want to thank Chairman

GRASSLEY and Ranking Member BAUCUS for including this provision in this bill.

I became concerned about the issue of health care quality after reading the work of Dr. Jack Wennberg of Dartmouth, which has shown that higher levels of Medicare spending do not lead to better health outcomes. Let me repeat this finding. Higher levels of Medicine spending do not lead to better health outcomes. Instead, spending tends to vary by region—generally reflecting the availability of physicians and hospitals—rather than the health or needs of the population.

I have followed Dr. Wennberg's work for a very long time. One of his early studies looked at rates of surgical procedures at Vermont hospitals. He found that communities in Vermont that had many more medical procedures were not necessarily healthier. I saw how this result led Vermont health care providers to join with the business community in achieving high quality, supportable outcomes. I also saw how our State government used this effort to improve health care across our State. Today, I am happy to say that Vermonters enjoy some of the highest quality health care in the United States, at a cost that is among the lowest in the country.

As we prepare to vote for the bill before us, I think it is critically important for us to consider some of the lessons learned from Vermont. Some of my colleagues have expressed concern about the costs of the bill before us. Others have expressed concern that the bill does not go far enough. The quality demonstration program in this bill will give us some of the answers we need to these funding questions.

The need for these demonstrations is critical. RAND Health published a study today in the New England Journal of Medicine that describes the problems with overuse and underuse of needed medical care services in the United States. The RAND study will make it clear that every American is at risk—not only for failing to receive needed medical care, but also for receiving care that is not needed and may even be harmful. This is a problem that belongs to each and every one of us, and we must find ways to fix it.

The legislation before us closes a significant gap in the health benefit package available to our Nation's seniors. However, providing coverage for health care services is not enough. We must do a better job of ensuring that people are getting the care they need, and also that they need the care they get.

In closing, I would like to urge my colleagues from both sides of the aisle to support this bill as we move forward. This bill will establish a drug benefit that is universal, comprehensive, affordable, and sustainable. This bill restores necessary and long-needed fairness to our physicians and providers in rural areas. And, the bill will improve the quality of care offered under Medicare.

Mr. DORGAN. Mr. President, over the last 2 weeks the Senate has debated the most significant changes to the Medicare Program since it was created in 1965. Today, we passed this legislation by a 76 to 21 vote, and I would like to take a few minutes to explain why I supported this bill.

This bill will, for the first time, provide the option of modest prescription drug coverage for nearly 39 million Medicare beneficiaries, including about 103,000 beneficiaries in North Dakota. It is also intended to give Medicare beneficiaries more choices of health plans. And it takes significant steps towards equalizing the Medicare payments that rural health care providers receive, compared to their urban counterparts.

There is no question that, if Medicare were being created today, it would include prescription drug coverage. Prescription medicines are a vital part of modern medicine. Last year alone, pharmaceutical companies introduced 26 new prescription medicines into the marketplace. But these advancements in medicine mean little if Americans cannot afford to access them. That is especially true for senior citizens who have reached their declining income years.

For years now, Congress has been debating proposals to add a prescription drug benefit to Medicare. Unfortunately, however, in past years we have not been able to reach agreement on just how to do this. With each passing year, older Americans continue to struggle to pay for their medicine. In North Dakota, about 48,000 Medicare beneficiaries have no prescription drug coverage, and many more have limited drug coverage. I hear from North Dakota seniors regularly who tell me that they have to choose between taking the medicines their doctor prescribed for them and other necessities such as food and heat.

These older North Dakotans say that they want and need Medicare drug coverage, and they want and need it now. If Congress doesn't enact legislation this year, chances are that several more years will go by before there is another serious opportunity to consider this issue. In other words, we could pass the legislation before the Senate today or we could do nothing for yet another year. In my judgment, doing nothing is not an option.

The prescription drug benefit in this bill is not as helpful to seniors as I would like or as generous as I think Medicare beneficiaries deserve—but it is a start.

Frankly, I think our budget priorities have been wrong. If I had my way, Congress would have reduced the size of the tax cuts for the very wealthy and instead set aside more money for improving and modernizing Medicare. During the Senate's debate earlier this year on the budget, I offered an amendment to set aside a total of $620 billion over the next 10 years for a Medicare prescription drug benefit. This is the amount of funding I felt was needed to provide a more generous and reliable benefit. Unfortunately, the majority in the Senate rejected my amendment, so we are limited to a package of just $400 billion over 10 years. When you consider that Medicare beneficiaries are projected to spend $1.8 trillion on prescription drugs over the next 10 years, it is impossible to develop a robust benefit within the $400 billion budget constraint, in my judgment.

The benefit provided for in this legislation is better than that which President Bush proposed in several key respects. Most importantly, this bill will not force seniors to leave the traditional Medicare Program—and the doctors they depend on—in order to get the prescription drug coverage they also need. I could not support a bill that coerces seniors out of the traditional Medicare Program that virtually all of North Dakota's Medicare beneficiaries rely on.

In addition, this bill provides extra assistance above the basic drug benefit for those older or disabled beneficiaries who have low incomes or very high drug expenses. Medicare beneficiaries with incomes below about $14,400 for individuals and $19,400 for couples—about 40 percent of North Dakota's beneficiaries—would qualify for extra assistance. And those with the highest drug costs—totaling more than about $5,800—would qualify for the catastrophic drug coverage. About 7 percent of North Dakota Medicare beneficiaries would reach this threshold.

Despite these improvements over the President's proposal, there are other concerns that I worked to address during the Senate's debate. In some instances, we were able to make changes to address these concerns, and in other cases, those efforts were rejected. In those instances where concerns still exist, I intend to continue working to fix them in conference with the House of Representatives.

For instance, as I have already mentioned, I am concerned that this coverage is not as generous as it should be, and in fact, there are some holes in the coverage. Under this benefit, seniors will have to reach a $275 deductible before their Medicare drug coverage starts. In addition, seniors whose drug expenses reach $4,500 will have to pay 100 percent of their drug costs between $4,501 and $5,800. Then, when their drug spending reaches $5,800, the catastrophic drug coverage will kick in and Medicare will pay 90 percent of their drug expenses after that. This means that there could be periods—in some cases as much as 3 months—when Medicare beneficiaries will have paid a premium for drug coverage but will be getting no benefit.

That makes no sense to me. No other insurance plans that I am aware of include such gaps in coverage. I supported various amendments on the Senate floor to close these coverage gaps or at least ensure that seniors

don't have to pay premiums for the periods when they aren't receiving coverage. Regrettably, however, those efforts were rejected.

I am also concerned that rural Medicare beneficiaries may not receive a benefit that is as stable or as generous as other beneficiaries receive. This bill envisions that seniors will basically have two options for receiving drug coverage. First, this bill creates a new Medicare Advantage Program through which beneficiaries could choose to get their drug coverage, as well as the rest of their medical care, through an HMO or a PPO. Frankly, however, I am very skeptical that HMOs or PPOs will want to serve rural areas, and even if they do, I don't think most North Dakota beneficiaries will want to leave the traditional Medicare Program.

Those seniors who want to remain in the traditional Medicare Program will be able to do so and get their prescription drug coverage through private ''drug only'' insurance plans. Budget experts estimate that Medicare beneficiaries who sign up for these drug-only plans will pay an average monthly premium of about $35. However, this is only an estimate, and the actual premium that seniors pay could vary substantially from area to area. That is already the case in the current Medicare HMO program—for instance, a Medicare HMO with drug coverage currently charges $99 per month in Connecticut and only $16 a month in Florida. I am worried that it would be rural seniors who would pay the highest premiums, even though they paid the same Medicare payroll taxes as other beneficiaries.

To address this concern, I supported an amendment by Senator DASCHLE that would have limited the variation in premiums to only 10 percent above the national average, no matter where beneficiaries live. In other words, insurance companies could charge beneficiaries a lower premium but they couldn't charge them more than 10 percent above the national average. Unfortunately, however, Senator DASCHLE's amendment was rejected.

In areas where there are not at least two private drug-only plans offered to Medicare beneficiaries in any given year, Medicare would step in and ensure that there is a ''fallback'' plan available. This is a vital guarantee for beneficiaries in rural States like North Dakota where I believe it is unlikely that there will be two stable drug-only plans available. But even with this fallback plan, seniors could still be bounced back and forth between different plans, depending on how private plans move in and out of an area.

I supported an amendment that would have addressed this concern by allowing all Medicare beneficiaries to choose the fallback option, no matter how many private plans are available where they live. When that amendment failed, I cosponsored an amendment with Senator CONRAD that would at least allow seniors who have the fallback option to remain in that plan for 2 years, not just 1 year. That amendment was also rejected.

Even though this bill doesn't require Medicare beneficiaries to leave traditional Medicare, I know there are some concerns that Medicare beneficiaries will be getting their drug coverage through private plans. I, too, would strongly have preferred that all seniors be able to choose from a Medicare-administered benefit.

However, let me say this if I felt that by structuring the drug coverage the way it is in this bill, we were undermining the entire underlying Medicare Program, I would not support it. Medicare has been a wonderful success, and in our efforts to modernize it, we should exercise extreme caution not to undermine it. However, virtually all of the major Medicare prescription drug proposals would have used a private entity in some way to provide the drug benefit. Indeed, the traditional Medicare Program currently contracts with private insurance companies to pay the millions of Medicare claims that come in each year. Furthermore, the Congressional Budget Office estimates that only 1 to 2 percent more beneficiaries will choose the new Medicare Advantage option, so it seems clear that the vast majority of seniors will continue to rely on the traditional Medicare Program for the bulk of their medical care.

One area where we had some success in improving the bill during the Senate's debate is in the area of reducing drug costs. This bill relies largely on private insurance companies to negotiate lower drug prices. However, we have seen from prior experience that insurance companies have not been able to keep drug spending from increasing by nearly double digits every year 9.7 percent in 2002, 17 percent in 2001, 18.8 percent in 2000, and 16 percent in 1999.

To help put downward pressure on drug prices, I offered an amendment that was passed by the Senate by a 62-to-28 vote to allow for the reimportation of lower-priced, FDA-approved medicines from Canada. As many North Dakotans know first hand, the same FDA-approved prescription drug that costs $1 in the United States costs only 62 cents in Canada, even though it is the exact same drug, in the same bottle, made by the same manufacturer.

It is not my intention with this amendment to require Americans to go to Canada in order to get lower drug prices. Rather, by allowing U.S. licensed pharmacists and drug distributors to do the importing for them, Americans can stay at home, and by breaking the monopoly that the drug companies currently have on drug pricing in this country, we will force a repricing of drugs here in the United States.

I also supported an amendment that will help to make more affordable generic drugs more readily available. Generic drugs are safe, effective, and lower priced alternatives to heavily advertised brand-name prescription drugs. Unfortunately, however, some of the big brand-name drug companies use loopholes in the patent laws to keep generic drugs off the market for longer than intended. This amendment, which passed the Senate by a 94-to-1 vote, will close these loopholes and thereby speed consumers' access to generic medicines.

I am also pleased that this bill improves Medicare's coverage of preventive services, especially by including a provision that I authored to provide for a cholesterol screening benefit for Medicare beneficiaries. I have felt for a long time that Medicare needs to do a better job of preventing disease, rather than just paying to treat it. In the case of cholesterol screening in particular, high cholesterol is one of the major, changeable risk factors for heart attacks, stroke and other cardiovascular diseases. Yet when Americans turn 65 and enter the Medicare Program, their coverage for cholesterol screening stops unless they already have cardiovascular disease. That makes no sense, and I am glad the Senate has taken steps to provide this coverage.

Finally, I am very happy that this bill includes a range of provisions that will make Medicare reimbursement more fair and equitable for our rural hospitals, physicians, and other health care providers. It is simply not right that Medicare has historically reimbursed urban health care providers at a much higher rate than their urban counterparts. This inequity in Medicare reimbursement has very real consequences for hospitals and clinics in rural States like ours. They have to reduce services, have greater difficulty recruiting staff, are less able to make capital improvements, struggle to give their patients access to the latest innovations in medical care, and in same instances, they even have to close.

I have been fighting for a long time to correct this inequity. In fact, some of the provisions in this bill are similar to legislation that I introduced in the Senate earlier this year, and I am glad they have been included in this bill.

I know there will be some who feel that this bill should have been rejected by the Senate because it relies too heavily on private plans and others because it does not place enough emphasis on enrolling seniors in private plans. Others will feel that the Medicare benefit is not generous enough, and some feel its coverage is too liberal. I agree that this legislation isn't perfect—far from it, in fact. In the coming months and years, I will continue working to improve it. But it is a start in the right direction, and that is why I have supported it.

The House of Representatives is also expected to pass its version of Medicare legislation this week. The House and the Senate will now need to have a conference committee to work out the differences between the two bills. I

have some serious concerns about the House-passed bill. I hope these concerns and the concerns that I have with the Senate bill can be resolved in the final bill, so that we can send a bill to the President for his signature this year.

Mr. SARBANES. Mr. President, I rise today to speak on S. 1, the Prescription Drug and Medicare Improvement Act of 2003. I applaud my colleagues in working toward enactment of legislation to provide prescription drug coverage under Medicare. However, I am deeply concerned that the bill before us today would not ensure an affordable, guaranteed benefit that would cover seniors' outpatient prescription drug expenses.

Under this legislation, the Secretary of the Department of Health and Human Services would temporarily issue prescription drug discount cards for seniors until the drug benefit begins in 2006. At that time, all Medicare beneficiaries would receive a standard prescription drug benefit whether they remained in traditional fee-for-service or in a private plan. For a $275 deductible and an estimated $35 per month, 50 percent of a beneficiary's drug costs would be covered up to $4,500. A beneficiary would receive no coverage for drug costs between $4,501 and $5,800, though they are still responsible for paying the monthly premium during this coverage gap. Furthermore, any assistance provided by employer-sponsored plans or third parties on behalf of the beneficiary does not count toward the out-of-pocket costs. After drug expenses reach $5,801, the plan would cover 90% of drug expenses.

The bill creates a new Medicare Advantage program, which would replace Medicare+Choice, and create a new agency, the Center for Medicare Choices, CMC, with authority parallel to the existing Centers for Medicare and Medicaid Services. The CMC would administer the Medicare Advantage program and the prescription drug plans. The drug plans would be administered through private plans, but when no private plans exist, the government would provide a fallback plan for seniors in fee-for-service. However, if a new private plan decides to enter an area, beneficiaries would again be forced to receive their coverage through that plan.

If this sounds terribly confusing, it is. One hundred Senators and their staffs found it difficult to work through this bill and understand exactly how the benefit would work. Seniors who don't sign up as soon as they are eligible are subject to a penalty similar to the penalty imposed on those who delay enrollment in Part B. It is unfair to expect seniors and their families to work through this web to make an informed decision.

The complexity of this drug plan is only one of numerous flaws with this bill. S. 1 does not provide a national fixed premium. The bill sets out an estimate of a $35 monthly premium, but there is no guarantee for seniors that they will not have to pay much more than that estimate.

The bill has the serious potential to cause a number of retirees to lose existing employer-sponsored prescription drug coverage. CBO estimates that as many as 37 percent of Medicare beneficiaries would lose existing coverage. This is an unacceptable consequence of legislation that is supposed to make life easier for seniors. This serious deficiency is the number one concern of constituents who have called into my office about this bill.

The bill before us leaves a large gap in coverage and forces seniors to continue premium coverage during that gap period. Seniors may have to face months without any assistance, waiting to reach the limit where catastrophic coverage begins. The seniors who fall into this coverage gap are among the most ill, with severe chronic conditions and prescription needs. It is difficult to support legislation that would cease coverage for prescription drugs for seniors at the very time when it is needed most.

Finally, because this proposal relies on private plans to deliver the drug benefit, seniors could be forced to shift from plan-to-plan, year-to-year as they did when Medicare+Choice HMOs pulled out of the Medicare program a few years ago. In my own State of Maryland, insurance companies left the Medicare program, abandoning more than 100,000 seniors.

This legislation makes our Nation's seniors the subject of an experiment to which none of us should be willing to subject our parents and grandparents. We don't know what the benefit is under this bill. We don't know how much it will cost. We don't know how private plans will participate and make a profit. We don't know how many seniors would lose existing coverage. What we know is we are prepared to spend approximately $400 billion over 10 years to create an inadequate drug benefit, a new bureaucracy, and subsidies for private insurance companies.

With modest additional resources, we could have closed the coverage gaps in this bill. Amendments offered by my colleagues to provide stability for seniors, move up the start date of the drug benefit, eliminate beneficiary premiums during the coverage gap period, and improve a variety of shortcomings have been defeated. We have lost so many opportunities to make this bill something all Medicare beneficiaries can support. I am hopeful that in the future we can improve upon this and create a system that is easier for seniors to understand, more affordable, and more reliable than what is offered today.

I want to highlight one amendment that would have provided Medicare beneficiaries with a substantial, reliable and straight-forward prescription drug benefit. I cosponsored and voted for this amendment offered by my colleague from Illinois, Senator DURBIN. His alternative would have provided a Medicare-delivered drug benefit that allows the Secretary of HHS to employ negotiating strategies used by the VA and other government entities to bring down drug prices. Under Senator DURBIN's plan, seniors would have no deductible, pay only 30 percent of costs until reaching the catastrophic limit, and face no coverage gap. In addition, employer contributions would count toward out-of-pocket limits so there would be much less risk of employers dropping retiree coverage. This was the proposal we should be working from today, but unfortunately the Durbin alternative was defeated by a vote of 56 to 39.

Those opposed to providing a richer benefit argue we don't have the money. The selective amnesia of these so-called fiscal conservatives is baffling. Not too long ago, this body passed a tax cut that primarily benefited the wealthiest Americans. Where was their sense of fiscal responsibility then? As my colleagues Senators DURBIN and HARKIN noted yesterday, this is about priorities. I'm sure others have raised this very good point as well. We can risk greater budget deficits to give huge tax cuts to Americans who are already prospering, but we cannot provide the necessary resources for millions of Medicare beneficiaries to get an affordable, reliable drug benefit that they can understand?

I have long been a strong supporter of providing older Americans and disabled individuals who rely on Medicare an affordable, comprehensive, reliable and voluntary prescription drug benefit. However, I want to ensure we do so in a way that does not worsen the situation in which many seniors find themselves as they face rapidly rising drug costs. As we consider proposals to expand our Nation's major health entitlement programs, it is appropriate to follow a guiding principle in the practice of medicine—do no harm. Our seniors deserve a drug benefit that is a real improvement, not a complex experiment that may cause more trouble than it's worth. We must not enact a law intended to help that might eventually harm millions. The American people deserve better.

Mrs. BOXER. Mr. President, for over 35 years, Medicare has been a savior for our seniors citizens. It has helped pay their doctor bills, their hospital bills, and their home health bills.

But it has not paid for their prescription drug bills, and millions of seniors across the country have been waiting a long time for the day when prescription drug coverage is offered through Medicare. That day is getting closer.

I am supporting—and the Senate will soon pass—a Medicare prescription drug benefit.

Let me tell you why this is important. In California, four million people are enrolled in Medicare. Every day, far too many of them are forced into the difficult choice of paying for their prescriptions or putting food on the table.

I want to tell you a few of their stories.

I recently heard from a California woman who told me she struggles to survive on $950 a month income. She cannot, she says, afford all of her prescription drugs. She is, unfortunately, all too typical.

A constituent from San Marcos, CA told me that her annual costs for prescription drugs this year will top $10,000.

Another constituent from Indio, CA told me that she has made five trips to Mexico over the last several years to purchase her prescriptions. She drives all day long to Mexico in order to purchase affordable heart medication. She wanted me to remind my colleagues that ''thousands of seniors are forced to do this.''

A retired physician from Marina Del Rey told me that a pill he takes for his heart disease has gone up 600 percent from $15 per month to $85.

These seniors—all of our seniors—need and deserve to have Medicare help pay for their prescription drugs. We need to end this situation where seniors are cutting their pills in half or forgoing their medications altogether or skipping meals in order to pay for their prescription drugs. That is unacceptable.

Today, we are making a prescription drug benefit a part of Medicare. And that is why I am supporting this bill—because, at long last, it puts a Medicare prescription drug benefit on the books.

But, this bill is wanting. It has problems. And I have voted for amendment after amendment to fix those problems.

I offered an amendment to close the benefit shutdown. Under this bill, even when seniors have paid and continue to pay premiums, Medicare stops covering prescription drugs, forcing seniors to pay the entire cost. When that failed, I offered an amendment to ensure that seniors with cancer would never have their benefit stopped.

I supported an amendment by Senator STABENOW to ensure that all seniors could get prescription drug coverage from Medicare itself—the tried and proven system—rather than from a private insurance company.

I supported an amendment by Senator GRAHAM to stop charging seniors premiums when they are not getting any benefits.

I supported an amendment by Senator LAUTENBERG to start this benefit next year not 2 and a half years from now.

I supported an amendment by Senator DODD to encourage employers not to drop their retiree health coverage so seniors who have good coverage can keep it. And the Levin amendment, which I also supported, would have ensured that if employers did drop such coverage, Medicare would be there to provide prescription drugs.

I supported an amendment by Senator DORGAN to reduce the premiums that beneficiaries must pay each month. And I supported an amendment by Senator DASCHLE to limit the disparities in premiums so that seniors in different parts of the country are not paying different premiums for the same benefit.

These amendments would have made the Medicare drug benefit a better drug benefit for seniors. Unfortunately, none of them passed.

But we should not—and I will not—stop trying to make it the best benefit it can be.

The good news is that Medicare will soon, for the first time ever, cover prescription drugs. The better news will be when we fix the problems with this bill and improve the coverage for our seniors. I look forward to the day when enough of my colleagues will join me in that effort.

Finally, let me say that I hope the conference report on this bill—the final version of the bill before it goes to the President—does not come back to the Senate in a way that would provide even less help to seniors or in a way that would undermine the entire Medicare program.

Ms. MIKULSKI. Mr. President, senior citizens are facing a crisis—a crisis in affording health care and a crisis in affording prescription drugs.

I have been in communities all over Maryland. Listening to seniors who are desperate. Listening to their families in the diners—who want to help their parents, yet face stresses of their own. Listening to the employers in the boardrooms—who want to help their retirees, but can no longer afford to.

Here is what they tell me. They say: We need a prescription drug benefit in Medicare. We need a safety net for seniors and families. Congress must enact a Medicare prescription drug benefit, and must do it now.

I absolutely agree. It is time Congress made Medicare prescription drug coverage a national priority.

For so many years, Congress has talked about prescription drugs and Medicare. Talk, talk, talk. You can't talk yourself out of high cholesterol; you need Lipitor. You can't talk your way out of diabetes; you need insulin.

The problem with the Senate is—when all gets said and done—more gets said than gets done. Finally—the Congress is acting.

Here are my principles. These principles are the yardstick by which I measure any proposal.

The benefit must be for seniors, not for insurance companies. That means the cornerstone must be Medicare. This bill does that. It does not force seniors to give up the Medicare they love to get the drugs they need.

It must help the majority of Marylanders. I work for Marylanders. So I did the numbers—570,000 Marylanders are on Medicare. According to Johns Hopkins, 68 percent of these seniors would benefit from this legislation. That means 394,000 would benefit from this bill.

It must be voluntary. And the answer is, yes, this bill is voluntary. No one should be coerced or forced into a private program or forced to give up coverage they currently have.

It must be affordable. I am not so sure. I am concerned about the significant deductible—$275 a year and the hefty premiums—almost $400 a year. It also has a coverage gap. Once you spend $4,500 a year—you get no help until you spend $5,800. This will cost too much. That is why I supported the Durbin amendment, which would have provided a better benefit at less cost to seniors.

It must be accessible. It must be available to all seniors, regardless of where they live. This bill does that.

It must be meaningful. It must cover the kind of drugs your doctor says you need, not what an insurance executive thinks you should get. This bill does that by creating a medical necessity override. This means your doctor has the final say on which drugs you get, not an insurance company. I feel pretty good about that.

I tried to improve the bill. I voted for amendments to improve the bill. For example: For the Durbin substitute which would have created a stronger, more comprehensive benefit at a lower cost to seniors.

For an amendment to get rid of the coverage gap. This would guarantee that seniors would have continuous coverage for their prescription drug costs.

For an amendment to provide seniors with a guaranteed prescription plan that is under Medicare. This would allow seniors to stay in a prescription drug plan that is operated by Medicare and not have to move in and out of private plans and a Medicare fallback plan that is only available when the private plans leave the market.

For amendments to protect the benefits of retirees who already have drug coverage. These amendments would help employers to continue to be able to offer quality health care to their retirees.

For an amendment to implement the drug benefit next year—instead of waiting until 2006 to start these benefits.

I am sorry all these amendments failed on party line votes.

This legislation is a beginning. It is something we can build on. What it comes down to for me is—will it help the majority of seniors in Maryland? The answer is, yes; it will help over 394,000 people. For people who spend at least $1,110 a year on prescription drugs—it will help. For someone who is facing a catastrophic disease like cancer and has very high drug costs—it will help. So I will vote for this bill. It is not the bill I want. Yet we can't let the perfect be the enemy of the good. We can't do nothing—as seniors struggle to pay for the drugs they need.

But let me be very clear, this is as far as I will go. If this bill comes back from conference and it is a benefit for insurance companies—say goodbye to my vote. If it increases costs for seniors, say goodbye to my vote. If it cuts benefits, say goodbye to my vote.

So I will vote for this legislation tonight because I don't want to say goodbye to this opportunity to provide a Medicare prescription drug benefit for seniors.

Mr. HOLLINGS. Mr. President, I rise today in opposition to the Prescription Drug and Medicare Improvement Act of 2003.

The Senate has spent the last 2 weeks debating how to help our Nation's senior citizens afford their prescription drugs. The Kaiser Family Foundation estimates that average annual out-of-pocket drug spending for Medicare beneficiaries grew from $644 3 years ago to $999 this year and will reach $1,454 by the time this bill takes effect in 2006. As a result, 25 percent of seniors without drug coverage declined to fill a prescription and 27 percent of seniors without drug coverage skipped doses to make their prescriptions last longer. This is unacceptable. These citizens deserve affordable, comprehensive, and reliable drug coverage. Unfortunately, the legislation now before us fails to provide sufficient coverage.

From the outset this proposal will confuse seniors. Enrollees in private plans better not get too comfortable because their plans could be gone in 2 years if the HMOs find them unprofitable just like they have with Medicare+Choice in my state of South Carolina. The same goes for enrollees in fallback plans. They will be kicked out of their plan in as early as a year if enough private plans enter their area. This volatile system could force seniors to move in between three separate plans, with three separate formularies, in 3 years. This bill should create a sense of stability in the system and reduce the confusion over coverage. That is why I supported first the Stabenow amendment and then the Lincoln-Conrad amendment, which would have extended the availability of fallback plans to ensure that seniors will have access to stable drug coverage.

Senior citizens will need to hire an accountant just to comprehend the benefits available to them under this legislation. Once seniors select their Medicare drug plan, they will have to maneuver a maze of premiums, deductibles and copayments for benefits that contain huge gaps in coverage. On top of their premiums, which will vary from region to region and plan to plan, seniors will get no help for the first $275 of their drug costs, pay half of costs from $276 to $4,500, pay all the costs from $4,501 to at least $5,813, and then pay a tenth of costs above $5,288. With a breakeven point of $1,115, many healthier Medicare beneficiaries will opt not to participate. With a coverage gap of $1,302, many of the sickest patients will still have to continue paying premiums even though they may have to resort to rationing their care until they can spend their way out of the ''doughnut.''

Once again, the Senate defeated a number of amendments that I supported that would have brought much needed simplicity and fairness to the bill including the Boxer amendment, which would have closed the coverage gap for all seniors, and the Daschle amendment, which would have limited the regional variation among premiums to 110 percent of the national average. Finally, we chose to provide $13 billion in new subsidies to PPOs and HMOs instead of using that money to reduce premiums or fill in the coverage gap for cancer or Alzheimer's patients. All in all, the bill provides Medicare beneficiaries with a benefit valued at about $1,000 less than the drug coverage available to Federal employees.

This is a plan only Washington could dream up. It should come as no surprise that the authors of this convoluted mess and their friends in the White House have decided to wait until after the 2004 election before allowing Medicare beneficiaries to see what they are in for.

I should also note that this Nation is more than $6.6 trillion in debt. This bill is part of budget resolution and economic plan that will run up an average deficit of $600 billion a year for the next 10 years. Make no mistake about it, we will borrow every red cent to pay for this program. And what do we get in return? Massive subsidies for HMOs, spotty drug coverage for senior citizens, and a lack of attention to the factors driving the rapid increase of health care costs in this country. If we are going to borrow from future generations to pay for this benefit, we should get it right.

Now that we have disposed of all amendments and final passage appears imminent, I have concluded taxpayers and Medicare beneficiaries would be better served if we go back to the drawing board. We should come back with a proposal with affordable premiums and cost sharing requirements with no gaps in coverage that is administered in a manner that gives seniors the same sense of security they receive under the current Medicare program. I have heard many of my colleagues say this is an important first step and it is important that we get something on the books. Nonsense. Thirty months will pass before the first beneficiary receives coverage. That was enough time to draft and ratify the Constitution. It was enough time to complete the Manhattan Project. Thirty months should be more than enough time for us to create a real, meaningful prescription drug benefit for our senior citizens.

I hope this body will have the wisdom to vote no and do this right.

Mr. FEINGOLD. Mr. President, I will vote for passage of the Medicare prescription drug bill that has been debated over the past several weeks.

I do so, however, with great reservations about many of the provisions in the bill.

I am voting for this measure for two principal reasons.

First, I believe that we owe our seniors a Medicare prescription drug benefit. I believe such a benefit is long overdue for our Nation's seniors. For years we have promised them we would give them the crucial help they need with their skyrocketing prescription drug costs. And I believe that it is finally time to deliver on that promise.

It has taken Congress too many years to act on this pressing need. We have been debating for years about the best way to provide this benefit, and I am afraid that if we do not take the opportunity in front of us today, it will take us even longer to provide seniors the help they deserve. Our seniors cannot wait any longer.

The costs of prescription drugs are soaring, and the financial toll they take on our seniors means that too often seniors must choose between eating and taking the medication that will help them live productive, healthy lives. Our seniors should not have to make that choice. They contributed to the Medicare system over their lifetimes. That system, which is supposed to provide health care to all seniors, needs to be able to help them obtain the prescription drugs they need to preserve their health.

The second reason I am voting for this benefit is that it takes a big step in addressing what I see as one of the biggest flaws of the current Medicare system—the geographic inequities within the Medicare reimbursement system. We need to end Medicare's continued discrimination against Wisconsin's seniors. As I have previously discussed on this floor, Wisconsin seniors already receive the short end of the stick when it comes to Medicare. Wisconsinites pay the same payroll taxes to Medicare as all American workers do, but receive fewer benefits in return. Instead, Wisconsinites' Medicare dollars are used to subsidize higher reimbursements in other parts of the country.

Wisconsin Medicare beneficiaries receive on average $4,318 in Medicare benefits per year, the eighth lowest in the country. By contrast, beneficiaries in the State with the greatest per capita reimbursement receive $7,209. This distribution of Medicare dollars among the 50 States is grossly unfair to Wisconsin. I thank the leadership of the Finance Committee for including provisions to begin to address this inequity in this prescription drug bill. But I know that we still have more to do to reverse the Medicare discrimination against States like Wisconsin.

I am pleased that key provisions have been accepted that greatly improve this bill. The Senate adopted the Gregg-Schumer-McCain-Kennedy amendment, which I was proud to cosponsor and support, which will bring more competition to the prescription drug market by preventing pharmaceutical companies from blocking generic drugs from entering the market. This amendment is one of the only provisions that will help to bring cost savings to seniors.

By adopting Senator DORGAN's amendment relating to the reimportation of prescription drugs from Canada, the Senate will help seniors obtain affordable prescription drugs. This legislation helps both consumers who buy prescription drugs and businesses which sell them. I supported this provision, both in its earlier legislative form and in this amendment, because it is the right thing to do. Our seniors and other Americans in need of affordable prescription drugs deserve no less.

I also supported Senator ENZI's amendment, which passed overwhelmingly, that will make sure that community pharmacies, like the ones in my home State of Wisconsin, can still operate within this new prescription drug program. Smaller pharmacies will be protected from being shut out by larger pharmacies through this amendment, and that means helping seniors to access the prescription drugs they need in their own communities.

I also worked with Senator ALLARD on an amendment to provide regulatory relief for home health care providers that the Senate adopted. Our amendment enables home health care providers to spend more time with patients and less time on paperwork. This is particularly important at a time when some home health care providers are leaving the home health industry because of burdensome paperwork requirements.

And I am pleased that an amendment I offered to bring some clarity to the Medicare Program for our seniors was adopted. The Medicare Program is already full of bureaucratic red tape, often creating barriers for seniors looking for basic information about their health care options. This prescription drug benefit is the biggest expansion of the Medicare Program since its inception in 1965. We are adding an entire new part to the program, and we need to help guide our seniors through it.

My amendment is simple. It establishes a Medicare Beneficiary Advocate Office within the Department of Health and Human Services, with the sole function of providing clear information to all Medicare beneficiaries. The office will serve as a one-stop information source on all of Medicare for our seniors.

This new office will provide a toll-free phone number, a regularly updated website and regional publications that will give our seniors all of the information they need to make informed health care decisions.

That is the good news. But as I said earlier, I have many reservations about this bill. This is not the bill I would have proposed.

This bill does not go far enough to deliver on our promise to give seniors a meaningful prescription drug benefit. It fails to provide any assistance after a senior's prescription drug costs total $3,450, until they spend another $1,850 on prescription drugs, or $5,300 total. And it adds insult to injury by making beneficiaries continue to pay a premium even during the time they receive no benefit.

I am also troubled that this bill does not provide clear, uniform benefits and premiums for all seniors. Many aspects of the benefits provided in the bill remain uncertain, and will continue to remain uncertain after the plan goes into effect. Under this bill, the premiums are not defined. The premiums for the Medicare prescription drug plan will be dictated by the private insurers who will offer the plans. The only thing we know for sure is that the Congressional Budget Office estimates that the national average for premiums will be $35. However, those premiums may vary dramatically. Just look at Medicare HMO premiums. Medicare HMO premiums in Connecticut are $99, but in Florida they are only $16.

Who will offer the plans is also uncertain. There is no guarantee that plans will be offered in regions where there may not be enough profit. History again shows us that private companies do not always find rural and smaller urban areas profitable enough to move in. All too often, private companies that do move into less desirable Medicare markets end up deciding to leave the region, leaving Medicare beneficiaries scrambling to figure out where they will turn for coverage.

Furthermore, my understanding is that this plan only offers a guaranteed Medicare-administered plan, or ''fallback plan,'' if there are less than two private plans in a region. This means that, if only one private plan offers a prescription drug benefit in the region that includes Almena, WI, a Medicare beneficiary living in Almena may instead choose the Medicare-administered fallback plan. While on the fallback plan, my Almena constituent would become familiar with the medications that are included in their formulary and the cost of their premiums. If a second private plan subsequently decides to move into that region, my understanding is that my constituent will be dropped from the Medicare fallback plan, and forced to join one of the private plans even if those plans have higher premiums, or do not include their prescriptions in their formularies.

Further, my Almena constituent can be forced to leave the plan that he or she has come to know, if that plan leaves the region. This leads to instability and uncertainty for seniors.

Benefits are also uncertain under this proposal. Again, benefit packages will be determined by the private insurers who offer the plans. And we can assume, from experience with the Medicare+Choice Program, that the benefits will vary widely. I am concerned about what this may mean for States like my home State of Wisconsin, States that have had a difficult time attracting and keeping private Medicare plans. Some Medicare prescription drug plans may be able to offer more brand name drugs at a lower cost to beneficiaries, while others in less profitable areas may limit the amount of brand name drugs they can offer at affordable rates.

I fear that as with Medicare HMOs, Wisconsin seniors may be faced with little choice with Medicare prescription drug plans.

And I am concerned that the uncertainty in this bill regarding monthly premiums, the possible differences in benefits packages and the stability of private plans that will deliver these benefits may lead to more inequity for Wisconsin seniors.

I was disappointed that Senator DURBIN's amendment, the MediSAVE Act, was not adopted in the Senate. Senator DURBIN's amendment, which I strongly supported, would have fixed most of the errors that exist in this bill. The MediSAVE Act would have made this benefit one that would truly help all seniors with all of their prescription drug benefit. Senator DURBIN's proposal offered a meaningful, enhanced prescription drug benefit that would have covered all seniors regardless of whether their prescription drug costs are high, low, or somewhere in between.

The MediSAVE Act not only put forth cost controls so that taxpayers as well as seniors could save money, but it also would have given seniors certainty. Seniors would have known exactly what their premiums and benefits were and would have the certainty of knowing that a Medicare-administered prescription drug benefit would be available to them, no matter what private plans were offered to them. Most importantly, the MediSAVE Act provided the certainty that a senior would have assistance with their prescription drug costs year-round and would never be caught in the so-called ''donut hole'' of coverage that this bill provides.

I am voting for this bill because something, some help for our seniors with their pressing prescription drug costs, is better than nothing. I will support this legislation with the intention of working with my colleagues over the next 2 years to improve this bill and finally deliver on our promise to give seniors a meaningful prescription drug benefit under Medicare.

Mr. JEFFORDS. Mr. President, this bill is a landmark piece of legislation the most significant modernization of the Medicare Program since its inception in 1965. Its passage by the Senate is a major accomplishment on the path toward enacting a prescription drug benefit for our Nation's seniors. It is the result of years of bipartisan, I might even say tripartisan, effort and it puts in place many long-sought changes. It has many significant features for the citizens of my home State of Vermont. It provides a sustainable, universal, and comprehensive prescription drug benefit. It guarantees access to traditional Medicare for all beneficiaries. It allows Medicare beneficiaries to participate, if they choose, in new systems of care that better reflect today's dynamic health care environment. The bill recognizes the high cost of providing quality care in rural settings and closes the reimbursement

gap between rural providers and their urban counterparts. Finally, it contains a provision that will allow us to better understand how to provide quality health care—not care driven by using more and more resources, but instead one based on ensuring quality patient outcomes.

Over the past 2 weeks, I have applauded the work of my colleagues who have labored over this bill. Today, I have the pleasure of congratulating them on their success and thanking them for their efforts.

I have worked for more than 3 years with my good friends, Chairman GRASSLEY and Senators SNOWE, BREAUX, and HATCH. In many meetings over many months, we delved into the details of what came to be called the Tripartisan Bill. This has been one of the finest experiences of my many years in Congress. I am very proud to have been a part of that group and that our efforts led the way to our success today.

I especially want to salute the efforts of Senator BAUCUS and Senator KENNEDY without whose hard work and commitment to working through an agreement we would not have accomplished this remarkable victory, and they deserve our accolades.

A bill such as this is the result of great effort on the part of many different people who are not elected to this body, but upon whom we all rely. I would like to recognize the staff members who have worked so hard on this bill and deserve much of the credit for its successful passage.

On Senator GRASSLEY's staff: Ted Tottman, Linda Fishman, Colin Roskey, Mark Hayes, Jennifer Bell, and Leah Kegler, and on Senator BAUCUS' staff Jeff Forbes, Liz Fowler, Jon Blum, Pat Bousliman, Kate Kirschgraber, and Andrea Cohen deserve considerable recognition for their tireless efforts. Catherine Finley, Tom Geier, and Carolyn Holmes from my friend Senator SNOWE's staff; Patricia DeLoatche and Trecia Knight of Senator HATCH's office; and most especially Senator BREAUX's legislative director Sarah Walters deserve enormous credit for this bill. Finally, we would not be claiming a victory today if it were not for the contributions of Senator KENNEDY's staff, especially, David Nexon and Michael Meyers.

On my own staff, I particularly want to recognize the contributions of Paul Harrington during the last Congress, and most especially the work of Sean Donohue who took up that effort on the tripartisan bill and who has continued to see it through to today's success, with the recent assistance of Daniel Crimmins, our Robert Wood Johnson Health Policy Fellow. Each and all have worked tirelessly to gather the input, analyze the issues, and build a consensus toward achieving this final product.

Mr. LEVIN. Mr. President, I support making a prescription drug benefit available to seniors. Most Members of the Senate do. However, there are honest disagreements about how to get it done and whether the bill before us will strengthen or weaken Medicare.

My principles are simple. The benefit should be voluntary, guaranteed, universal, and affordable.

Perhaps my greatest concern with the bill before us is the effect its passage is likely to have on retirees who currently have prescription drug coverage provided by their former employers. Many retirees currently enjoy good prescription drug coverage from their former employer. However, the Congressional Budget Office has indicated that if we adopt the legislation before us approximately 37 percent of retirees who are currently receiving prescription drug coverage from their former employers will lose that coverage. Specifically, on June 12, the Director of the Congressional Budget Office, CBO, Mr. Douglas Holtz-Eakin, who previously served for 18 months as chief economist for President Bush's Council of Economic Advisers, testified at a Finance Committee markup that 37 percent of retirees would be dropped from their former employers coverage. At that same markup, the Administrator of HHS' Center of Medicare and Medicaid Services, CMS, Mr. Tom Scully, stated that for current retirees ''who have employer-sponsored insurance, our estimate is consistent with 37 percent having their coverage dropped.'' During the debate so far, amendments to strengthen incentives for employers to maintain their prescription drug coverage for their retirees have failed.

Also very troubling is what I call the yo-yo effect. To participate in the proposed plan, a senior in any service area where two or more private plans are offered, no matter what the premium, would only have the option of purchasing private insurance. The reason is that only if there are not two private plans offered in the region is the so-called Medicare fallback plan available. So let's assume that there are two plans offered in 2006 in a particular service area and a senior opts in. Assume further that in 2008, one of the two insurance companies pulls out of the service area and the so-called Medicare fallback plan is then available. So the senior opts for the Medicare fallback plan. However, if two private plans become available a later time, say 2009, the Medicare fallback plan is no longer available to the senior and she would then be required to again enroll in one of the private plans to retain coverage. This yo-yo effect could be repeated forcing seniors to deal again and again with different programs with different costs and different benefits and lots of paperwork. This is totally unacceptable. Seniors want stability and continuity in their Medicare Program. They want a program on which they can trust and rely.

In addition, the legislation we are considering has a large gap in the prescription drug coverage. Once a senior's total drug spending reaches $4,500 for the year, she will have to pay 100 percent of the cost of their prescriptions until her total drug spending reaches $5,800. This has come to be called the donut hole. This coverage gap will leave many seniors to pay the full cost of prescriptions at a time when they most need assistance. I know of no other insurance program that is so unfairly structured in that way. There is a gaping hole in coverage but no gap in the requirement to pay premiums. That obligation continues even during the period that benefits are halted.

The bill before the Senate also has an unspecified premium that could fluctuate from service area to service area as well as from year to year. Premium amounts are left up to the insurance companies. I believe there should be a cap on those premiums. The effort to adopt one failed.

Adding a prescription drug benefit to Medicare is one of the most important things Congress can do this or any other year. We spend more on prescription drugs than we do on hospital costs. Members of Congress have been promising for years that we would pass a Medicare prescription drug benefit for seniors. The only way to assure that the benefit will be available reliably and without complications to our seniors is to make it a guaranteed part of Medicare. The bill before us falls short of that. We should at least do no harm. When CBO estimated 37 percent of seniors currently receiving a prescription drug benefit from their former employer are going to lose the benefit because of this legislation, that is real harm.

I hope the major flaws of this bill are somehow corrected in conference so I can vote for a conference report. But I cannot vote for the version before us.

Ms. COLLINS. Mr. President, I was pleased to join my colleagues, Senators BOXER, COLEMAN, LANDRIEU, KOHL & MURRAY in offering an amendment to authorize a Medicare demonstration project on pancreatic islet cell transplantation to help advance this tremendously important research that holds the promise of a cure for more than 1 million Americans with Type 1 or juvenile diabetes.

As the founder and cochair of the Senate Diabetes Caucus, I have learned a great deal about this serious disease and the difficulties and heartbreak that it causes for so many Americans and their families as they await a cure. Earlier this week, I had the privilege of chairing a hearing featuring young delegates from the Juvenile Diabetes Research Foundation's Children's Congress who had traveled to Washington from every State in the country to tell Congress what it is like to have diabetes, just how serious it is, and how important it is that we find a cure.

Diabetes is a devastating, lifelong condition that affects people of every age, race, and nationality. It is the

leading cause of kidney failure, blindness in adults, and amputations not related to injury. Moreover, a study released by the American Diabetes Association earlier this year estimates that diabetes cost the Nation $132 billion last year and that health spending for people with diabetes is almost double what it would be if they did not have diabetes.

The burden of diabetes is particularly heavy for people with juvenile diabetes. Juvenile diabetes is the second most common chronic disease affecting children. Moreover, it is one that they never outgrow.

In individuals with juvenile diabetes, the body's immune system attacks the pancreas and destroys the islet cells that produce insulin. While the discovery of insulin was a landmark breakthrough in the treatment of people with diabetes, it is not a cure, and people with juvenile diabetes face the constant threat of developing life-threatening complications as well as a drastic reduction in their quality of life.

Thankfully, there is good news for people with diabetes. We have seen some tremendous breakthroughs in diabetes research in recent years, and I am convinced that diabetes is a disease that can be cured and will be cured.

I am encouraged by the development of the Edmonton Protocol, an experimental treatment developed at the University of Alberta involving the transplantation of insulin-producing pancreatic islet cells, which has been hailed as the most important advance in diabetes research since the discovery of insulin in 1921. Of the 257 patients who have been treated using variations of the Edmonton Protocol, all have seen a reversal of their life-disabling hypoglycemia, and 80 percent have maintained normal glucose levels without insulin shots for more than 1 year. Amazingly, many of the transplant recipients have even reported a reversal of some of their complications, such as improved vision and less pain from neuropathy.

Earlier this year, I joined with my colleague from Washington, Senator PATTY MURRAY, as well as my colleague and cochair of the Senate Diabetes Caucus, Senator JOHN BREAUX, in introducing the Pancreatic Islet Cell Transplantation Act of 2003, which will help to advance this significant research that holds the promise of a cure for the more than 1 million Americans with juvenile diabetes. The amendment we are introducing today is based on one of the provisions of that bill, which currently has 43 Senate cosponsors.

Diabetes is the most common cause of kidney failure, accounting for 40 percent of new cases, and a significant percentage of individuals with Type 1 diabetes will experience kidney failure and become Medicare-eligible before they are 65. Medicare currently covers both kidney transplants and simultaneous pancreas-kidney transplants for these individuals. To help Medicare decide whether it should cover pancreatic islet cell transplants, the amendment authorizes a 5-year demonstration project to test the efficacy of pancreatic islet cell transplantation for individuals with Type 1 diabetes who are eligible for Medicare because they have end-stage renal disease, ESRD.

The cost of this demonstration would not be high. The Health Strategies Consultancy LLC, a highly regarded independent health policy firm, estimates that the net Federal cost of the proposal would be about $6.2 million in 2004 and about $84 million over 10 years.

The cost of the demonstration project is low because the number of islet cell transplants that could be performed is limited. Islet cells are extracted from a donated pancreas, and the number of pancreas donors is extremely small when compared to the number of Medicare beneficiaries who could benefit from islet cell transplants. In 2002, there were 1,875 pancreas donations, but there were over 27,000 Medicare beneficiaries who have diabetes as the primary cause of their end-stage renal disease and who might potentially benefit from islet cell transplants.

The Health Strategies' cost estimate does not include the financial benefits that would accrue to Medicare for the reduced medical care costs that would occur for beneficiaries who receive islet cell transplants and, as a result, suffer fewer diabetes-related complications such as kidney failure, heart disease, blindness and amputation. Since diabetes currently accounts for one out of every four Medicare dollars, I believe that this amendment actually holds much promise for reducing Medicare spending in the future.

I understand this demonstration project has been included in the Medicare prescription drug legislation that is being considered by the House. I hope that the Senate demonstrates similar wisdom, and I urge all of my colleagues to support it.

Mr. KOHL. Mr. President, I rise to oppose S. 1, the Prescription Drug and Medicare Improvement Act. This bill is good for drug companies, insurance companies, and people who make TV ads for politicians—but it is not good for Wisconsin seniors.

I know that many of my colleagues will vote for this legislation and that it will pass the Senate. I know that many of my colleagues believe that this is a first step, if an imperfect one. I would like to agree with them. I would like to vote for a bipartisan compromise that delivers even a part of the drug benefit our seniors rightly demand. But this is not that bill. This is, instead, an empty promise of straightforward help for seniors struggling with crippling drug costs. When they figure out the details—when they see the costs—when they understand the limited benefit provided—when they work through the complicated formulas determining whether they ought to sign up—when they see the drug industry continue to raise their prices and reap record profits—they will—rightly, rightly—revolt.

I warn my colleagues, this is no bird in the hand—it is a vulture. And I cannot support it.

I cannot support a so-called benefit that asks many seniors, for months at a time, to pay premiums but receive absolutely no help with their drug costs. I cannot support a ''benefit'' that could cause up to 37 percent of retirees to lose their retiree health plans, leaving their former employees worse off than before we passed this bill. And I cannot support a ''benefit'' which is denied to low-income seniors eligible for both Medicaid and Medicare. A ''benefit'' of no benefit for seniors above average drug costs, for seniors with decent retiree plans, for seniors who are poor.

I also cannot support a plan that neither I nor anyone in this body can explain because its details depend on the vagaries of a private market that doesn't exist yet. Under this system, seniors could be forced into a different plan, pay a different premium, and have different medicines covered every year. Insurance companies can come in and out, leaving seniors lost and confused in a maze of paperwork and choices every year. And we know that for those insurance companies that do participate, premiums are sure to increase because there is no limitation on premiums in this law.

I also cannot support a plan that relies so heavily on the private sector to offer something they have never been willing to offer before. Drug-only plans are virtually nonexistent in today's marketplace. And the Medicare+Choice experiment, which also uses private insurance companies, has not worked in Wisconsin and in many other States. I cannot support a plan that has to pay insurance companies huge subsidies in order to offer a drug benefit. Not only is there no guarantee that they will participate; but precious Medicare dollars that could be used to pay directly for medicines are wasted, funneled to a drug industry that, last I checked, was not in need of a Federal handout. Even worse, this plan does not take advantage of the potential for controlling drug costs by utilizing the purchasing power of the millions of Medicare beneficiaries.

I do not want to point out that aside from the Medicare drug benefit, there are several provisions that I strongly in this bill. I am very pleased that the bill includes long-needed reforms that will finally take a strong step toward fixing the distorted Medicare system we have today—a system that penalizes Wisconsin health care providers by paying them less than other States, and a system that penalizes Wisconsin seniors by offering them fewer benefits than seniors in other States enjoy. Not only is this unfair for people in the Medicare system; it also increases costs for Wisconsin businesses, employees, and families, who pay higher costs

to make up the Medicare shortfall. The bill before us changes many of Medicare's payment systems, especially for rural areas, and goes a long way toward making Medicare fair for seniors and providers, no matter where they live.

I am also pleased that the bill includes provisions to make generic drugs more available to all Americans. It will close loopholes in our current law that keep generics off the market and keep drug prices too high for too long. The CBO estimates that this provision will save Americans $60 billion over 10 years.

I hope, but don't expect, that these two important provisions will survive the upcoming conference with the House of Representatives. And while I continue to hope that the conference will come back with a better Medicare drug benefit, I regret that it is unlikely to be the case. The House bill is in many ways even worse than the Senate bill before us.

Mr. President, I regret that none of the amendments that I supported during this debate prevailed. These amendments would have greatly improved this bill and provided a real prescription drug benefit to seniors—a benefit we could all have been proud of. Instead, this bill is an empty promise to seniors and the disabled on Medicare. This is not the kind of plan they have been asking for or have a right to expect. We could and should have done better. But at minimum, we could and should be able to hold our work here to the standard set in the Hippocratic Oath: do no harm. And we have failed.

I yield the floor.

Ms. COLLINS. Mr. President, I want to thank the chairman of the Finance Committee for including provisions in S. 1 that will provide a measure of relief to rural health care providers, and in particular to home health agencies serving patients in rural areas. I am concerned, however, that the underlying bill does not go quite far enough and have filed an amendment with Senator BOND to increase the rural add-on payment for home health agencies to 10 percent. This was the amount of the payment prior to its expiration on April 1, and I believe it is the amount that is necessary to ensure that Medicare patients in rural areas continue to have access to the home health services that they need.

Home health has become an increasingly important part of our health care system. The kinds of highly skilled—and often technically complex—services that our Nation's home health agencies provide have enabled millions of our most frail and vulnerable older persons to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes.

Surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly because of the extra travel time required to cover long distances between patients, higher transportation expenses, and other factors. Because of the longer travel times, rural caregivers are unable to make as many visits in a day as their urban counterparts. Saundra Scott-Adams, the executive director of the Visiting Nurses of Aroostook in Aroostook County, ME, where I am from, tells me her agency covers 6,600 square miles with a population of only 72,000. Her costs are understandably much higher than the average agency due to the long distances her staff must drive to see clients. And, her staff is not able to see as many patients.

Agencies in rural areas are also frequently smaller than their urban counterparts, which means that their relative costs are higher due to smaller scale operations. Smaller agencies with fewer patients and fewer visits mean that fixed costs, particularly those associated with meeting regulatory requirements, are spread over a smaller number of patients and visits, increasing overall per-patient and per-visit costs.

Moreover, in many rural areas, home health agencies are the primary caregivers for homebound beneficiaries with limited access to transportation. These rural patients often require more time and care than their urban counterparts, and are understandably more expensive for agencies to serve. If the rural add-on payment is not reinstated, agencies may be forced to make decisions not to accept rural patients with greater care needs, and access will suffer further.

The loss of the rural add-on has already caused many agencies to reduce their service areas. Some are eliminating services altogether in remote areas. There are some counties in Montana, for example, that have no home health services. And agencies in my home State of Maine have had to eliminate delivery of services to some of our outlying islands.

If the 10 percent rural add-on payment is not restored, it will only put more pressure on rural home health agencies that are already operating on very narrow margins and could force more of these agencies to close. Many home health agencies operating in rural areas are the only home health providers in a vast geographic area. If any of these agencies are forced to close, the Medicare patients in that region will lose complete access to home care.

There is strong support in the Senate for restoring the rural add-on. Earlier this month, 55 Senators joined me in sending a letter to the chair and ranking member of the senate Finance Committee urging that they extend the 10 per cent rural add-on for home health agencies, and I ask unanimous consent that this letter be printed in the RECORD.

The chairman of the Finance Committee and his staff have been working with us to try to accommodate my amendment, and I am very appreciative of their efforts. I am hopeful that we will be able to work this out so that we will be able to ensure that Medicare patients in rural areas continue to have access to the home health services that they need.

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

U.S. SENATE,
Washington, DC, June 5, 2003.

Hon. CHARLES E. GRASSLEY, *Chairman,*
Hon. MAX BAUCUS, *Ranking Member,*
Senate Committee on Finance, Dirksen Senate Office Building, Washington, DC.

DEAR SENATORS GRASSLEY AND BAUCUS: Home health has become an increasingly important part of our health care system. The kinds of highly skilled and often technically complex services that our nation's home health agencies provide have enabled millions of our most frail and vulnerable older persons to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes.

By the late 1990s, home health was the fastest growing component of Medicare spending. The rapid growth in home health spending understandably prompted the Congress and the Administration—as part of the Balanced Budget Act of 1997—to initiate changes that were intended to slow this growth in spending and make the program more cost-effective and efficient. These measures however, produced cuts in home health spending far beyond what Congress intended. Home health spending dropped to $10 billion in FY 2002, nearly half the 1997 amount, and it is clear that the savings goals set for home health in the Balanced Budget Act have not only been met, but far surpassed.

According to the Congressional Budget Office (CBO), the post-Balanced Budget Act reductions in home health spending totaled more than $72 billion between fiscal years 1998 and 2002. This is over four times the $16 billion that the CBO originally estimated for that time period and is a clear indication that the Medicare home health cutbacks have been far deeper than Congress intended.

As a consequence of these cutbacks, over 3,400 home health agencies nationwide have either closed or stopped serving Medicare beneficiaries. Moreover, the number of Medicare patients receiving home health care nationwide has dropped by 1.3 million—more than one-third. Which points to the central and most critical issue—cuts of this magnitude simply cannot be sustained without ultimately affecting patient care.

On October 1, 2002, home health agencies received an additional across-the-board cut in Medicare home health payments, and the Centers for Medicare & Medicaid Services has dramatically reduced projections for home health spending under the Medicare program over the next ten years. We are concerned that any further cuts in payments for home health services simply cannot be sustained without affecting patient care, particularly for those Medicare beneficiaries with complex care requirements.

As you begin consideration of a Medicare modernization package, we urge that you avoid any further cuts in payments for home health services and preserve the full market basket update for payments for home health services for 2004. In addition, we urge that you extend the 10 percent add-on payment for home health services in rural areas that expired on April 1, 2003. Surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly because of the extra travel time required to cover long distances between patients, higher transportation expenses, and

other factors. Extension of this add-on payment will therefore help to ensure that Medicare patients in rural areas continue to have access to the home health services they need.

Thank you for your consideration, and we look forward to working with you to ensure that elderly and disabled Americans continue to have access to quality home health services.

Sincerely,

Susan M. Collins; Christopher S. Bond; Wayne Allard; Gordon Smith; Robert F. Bennett; Richard Lugar; Jack Reed; Russell D. Feingold; Patty Murray; John W. Warner; James Talent; Carl Levin.

Charles Schumer; Chuck Hagel; Barbara Mikulski; Jon Corzine; Tim Johnson; Patrick Leahy; Herb Kohl; Mary Landrieu; Evan Bayh; Dianne Feinstein; Hillary Rodham Clinton; Maria Cantwell; Frank Lautenberg; Ron Wyden; John Kerry; Ben Nelson; Debbie Stabenow; Mark Dayton; Ben Nighthorse Campbell; Mike DeWine.

Arlen Specter; George Voinovich; James Jeffords; Bill Nelson; Saxby Chambliss; Conrad Burns; Christopher Dodd; Joseph Lieberman; Blanche L. Lincoln; Larry Craig; Paul Sarbanes; Lincoln Chafee; Mike Crapo; Richard Durbin; Barbara Boxer.

Tom Harkin; Pat Roberts; Jim Bunning; Ted Kennedy; Sam Brownback; Byron Dorgan; Thad Cochran; and Richard Shelby.

Mr. DODD. Mr. President, I rise today to speak in support of S. 1, the Prescription Drug and Medicare Improvement Act of 2003. However, I do so with great trepidation. While I intend to vote for the bill that is presently before the Senate, I believe that drastic changes are still necessary to make the benefit created by this legislation one that meets the needs of our senior citizens.

I am also deeply concerned that Members on the other side of the aisle—as well as those in the House of Representatives, and the administration—will attempt to move this bill in a destructive direction during conference. Let me reiterate what I said in an earlier statement on this issue: we must not approve any Medicare reform measure that would force seniors to join private plans in order to receive a more generous prescription drug benefit. Such a measure would signal an end to the Medicare Program as we know it and should be rejected out of hand. I urge my colleagues to protect the Medicare that our seniors have come to rely on, and I urge the President not to sign any bill that privatizes Medicare. If such changes are made, I will not hesitate to oppose the conference report.

Given these concerns, it is reasonable to ask why I am supporting this bill. The answer is quite simple—seniors in my home State of Connecticut and across the country have been waiting far too long for a prescription drug benefit under Medicare. And it is time that we in Congress heard them.

Over the past month I had the opportunity to convene a series of forums on senior health care in Connecticut in an attempt to frame the scope of this debate. At these forums I heard from my constituents on many matters regarding their health care. But the present lack of coverage for prescription drugs under the Medicare program was by far the issue raised most often.

At these forums I heard from seniors who literally could not afford to fill prescriptions called for by their doctors. I heard from elderly Medicare beneficiaries forced to choose between purchasing groceries or filling their prescriptions. I heard from seniors who were forced to skip dosages of their medicines in an attempt to stretch their limited supplies of needed medicines. I heard from Medicare beneficiaries requiring more than 10 prescribed medicines a day unable to afford even half of these prescriptions. Clearly, what I heard from hundreds of Connecticut's more than 500,000 Medicare beneficiaries is their grave concern over the present lack of a prescription drug benefit under the Medicare Program.

I believe that the legislation about to be approved by this body offers an answer to those concerns. It is not the most complete answer, but it is a start—based on which we can improve in the future. It is a start because it will make so many seniors better off than they are today. And that should be our ultimate goal as legislators—to make people's lives better. Often this must be done incrementally, in steps. This bill is a positive first step.

What do I mean when I say that it will make people better off? In Connecticut, one-third of all Medicare beneficiaries have incomes below 160 percent of poverty. For many of these seniors, drug costs can be crippling. They are forced to choose between putting food on the table, and buying the medicines that they need to live healthy lives. With the passage of this bill, these seniors will no longer have to make this choice. The new Medicare prescription drug benefit will cover most, if not all, of their drug costs. I congratulate Senator GRASSLEY and Senator BAUCUS, and other members of the Senate Finance Committee for including in this bill such a generous benefit for those low-income seniors.

This legislation is not as clear cut for those seniors who have incomes above 160 percent of poverty. However, I believe that the majority will be helped by passage of this bill. The break even for this benefit—the point where an individual is better off with the benefit rather than just paying for all prescription drugs our of their own pocket—is about $1,100 in total annual drug costs. The average Medicare beneficiary spends approximately $2,300 on prescription medicines today. That number will undoubtedly be higher when this new benefit goes into effect in 2006. With the benefit created by this bill, that average beneficiary will realize nearly $600 in savings. The savings will be even greater for the 11 percent of beneficiaries who spend more than $5,000 per year on prescription drugs. These are the seniors facing the most sever health problems, and most in need of financial assistance. That is what this bill provides—even if it is not to the extent that many of us would have liked.

I am voting for this bill because so many seniors in Connecticut and throughout the country stand to benefit. However, no bill is perfect and S. 1 clearly still leaves much room for improvement even as it moves toward final Senate passage. I am particularly disheartened that, despite numerous attempts over the past 2 weeks, we have failed to address concerns over the present bill's lack of adequate provisions to ensure that those companies presently providing their retirees with prescription drug coverage receive adequate Federal support for their laudable efforts. While the creation of a prescription drug benefit under the Medicare program is laudable, it should not come at the price of displacing the employer-based benefits that so many seniors have come to rely on.

Additionally, I remain concerned that the gap in coverage in the present bill, the so-called donut hole, will leave many Medicare beneficiaries facing high prescription drug costs with no assistance at the very time when it is most needed. Over the past 2 weeks, I have both offered and supported amendments designed to provide assistance to those with prescription drug costs within the hole, especially those with lower incomes who can least afford any gap in coverage, that have failed to win support by the Senate. Failure to close this gap, in my view, constitutes a glaring failure, one that I hope can be reversed as this bill moves into conference.

I also am concerned that S. 1 fails to adequately protect Medicare beneficiaries form the very understandable confusion and uncertainty that may surround them just as they begin to navigate the intricacies of a brand-new program. Specifically, if enacted the underlying bill will require Medicare beneficiaries choosing a prescription drug plan to stay with that plan for a minimum of 1 year. With the enactment of such broad and weeping changes to the Medicare program, I am fearful that many Medicare beneficiaries will face great uncertainty trying to find the best plan to meet their particular needs. For this reason, I offered an amendment to S. 1 that would have simply granted Medicare beneficiaries navigating this new benefit for the very first time the ability to switch plans as they seek to determine which plan fits their particular health care needs in the first 2 years of the bill's benefit. Unfortunately, this amendment was not agreed to and I remain concerned that without its protections, senior Medicare beneficiaries will be unfairly locked into plans that do not meet their needs.

Mr. President, I am pleased that S. 1 represents a significant departure from

previous plans supported by the administration that would have required Medicare beneficiaries to leave the traditional fee-for-service Medicare Program in order to receive coverage for their prescribed medicines. Such a move would be unconscionable as 89 percent of all Medicare beneficiaries today are in the traditional program. To force these beneficiaries to leave their present system of coverage, and most likely the doctor that they have come to know and trust, would not only create great disruption, it would also for the first time since the program's inception create a tiered benefit system under Medicare that would more greatly reward those who choose to join a private preferred provider organization, PPO, or health maintenance organization, HMO.

And while I am pleased that the bill before us soundly rejects a tiered benefit system, I am deeply concerned that the plan presently taking shape in the House of Representatives appears to rely on such a flawed plan. As I said earlier, such a measure should be soundly rejected.

So it is with great caution that we come to the final moments of debate on this important issue. Medicare's nearly 41 million beneficiaries clearly need assistance in affording their needed medicines. The result of our efforts over the past 2 weeks, and more important, the result of the coming conference committee on this legislation will greatly determine to what extent we assist our Nation's Medicare beneficiaries to afford their needed medicines.

Clearly, a great opportunity is presently before us. As the underlying bill moves to conference committee. I look forward to working with my colleagues to ensure that we seize this opportunity by strengthening the underlying bill. With passage of the bill presently before us, we now face a choice. We can insist on the good start that we have made here with passage of S. 1, and work to strengthen its provisions. Or, conversely, we can accede to the House legislation that in my view unfairly jeopardizes the traditional Medicare Program by tilting the system in favor of risky privatization schemes and against seniors.

I ask my colleagues to join with me in working to ensure that any Medicare prescription drug legislation passed by this Congress is at least as strong as the bill we are about to vote on. A tilt toward the House-drafted language would signify not a strengthening of Medicare, but rather a weakening of this vital program's foundation and must be avoided at all costs.

Nearly 38 years ago on July 9, 1965, this body passed the legislation creating the Federal Medicare Program sending it to a conference committee with the House. On that day, President Lyndon Baines Johnson remarked, ''This is a great day for older Americans. And it is a great day for America. For we have proved, once again, that the vitality of our democracy can shape the oldest of our values to the needs and obligations of today.'' Nearly four decades later, we are on the cusp of a similar challenge. Let us move Medicare toward the future without threatening its proven ability to provide for the health and well being of this Nation's senior citizens.

Mr. COLEMAN. Mr. President, I am proud to mark this extraordinary day by coming to the floor of the Senate to celebrate the imminent passage of a prescription drug benefit for Medicare. This is a triumph not for a party or a President, but for America's seniors and their families. This is an incredibly hopeful day for all Americans who long for a national government that can get things done for people.

Thirty-eight years ago Congress voted to create a health care program that would be the primary source of health insurance for this Nation's seniors. Most people would agree that this program has served us well for almost four decades. However, the practice of medicine has changed. Drug therapies, medical devices, and human genome research all hold great hope for breaking through physical limitations that hinder many seniors' ability to enjoy the later years of life.

The question we now ask is what level of care are we going to provide our seniors and is the current system equipped to provide the type of care our seniors need and deserve.

The benefits provided under Medicare, considered generous at its inception in 1965, pale in comparison to those enjoyed by Federal employees and most workers in the private sector today. A recent report submitted by the Joint Economic Committee found that Medicare has the least generous benefit package among leading forms of insurance. Medicare covers 56 percent of total health care expenses, while typical employment-based health insurance covers 70 percent.

Seniors need prescription drug coverage. Seniors need better access to preventative care and disease management. Seniors need more choices in their health care options than they have today. Without updating, it may take years to add this kind of care to the current program—after all, it has taken over 30 years to add a prescription drug benefit.

The Prescription Drug and Medicare Improvement bill is a step toward meeting the needs of this Nation's seniors.

This bill provides a solid drug benefit that will provide assistance to every senior struggling to pay for prescription drugs as well as the security of knowing they are covered for unforeseen drug expenses.

Under this plan, the average senior's annual drug costs will be reduced by 53 percent each year. That amounts to $1,677 each year back in the pocket of our seniors. And seniors with the greatest needs will receive additional assistance through increased cost-sharing, and reduced or waived monthly premiums and deductible.

Equally important, this plan provides seniors with the security of knowing that they are covered in the event something happens and they find themselves facing exorbitant drug costs. At $3,700 in out of pocket drug costs, stop-loss coverage kicks in and the senior is only responsible for 10 percent of costs beyond this amount.

This bill is also about expanding options for this generation and future generations of seniors. The incremental improvements to the Medicare program have largely been the result of legislative action over the last 40 years. The legislative process, however, is not a quick process, and it is simply not possible to keep the program current in the first parcel environment we currently live.

The Medicare Advantage program included in this bill offers seniors the choice of receiving their health care benefits in a Preferred Provider Organization, PPO, the same type of health plan enjoyed by many families.

Under this health care option—not mandate—seniors will have increased access to the latest advances in care such as desire management and better preventive screenings. Additionally, seniors who chose this option will also have a lower deductible for inpatient and hospital care than those in traditional Medicare.

This bill lays the foundation for a Medicare program that is better able to respond to an evolving health care system by harnessing the efficiencies of the health care market, while preserving traditional Medicare for those seniors who are satisfied with their current coverage.

This bill is about expanding options for seniors so our parents and grandparents have access to the type of care best suited for them.

Is this bill everything everyone wants? Of course not. Are there decisions still to be made as it is implemented and we see how it actually works in the marketplace? Certainly. But this bill says we are not going to let the lack of perfection stop us from doing real good for people as soon and as effectively as we practically can.

I would be remiss if I didn't express my appreciation to Senators GRASSLEY and BAUCUS for their leadership in including many provisions in this bill to strengthen rural health care.

The availability of health care in rural areas in Minnesota is absolutely critical to the stability and viability of many communities.

The provisions in this bill to improve payments to hospitals in rural areas and reduce the geographic disparity in physician payments are critical to ensuring that these hospitals that threat not only seniors, but entire communities continued to receive care.

I am pleased that we did not allow perfect to be the enemy of good as we considered this package.

This is a substantial and dependable benefit for America's seniors. Again,

it's not everything everyone wants. There are still decisions to be made as it is implemented and we monitor how it works in the marketplace. But today we are delivering on a promise to provide quality care to our seniors.

I am hopeful that with bipartisan support this landmark legislation will pass the Senate and the House of Representatives by the July 4th holiday. When it does, there may not be any fireworks and parades but millions of seniors will be able to declare their independence from worrying about getting the prescription drugs they need to live a quality life.

Mr. BIDEN. Mr. President, after many years of preparation and deliberation, and following weeks of debate and discussion on the floor this year and last, we in the Senate are about to vote on a bill providing some prescription drug benefits for Medicare beneficiaries that is widely expected to pass.

Seniors have been demanding prescription drug coverage for many years now. They need it and they deserve it, and I believe what we should be passing here today is a bill that will bring the American people the type of prescription drug benefit they have been seeking—one that is easy to understand and use, one that covers a substantial portion of all their costs, and one that is affordable.

But to the many Medicare beneficiaries who will read the details of this bill and say, ''there isn't much in here for me and it will cost me more than I am now paying for drugs,'' I would say: I hear you. This bill is not enough, not nearly enough.

I have a lot of concerns about this bill. There is no uniformity from region to region in the benefit package or beneficiary payments. Seniors in the East could be paying far higher premiums than their relatives in the Midwest.

The drug plan relies on private insurance companies to provide a type of insurance policy that they have already said they are unwilling to sell. I am skeptical that these private plans will stay, and that could mean seniors will have no stability in their coverage. The bill does allow traditional Medicare to step in and fill the gap but seniors might have to move back to a private drug plan if new ones come to the region.

There is also a gap in coverage which I think is unfair and will surprise a lot of people.

Finally, the bill falls short in its efforts to induce employers not to abandon their retiree prescription drug coverage, a situation that too many retirees have already faced in recent years.

In summary, I view this bill not as a situation where we would say that the glass is half full and half empty; to my thinking, the glass is only about one-quarter full. In 2003, prescription drugs are as important in medical care as surgery; consequently, it seems logical to me that if Medicare pays for the bulk of the cost of a heart bypass operation for all beneficiaries, it should similarly pay the bulk of the cost of the drugs used to lower the cholesterol, and which would prevent the need for the bypass operation, for all beneficiaries. This bill does not achieve that commonsense goal. Not even close.

But we need to start somewhere. This is the first step in gradually moving the health plan that covers nearly 40 million seniors and disabled individuals into the 21st century. And it is, very frankly, the best that we can expect to pass this Congress and that the President will sign.

There are some good provisions in this bill. All Medicare beneficiaries will have access to a prescription drug plan. Individuals with low incomes, below 160 percent of Federal poverty level, will have access to prescription drug coverage at very little cost. Those with very high prescription drug expenses, in the many thousands of dollars, will have stop-loss protection to help protect them against catastrophic drug costs. And no one is forced to abandon the traditional Medicare Program for their basic health care, with which they are so familiar, in order to obtain prescription drug coverage.

During the Senate deliberation on this bill, I have voted for amendments that would improve the prescription drug coverage and decrease the cost to beneficiaries. Almost all of these amendments were not adopted, mostly with the rationale that there was not enough money. I do not feel constrained by some arbitrary $400 billion cost limit on this bill. I never agreed to such a limit. In fact, my sense of values tells me that prescription drug benefits are a high priority, and I would be willing to spend more than $400 billion for a good prescription drug plan, while cutting budget items of lower priority, such as tax cuts for the very wealthy.

In the end, I decided to vote for this bill, despite its severe limitations. Given the many past years of fruitless discussions on this matter, I feel it is critical to put something into law now that can serve as a starting point for development of a true prescription drug plan. But that is not to say that I will accept any lesser of a bill, and my colleagues should not count on my continued support, if the final version of this bill that comes out of negotiations with the House of Representatives undercuts the Medicare Program or moves toward reducing protections for beneficiaries.

We also need to remember, this bill comes with a warning to all of us: the public is a lot smarter than they are sometimes given credit for, and if we do not work diligently to improve what we have begun, they will rightly take out their anger on us. We need to ensure that this bill is the first step, not the last step.

Mr. GRASSLEY. Mr. President, parliamentary inquiry. Are we now ready for third reading?

The PRESIDENT pro tempore. The question is on agreeing to the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

The PRESIDENT pro tempore. The question is on engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that following passage of S. 1, the bill be held at the desk; further, when the Senate receives from the House the companion measure to S. 1 the Senate proceed to its consideration, all after the enacting clause be stricken, and the text of S. 1 as passed be inserted in lieu thereof; the bill then be read a third time and passed with the motion to reconsider laid upon the table; further, that the Senate then insist on its amendments and request a conference with the House, and the Chair be authorized to appoint conferees with a ratio of 5 to 4; finally, with that action, I ask unanimous consent that passage of S. 1 be vitiated and the bill be placed back on the calendar.

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

Mr. BAUCUS. Mr. President, I want to take a few moments to return to the basics of what this bill is all about. Let's keep our eyes on the ball.

We are working here to make a meaningful improvement in health care for seniors. We are working to bring prescription drug coverage to Medicare beneficiaries.

Too many seniors do without drug coverage. The Congressional Budget Office reports that roughly a quarter of Medicare beneficiaries have no drug coverage. Ten million people. They have to pay all of their drug costs out of their own pockets. They pay full price.

Lack of coverage means poorer health. Seniors who get along without drug coverage get fewer of the healing benefits that prescription drugs provide. CBO reports that when seniors do not have drug coverage, they fill about a quarter fewer prescriptions, on average, than do those who have coverage.

But whether seniors have coverage or not, they still need a significant amount of prescription drugs. CBO says that in 1999, Medicare beneficiaries who had coverage filled an average of 32 prescriptions a year. Those without coverage still filled an average of 25 prescriptions a year.

These prescriptions cost seniors a good deal of money. The average Medicare beneficiary spends about $2,500 a year on prescription drugs. That's a big number—especially as the median income for all elderly households in 2001 was less than $19,000.

Those costs are rising fast. CBO projects that the average Medicare beneficiary's drug costs will rise at a

rate of more than 10 percent a year over the next decade. That is far faster than the cost of living. That means that without this legislation, seniors will need to devote larger and larger shares of their income to paying prescription drug bills.

So we are here to try to make prescription drugs more affordable for seniors. And we are here to extend coverage to the roughly 10 million seniors who have no prescription drug coverage at all.

We are here to try to end seniors' painful choice between filling prescriptions and buying food. Seniors should not have to choose among the necessities to maintain their health. We are here to do something about that today.

Let me review what this bill would do.

This bill would make available prescription drug insurance to all seniors.

This bill would ensure that 44 percent of Medicare beneficiaries—those with the lowest incomes—would have truly affordable prescription drug coverage with minimal out-of-pocket costs. For these lower-income seniors, with incomes up to 160 percent of the poverty level, copayments would never exceed 20 percent of the cost of drugs.

Let me take some examples. Let's look at what this bill would do for beneficiaries with what will likely be average drug spending of $3,155 in 2006.

For seniors with average drug expenses, even with higher incomes, this bill would save them $1,677. That is a 40 percent savings in out-of-pocket costs.

The savings would be greater for lower income seniors. For an individual making $14,000 or a couple making $19,000 a year, with average drug spending, they would save $2,842. That is a 90 percent savings in out-of-pocket costs.

For an individual making $12,000 or couple making $16,000 a year with average drug spending, they would save $2,842 in out-of-pocket costs. That would be a savings of 96 percent in out-of-pocket costs.

This bill would thus ensure that those who have been least able to receive the healing benefits of prescription drugs would now be able to do so. Millions of people would have a better quality of life. Lives would be saved.

This bill would create a strong Government fallback. Seniors would have access to at least two private plans for a prescription drug benefit, or the Government would provide a standard fallback plan. If there is not true competition, then traditional Medicare would provide a fallback.

The Department of Health and Human Services would continue to oversee these plans. The plans would operate within tightly controlled limits. This bill includes strong consumer protections.

And this bill does not tilt the playing field. This bill does not make private plans a better deal than traditional Medicare.

This bill would make a nearly $400 billion expansion of a major entitlement program. This is a historic opportunity to make a fundamental change for the better for millions of Americans.

In so doing, this bill would finally do something that the overwhelming majority of industrialized nations have already done.

This is a broad compromise. This is not a bill of the left or a bill of the right. This is a weaving together of approaches, in the finest American tradition.

This is a historic opportunity. Let us finally seize that opportunity, and improve health care for our seniors. Let us finally seize the opportunity, and bring prescription drug coverage to all.

Mr. GRASSLEY. Mr. President, we are about to take a historical vote.

Since 1965, Medicare hasn't covered prescription drugs. Now, 38 years later, we're changing that—on a strong bipartisan basis.

Because of this bill, on January 1, 2004, seniors across America will have immediate help with prescription drug costs. Moreover, on January 1, 2006, seniors will have access to affordable, comprehensive drug coverage as a permanent part of Medicare.

No longer will seniors have to make hard choices when it comes to paying for prescription drugs.

This bill also strengthens and improves Medicare, giving seniors more choices and better benefits than they have today.

At the same time, it brings long overdue Medicare equity to the people of Iowa and to other rural States.

We are on the verge of a major victory.

I urge my colleagues to support S. 1.

Mr. BAUCUS. Mr. President, we are about to vote. I want to thank all Senators for their tremendous patience. It is not an easy task. I particularly thank the chairman of the committee but also all Senators.

Second, I thank the staff who have not had any sleep in the last two or three weeks. I don't know how they are still standing. A lot of people have been working on this bill. My thanks. I know I speak for all the Senators in thanking all the staff that worked so hard to help achieve this end.

The PRESIDENT pro tempore. The bill having been read the third time, the question is, shall it pass?

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

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Oklahoma (Mr. INHOFE) is necessarily absent.

Mr. REID. I announce that 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 ''nay''.

The PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 76, nays 21, as follows:

[Rollcall Vote No. 262 Leg.]

YEAS—76

Akaka	Daschle	Lugar
Alexander	Dayton	McConnell
Allen	DeWine	Mikulski
Baucus	Dodd	Miller
Bayh	Dole	Murkowski
Bennett	Domenici	Murray
Biden	Dorgan	Nelson (FL)
Bingaman	Durbin	Nelson (NE)
Bond	Enzi	Pryor
Boxer	Feingold	Reid
Breaux	Feinstein	Roberts
Brownback	Fitzgerald	Schumer
Bunning	Frist	Sessions
Burns	Grassley	Shelby
Campbell	Hagel	Smith
Cantwell	Hatch	Snowe
Carper	Hutchison	Specter
Chafee	Inouye	Stabenow
Chambliss	Jeffords	Stevens
Cochran	Johnson	Talent
Coleman	Kennedy	Thomas
Collins	Kyl	Voinovich
Conrad	Landrieu	Warner
Corzine	Lautenberg	Wyden
Craig	Leahy	
Crapo	Lincoln	

NAYS—21

Allard	Graham (SC)	McCain
Byrd	Gregg	Nickles
Clinton	Harkin	Reed
Cornyn	Hollings	Rockefeller
Edwards	Kohl	Santorum
Ensign	Levin	Sarbanes
Graham (FL)	Lott	Sununu

NOT VOTING—3

Inhofe	Kerry	Lieberman

The bill (S. 1), as amended, was passed.

(The bill will be printed in a future edition of the RECORD.)

The PRESIDENT pro tempore. Without objection, the title amendment is agreed to.

The title was amended so as to read: ''A bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program and to strengthen and improve the medicare program, and for other purposes.''.

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

The PRESIDENT pro tempore. The Chair, in my capacity as a Senator from the State of Alaska, moves to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. INHOFE. Mr. President, because of urgent business back in my State of Oklahoma, I will be unable to be in attendance to vote on S. 1. It makes no difference, however, because I would have voted against it.

Last week, I addressed this Chamber regarding S. 1, the Prescription Drug and Medicare Improvement Act. At that time, I said I could not support the legislation in its current form and expressed my hope that it could be improved on the floor. Unfortunately, that has not occurred. I am restating my opposition to this legislation.

This is simply another Federal entitlement program designed to balloon past expected costs of $400 billion. For

example, in the past, Medicare expenses have soared nearly five times the projected costs. I remember that well because I remember in 1965 when it was passed. This trend will only escalate if we continue to add unfunded obligations without ensuring the long-term solvency of the entire program.

We must examine the necessity of such obligations prior to placing the burden on the backs of the future taxpayers. And is a full prescription drug benefit necessary? Currently, 76 percent of seniors already have some form of prescription drug coverage. A recent Zogby poll found that three-fourths of seniors thought the coverage offered under this plan would be no better than what they currently have. In fact, less than one-half would even purchase the option if given the choice. However, with the passage of S. 1, those individuals may not be given that choice. CBO estimates that one-third of Medicare beneficiaries with employer-sponsored coverage will lose those benefits once the bill takes effect. Seniors who currently have private coverage that they like will be forced to buy the Government-sponsored benefit simply because it is the only thing that will be available.

There is something wrong with that picture. The Government should not be replacing coverage that already exists. However, this legislation opens the door for continued Government intervention. With the inclusion of the fallback provision, this benefit has the potential to become fully federalized if private plans do not surface. Once again, we are placing more and more expense at the door of the taxpayers, our children, and our grandchildren.

I am concerned about the effect this bill could have on the future of the entire Medicare Program. I have worked with my colleagues to support improvements to this legislation. I and many of my colleagues have signed letters to both Senator FRIST and President Bush outlining the principles that need to be included in the final version of this bill. I also cosponsored an amendment with Senators ENSIGN, HAGEL, and LOTT to provide a more reasonable prescription drug benefit that does not create a massive entitlement program. I believe the House of Representatives is on the right track with this issue.

I am hopeful that with the passage of S. 1, the conferees will work to see that the final legislation adheres to the principles stated in the letters to President Bush and Senator FRIST and the proposal supported by the House. At that time, I will look forward to supporting this legislation.

The PRESIDENT pro tempore. The majority leader.

Mr. FRIST. Mr. President, for years Congress has debated providing prescription drug coverage to seniors and how to strengthen and improve the Medicare Program. Tonight we have acted. Tonight America is one step closer to being a more caring society for millions of seniors and individuals with disabilities. Tonight seniors and individuals with disabilities, through this bill, will get relief from high prescription drug costs and outdated, often inadequate medical care. Tonight we are one step closer to providing real health care security to seniors all across the Nation.

We stand on the shoulders of many in this body and in the House of Representatives who have labored mightily to improve the Medicare Program. We have reached this point of success because of the commitment of the leadership in the House as well as the Senate. Above all, we are indebted to the bold leadership of the President of the United States without whom we would not be transforming or improving the system.

Indeed, the bill we have just passed is nothing less than historic. By dramatically expanding opportunities for private sector innovation, it offers genuine reform that will dramatically improve the quality of health care for all seniors. At the same time, the legislation preserves traditional Medicare so that those who wish can remain in traditional Medicare and keep exactly what they have today.

This bill combines the best of the public and private sectors and positions Medicare to evolve with the medical treatments of the future. It is entirely voluntary.

I am very pleased by the overwhelming majority of this body who tonight voted to move this legislation towards a more competitive private model but a partnership between the public and private sector.

I am also pleased that the amendment maintained the balance that has been so important in what I set out a few weeks ago, to be a truly bipartisan effort. The bill devotes increased resources and expands opportunities within the traditional Medicare Program for chronic care coordination, for disease management, for preventive care.

As many people have stated, it is not a perfect bill, but we will continue to move this legislation forward now to conference once, later in the evening or in the hours of the morning, after the House passes its legislation, we will have the opportunity to make the private sector provisions more flexible, indeed more competitive, and more like the Federal Employees Health Benefits Plan. All of us in this body are familiar with the impressive record of that plan, the Federal employees plan. Every Member of Congress and over 8 million other Federal workers and retirees enjoy the ability to choose the plan that best suits their medical needs.

Indeed, as we go through conference and once the bill is signed by the President of the United States, all seniors will have that same opportunity to voluntarily choose the plan that best meets their medical needs.

I look forward to working with my colleagues on both sides of the aisle to improve this legislation and to make sure that it does not inadvertently displace good private health care coverage that exists today—options that are available to millions of Medicare beneficiaries, including employer-sponsored health coverage.

Compromise and debate are the cornerstone of this great democratic system of government. I commend my colleagues for their admirable show of bipartisan spirit. Thanks to the leadership of our colleagues in the Senate and the commitment of President Bush, America's seniors will finally receive the health coverage they need and the security they deserve.

I want to take a brief moment to thank all of my colleagues for their hard work and dedication over the last several weeks. It has been about 3 months ago that I set out that we would address Medicare for these 2 weeks—the 2 weeks prior to the July 4 recess. Many people said we were trying to do too much in too short a period of time. Others said it is something that has been debated for weeks and months, and indeed years, and there is no way we can finish it before July 4.

Yet through the hard work of our colleagues—again, on both sides of the aisle—we have fulfilled that vision. Again, it is a first step, a step that will be improved in that conference before us. Nevertheless, we succeeded in what we set out to do with the legislation that is built upon the work of many Members of the Senate, as well as the House of Representatives and, in particular, the members of the Senate Finance Committee. I do want to thank especially Senators HATCH, NICKLES, LOTT, SNOWE, KYL, THOMAS, SANTORUM, SMITH, BUNNING, and BREAUX for their hard work and leadership.

In particular, of course, I thank Chairman GRASSLEY and Senator BAUCUS, the managers, who for the last 2 weeks have so capably managed the bill on the floor. Their cooperation and their leadership has been invaluable. Without it, we would not be here so close to the finish line.

I would like to recognize all of the staff who have contributed to this effort:

First, I would like to thank my chief of staff, Lee Rawls: my policy director, Eric Ueland; and my health policy director, Dean Rosen. Paul Jacobson, Bob Stevenson, Nick Smith, Bill Hoagland, and Amy Holmes of my Leadership office also made important contributions. I also would like to recognize the other members of my health team who worked so hard to help make possible the passage of this legislation: Elizabeth Scanlon, Craig Burton, Susan Goelzer, Shana Christrup, Allison Winnike, and Jennifer Romans.

The Majority Whip's staff deserves special recognition, especially Kyle Simmons, Michael Solon, and Amy Swonger, for the long hours they put in and for the guidance they provided to our Finance Committee Chairman and our entire Republican leadership team.

As I have said, passage of this legislation was made possible in the United States Senate because of the genuine spirit of bipartisan cooperation. Both the Republican and Democratic staff of the Senate Finance Committee worked incredibly hard, long hours these past several weeks and months. Their expertise, support, and stamina has been invaluable.

I would like to thank Kolan Davis, Ted Totman, Linda Fishman, Colin Roskey, Leah Kegler, Mark Hayes, Jennifer Bell, and Alicia Ziemiecki of Chairman GRASSLEY's staff.

And I would also like to thank Jeffrey Forbes, Elizabeth Fowler, Bill Dauster, John Blum, Pat Bousilman, Kate Kirchgraber, and Andrea Cohen of Senator BAUCUS' staff for their contributions.

Hazen Marshall, Stacey Hughes, and Megan Hauck of the Senate Budget Committee staff are also commended for their efforts.

Thank you to you all.

I look forward to working with Chairman GRASSLEY and our colleagues in the House of Representatives to produce a conference report that can pass both Houses and be signed by the President in a timely manner later this year.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

ORDER TO PRINT S. 1

Mr. FRIST. Mr. President, I ask unanimous consent that S. 1, as passed, be printed.

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

(This bill will be printed in a future edition of the RECORD.)

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

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

INDEPENDENCE DAY

Mr. BYRD. Madam President, the Senate is poised to adjourn, but before we adjourn, I want to call us away from the onrushing press of Senate business and impending airline schedules to pay tribute to Independence Day. Next Friday is the glorious Fourth of July, that most patriotic and star-spangled of holidays. With the Fourth of July holiday, summer is at its Halcyon best, with temperatures still enjoyable, skies richly blue, and trees and lawns still lush and green, and gardens coming into bewildering abundance. In fields and along the roadsides, wildflowers bloom in profusion, and wild blackberries earn our forgiveness for their thorns by offering the tender treasures of their glossy berries.

It is a golden period of enjoyment for students on summer holiday, the respite still feels luxuriously long, full of golden days of enjoyment.

The Fourth of July this year falls on a Friday, easily making a long weekend for summer pleasure. With luck, the Fourth will be clear and cooler, comfortable for marching bands and hometown parades, bathed in glorious sunshine for family picnics and perfect for evening symphonies and fireworks to compete with the glittering stars above.

If the weather is sweltering, however, then we might be better able to empathize with the Delegates to the Second Continental Congress, who met in Philadelphia in the spring and summer of 1776. In hot and muggy summer weather, clad in heavy styles that were designed for a cooler European summer, the Delegates debated and amended, reportedly fending off flies from a nearby stable that swarmed the Hall and bit the Delegates through the silk hose on their lower legs. But they persevered in their momentous task.

On June 7, 1776, Richard Henry Lee of Virginia offered a motion to declare independence from England. His resolution declared:

> These United Colonies are and of right ought to be free and independent States.

His resolution passed on July 2 by a 12–0 vote, with New York temporarily abstaining.

The next day, on July 3, John Adams wrote to his wife, Abigail, rejoicing over the decision to secede. To Abigail, he wrote:

> The 2nd of July will be a memorable epoch in the history of America. I am apt to believe that it will be celebrated by succeeding generations as the Great Anniversary Festival.

He further suggested that it ought to be commemorated as the day of deliverance, by solemn acts of devotion to God Almighty.

This is John Adams speaking. This is not some rustic boob like I was when I came to the House more than half a century ago. Listen to him again:

> It ought to be commemorated as the day of deliverance by solemn acts of devotion to God Almighty.
>
> It ought to be solemnized with pomp, shows, games, sports, guns, bells, bonfires, illuminations, from one end of this Continent to the other, from this time forward, forever.

How remarkably prescient. Adams was off on the date, as we celebrate the approval of the Declaration of Independence rather than of the adoption of the motion, but he certainly knew how Americans like to celebrate. As well, he accurately predicted the explosive growth of an embryonic nation into a continent-spanning colossus.

That vision took great courage, coming as it did on the eve of putting his signature to a document that could easily become his death warrant. Every signer of that Declaration of Independence committed treason against England, against the King of England, against the crown. Every signer could have been arrested, put in chains and sent by boat to England; tried, convicted, and hanged. The delegates to the Continental Congress had, with this act, committed treason against the crown and set their nascent nation-state on the road to war. After the failed Jacobite uprising against England in 1745 under Bonnie Prince Charles, only 31 years before the delegate met in Philadelphia, the Scottish leaders had been beheaded in public ceremonies.

One Delegate to the Congress, John Witherspoon, put it thus:

> There is a tide in the affairs of men, a nick of time. We perceive it now before us. To hesitate is to consent to our own slavery. That noble instrument upon your table, that insures immortality to its author, should be subscribed this very morning by every pen in this house. He that will not respond to its accents, and strain every nerve to carry into effect its provisions, is unworthy of the name of free man. For my own part, of property, I have some; of reputation, more. That reputation is staked, that property is pledged on the issue of this contest; and although these grey hairs must soon descend into the sepulcher, I would infinitely rather that they descend thither by the hand of the executioner than desert at this crisis the sacred cause of my country.

What beautiful words. The signers knew full well what risks they were running.

The first anniversary of the adoption of the Declaration of Independence took place in a nation at war, with our battle fortunes at low ebb. But Americans still celebrated in Philadelphia, U.S. ships of war were decked in red, white, and blue. At 1 o'clock, each ship fired a salvo of 13 cannons to honor the 13 States. Members of Congress dined in state with other civil and military dignitaries and made toasts to liberty and to fallen patriots. After dinner, the Members and officers of the Army reviewed the troops, followed by a ringing of bells and a show of fireworks.

In 1788, Philadelphia was serving as the U.S. Capital. On that year, not only was the Declaration of Independence celebrated, but also the U.S. Constitution, which had recently been ratified by 10 States. This July Fourth celebration included another new feature—a parade with horse-drawn floats. One float, that of an enormous eagle, carried the Justices of the Supreme Court in lieu of today's beauty pageant queens.

In 1826, the Nation achieved a milestone when the 50th Independence Day celebration was being planned. The mayor of Washington wrote to invite the surviving ex-Presidents and Signers of the Declaration to attend the festivities. The five men, John Adams, Thomas Jefferson, James Madison, James Monroe, and Charles Carroll,