

health care. The problem is what we call sometimes a "health care system" is not a system but a patchwork of different delivery methods. It is a local taxing jurisdiction, hospital districts, using property taxes in some States, of course supplemented by other taxes, and of course there is Federal Government-provided health care available, partially, at least, through the CHIPS Program, through Medicaid and through Medicare.

We do know there is a tremendous challenge to make sure everyone in this country has access to good quality health care. Those who do not have health insurance represent one of the biggest challenges. One of the things we have learned is this is not so much a challenge of getting everyone insurance. The real question is, How do we make sure everyone has access? Even for those who do not have health care insurance, we need to make sure they have access to health care.

Right now the irony is the Federal Government has already gotten into this area and mandated if you have nowhere else to turn for health care, you know you can always show up at the local emergency room at your hospital and get that health care provided. If you cannot pay for it, it is provided without charge to the patient. The problem is, in many major metropolitan areas on any given Friday or Saturday night, when the demands on the emergency room are great, many emergency rooms are on divert status, which means they cannot take any more patients because they are full.

However, 80 percent of those people being treated in emergency rooms could be and should be more humanely, more efficiently, and less expensively provided health care in some other setting—in a clinic, for example.

One of the most amazing things about our health care delivery system in our country, while we do compensate—although some argue it is not as generous as it should be—we do compensate health care providers for providing health care to people after they are sick, we do a pretty lousy job of trying to give people access to what they need in order to prevent their getting sick.

We have made good strides forward with the Medicare bill we passed last year to provide prescription drugs to many seniors who did not have that. Of course, this Medicare discount drug card Senator TALENT talked about is an interim step that leads to the full implementation of that program in a couple of years when the vast infrastructure can be created to deliver that system.

For example, for someone who has not previously had access to a drug like Lipitor, one of the statin drugs—and there are a number of them; that is just one trade name—that perhaps can prevent someone from having to have more expensive, invasive, and dangerous surgery, either bypass surgery or angioplasty or perhaps placement of

a stent, or something that costs a lot of money to treat if the basic cause that could be prevented is left untreated through the use of prescription drugs.

We have made a great step forward to broaden the number of people, to increase the number of people preventive measures are available to. That is smart. We ought to continue along that trend.

Mr. President, I ask to be reminded when I have 1 minute remaining of my time.

One of the things I believe is a great safety net in this country, that I have come to learn about and see used so well in my State, is federally qualified community health centers. The great thing about community health centers is they provide clinical—that is, non-emergency room—access to health care in your neighborhood, where you pay based on a sliding scale, based upon your ability to pay. These are actually designated health centers by the Federal Government. They have access to a number of important programs, for example, the Federal 340B Discount Pricing Program. This task force recommends that program be expanded to more people, so we can bring down the price of prescription drugs.

But these community health centers provide, on a sliding scale, access to care in one's local community, which I think is very important. I was told by the head of Parkland Hospital, one of the largest public hospitals in Dallas, TX, for example, that people show up in the emergency room to have a baby, where they have no health insurance. Because they have no health insurance, and may never have seen a doctor before they show up in the emergency room, the risk of injury to that baby—either it being born prematurely or some other health risk—goes up exponentially.

Even though they do not receive any income for it, Parkland Hospital routinely provides prenatal care for mothers, on a free basis, even though they do not get a penny paid by that pregnant mom. One reason is because they know the cost of 1 day in the neonatal intensive care unit at the Parkland Hospital costs about \$10,000. Now, of course, I would like to say we would do that from our sheer desire to see healthy babies, but, unfortunately, money drives access.

My point is, in this instance what Parkland Hospital, in Dallas County, has decided to do in a way to help control costs is to ensure more healthy babies are born who do not need access to the neonatal intensive care unit, as they provide free prenatal care to these pregnant moms. But community health centers can make sure this pregnant mom has access to somewhere other than the emergency room of the hospital in which to get that important prenatal care.

We also would increase, as part of this task force report, the number of medical volunteers by extending crit-

ical Federal tort claims act liability coverage. This is an area that I think is very important.

The PRESIDING OFFICER. The Senator has 1 minute.

Mr. CORNYN. That is very important because the medical liability crisis in this country does not only hurt doctors and hospitals, but it hurts patients who are denied access to health care. One of the issues we have to deal with—I know the leader has brought it up several times, and we have been unable to get 60 votes to get an up-or-down vote on the merits of the legislation—is medical liability reform.

Whether it is increasing access to specialty care, increasing the number of federally qualified community health clinics, increasing access to prescription drugs by extending the Federal 340B Program, or creating an exemption so religiously sponsored health systems can create community health systems, integrated health systems, we have to do something about this crisis in this country. It is a crisis of access, not only of insurance. But I think we are well on our way to a good start.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

ORDER OF PROCEDURE

Mr. REID. Mr. President, how much time is remaining on the side of the Democrats?

The PRESIDING OFFICER. There is 20 minutes.

Mr. REID. Mr. President, I yield 5 minutes to the Senator from Oregon, Mr. WYDEN, and 15 minutes to Senator STABENOW.

The PRESIDING OFFICER. The Senator from Oregon is recognized for 5 minutes.

HEALTH CARE

Mr. WYDEN. Mr. President, I have always believed health care policy needs to be bipartisan, and needs to be ideas driven. So as we talk about health care, I come to the floor to mention an idea our colleague Senator KERRY has talked about which I think is especially promising for small business.

The reality is, a very high percentage of the uninsured work in small businesses. These small businesses are dying to cover their people. The owners of those small businesses do not get up in the morning and say: We want to be rotten to our workers in not giving coverage. They are dying to figure out ways to help their small businesses.

Senator KERRY has come up with an idea that I think is really innovative. He has said, given the fact resources are scarce, that dollars for trying to address the uninsured, the needs of our small businesses, are restricted, we ought to target those dollars where they are needed the most. He has proposed the Federal Government, with

respect to small business, concentrate on instances where there are very large bills, bills above \$50,000. He would have the Federal Government step in and pick up about 75 percent of those costs. The premiums that would be charged employers and their workers could be trimmed about 10 percent in this fashion.

We know it has been documented that those who are particularly in need of assistance when they face these very high bills are a very large proportion of the health care costs in America. These health care costs are particularly punitive for the small businesses. Small businesses are always walking on economic tightropes. If one employee at a small business gets sick, this can devastate the entire budget of the company for not just health care coverage but the entire coverage of the business.

I am very pleased Senator KERRY has brought forward this idea. I think it is one that can be supported in a bipartisan way. The Congress, over the years, has tried to look at ways to strengthen the employer-based system of coverage. I think we all understand if you are talking about starting scores of new programs, that would be very difficult at this time. I also do not think it is warranted at a time when we are spending \$1.7 trillion on health care. If you divide that up by 270 million Americans, it comes to more than \$17,000 for a family of 4. So we are spending a lot of money.

The challenge now is to really zero in on areas where the Government can be best utilized. I think Senator KERRY's proposal with respect to trying to deal with the costs of individuals who work at small businesses with very high bills is particularly appropriate at this time. It is something I think could be built in a bipartisan way.

I will have more to say about this and other proposals in the days ahead. But as we come to the floor and talk—Democrats and Republicans—about health care, I think we ought to make our policies bipartisan. We ought to make them ideas driven. The kind of idea that has been outlined by Senator KERRY with respect to the needs of individuals who work at small businesses with very large bills is the kind of thinking that would make a difference now. It is cost effective. I think it warrants support on a bipartisan basis.

With that, Mr. President, I yield the floor.

The PRESIDING OFFICER. Who seeks recognition?

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Ms. STABENOW. Mr. President, I rise to lament the fact that we have

made no progress in reducing the uninsured since 2001. This is an issue we all need to be working together on because it affects everyone we represent, every family, every business. In fact, nearly 4 million more people are uninsured today than the day this administration took office.

We need to light a fire. We need to have a sense of urgency about getting this done for people. We can do much better than we are doing. We live in the United States of America. We are the greatest, the richest country on the face of the Earth. When we have the will, we can make great things happen. That is what we need to do here.

We enacted Social Security in 1935. This program now serves as our universal retirement, life insurance, and disability insurance system for millions of people. A generation later we passed Medicare, our Nation's universal health plan for seniors and the disabled. Even though I am very concerned about the recent law that we passed and whether it is a step backward—and I believe it is—the fact is, we put in place in 1965 a policy based on a set of values that said, if you are 65 or older, if you are disabled, you are going to receive health care.

Interestingly, at that time, if we go back and read the record, this was viewed as a compromise, a first step. Originally in 1960, what was being debated was health care for everyone. Then when there was not the support to pass that, the compromise was to start with older Americans and with the disabled, to provide health care first to them and then to open it up to all of our citizens. Yet today we are not seeing that happening. It is now time to go the last mile. We need to make sure all Americans have the same access to health insurance that we do in the Senate.

As most colleagues know, approximately 80 percent of the people who don't have health insurance are working—one job, two jobs, three jobs, working very hard to care for their families. They have jobs. They go to work. They play by the rules. Unfortunately, health insurance is so expensive, they can't afford it or the business they work for can't afford it. We need to value the hard work these people are doing. We need to recognize and ensure that if they work for a living, they have the health insurance they need for themselves and their families.

Regrettably, this administration has been basically silent on the uninsured. When members of the administration do speak, they are negative and pessimistic about providing access to affordable health care for all Americans. For example, in January of this year, the National Academy of Sciences said that the President and Congress should work to achieve health insurance coverage for all Americans by 2010. That is a worthy goal, although I would argue too far into the future.

What was the response? The administration's top health official, Health and

Human Services Secretary Tommy Thompson said universal health coverage is "not realistic . . . I don't think, administratively or legislatively, it's feasible."

Then 2 months later Secretary Thompson went on to minimize the Nation's uninsured problem by saying:

Even if you don't have health insurance in America, you get taken care of. That could be defined as universal health care.

In other words, just go to the emergency room to get your health care coverage.

In fact, too many people are doing that now. Sometimes you can just get taken care of, but by the time an uninsured patient reaches the emergency room, it is often too late to provide lifesaving health care. Many of the uninsured forgo less costly preventative care and early treatments, getting sicker as what money they have goes for the rent, the car, the kids, and food.

Hospitals in Michigan indicate they have provided over \$1 billion in health care for the uninsured, uncompensated care this last year. Think what we could do if we could capture that \$1 billion and put it into a system that worked on the front end, that kept people healthy, that provided preventive care, that made sure they could see the doctor in his office or her office rather than having to wait for the emergency room.

We can do better than this in the greatest country in the world. I do not think we should throw in the towel. We should not say we can't do it, it is not feasible. It is time to create the will. The fact is, we can do it, if we pick the right priorities. We can do the same thing we did when we passed Social Security and Medicare—two great American success stories that have provided economic security for people as they grow older and retire and health care for older Americans and the disabled. In my book, that was all about values, about what is important. This certainly is equally important. We should be optimistic. We should join all other modern countries and make sure all Americans have access to affordable health insurance.

One of the reasons more and more families can't get health care is because the costs are spiraling out of control. In fact, from 2000 to 2003, the average annual cost of premiums doubled, making health insurance out of reach for more and more middle-income families and small businesses. In 3 years, the costs have doubled. Medical problems, in fact, were a factor in nearly half of all nonbusiness bankruptcy filings. Overall, health care costs have gone up nearly 14 percent last year. Meanwhile, workers' earnings increased by only 3 percent. You can see the hole people find themselves in.

This is the fifth year in a row premiums outpaced earnings. We all know that one of the reasons health care costs have escalated so fast is the spiraling price of prescription drugs. I

have talked frequently about this. I speak about it and focus on it because it is such a driver for the costs of health care and health insurance.

What has Congress done to fix this problem? Unfortunately, absolutely nothing. In fact, the new Medicare law failed to do anything to lower prescription drug prices. At the same time approximately 3 million retirees will actually lose their prescription drug coverage under this new law. This bill actually takes us backward instead of forward.

The only major health care coverage initiative this administration has proposed is actually for the Iraqi people. Our country has made a commitment to moving forward with universal health coverage for all Iraqi citizens. We have provided \$950 million to build hospitals and clinics in Iraq.

Please do not misunderstand what I am saying. I certainly want to be supportive of efforts to provide health care in Iraq.

What about us? What about Americans? I also want to help American families who are working hard every day, playing by the rules in this great country, and struggling to pay their bills and care for their families. I think we can help both the people of Iraq and Americans at the same time. It is our moral obligation, I believe, to make sure we are helping American families as well as others.

Mr. President, working families deserve access to affordable care for themselves and for their families. It is going to take leadership to accomplish this. The administration has had almost 4 years to take action, and it has not.

I believe it is time for bold change. I believe that when we are looking at the price of prescription drugs, we need to take out that provision in the new Medicare law that says Medicare cannot negotiate for group discounts. That is pretty basic. We know that one of the main ways you are able to lower prescription drug prices, or the price of any product, is to be able to get a group discount. Everybody knows that. Yet, in this new Medicare law, Medicare is specifically prohibited from doing that. Who benefits from that? Certainly not the taxpayers, certainly not American seniors or the disabled, and American families certainly don't benefit from that. The prescription drug industry benefits from that. What we have seen under the new Medicare law, rather than providing lower prices for people, we have 40 million seniors who are being locked into paying top dollar, and that makes absolutely no sense.

We can do something about that. We can make changes in the Medicare law so it works for people. We can also lower prices immediately by simply allowing the local pharmacists at the local drugstores in America to be able to do business with pharmacists in Canada or other countries, where they can provide FDA-approved drugs and

processes and bring the prescription drugs—actually made in America—back to America so we can get the same deal everybody else gets around the world.

We have a wonderful, bipartisan bill that has been put together. I am hopeful that we will bring it to the Senate floor as soon as possible and that we are able to pass what is called re-importation of prescription drugs and lower prices. I am very hopeful and I am proud to be a cosponsor of Senator DASCHLE's effort and vision to say that, by 2006, we are going to make a commitment that every American has access at least to the same level of health care that we receive. This is one of the few instances where employees—elected officials—have better health care and benefits than the employers. It is time to turn that around. It is time to make a commitment.

Medicare, after it was passed, was put together in 1 year. We have great American ingenuity. If we are bold and have a vision and have a right priority, we can make sure that a year from now we are talking about the implementation of health insurance for everyone that is affordable and available to every single American.

I yield the floor.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. All time has been yielded. Morning business is closed.

INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT OF 2003

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of S. 1248, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1248) to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

There being no objection, the Senate proceeded to consider the bill, which had been reported from the Committee on Health, Education, Labor, and Pensions, with an amendment to strike all after the enacting clause and inserting in lieu thereof the following:

S. 1248

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

[This Act may be cited as the "Individuals with Disabilities Education Improvement Act of 2003".]

TITLE I—AMENDMENTS TO THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

ISEC. 101. AMENDMENTS TO THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT.

[Parts A through D of the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.) are amended to read as follows:

["PART A—GENERAL PROVISIONS

["SEC. 601. SHORT TITLE; TABLE OF CONTENTS; FINDINGS; PURPOSES.

["(a) SHORT TITLE.—This Act may be cited as the 'Individuals with Disabilities Education Act'.

["(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

["PART A—GENERAL PROVISIONS

["Sec. 601. Short title; table of contents; findings; purposes.

["Sec. 602. Definitions.

["Sec. 603. Office of Special Education Programs.

["Sec. 604. Abrogation of State sovereign immunity.

["Sec. 605. Acquisition of equipment; construction or alteration of facilities.

["Sec. 606. Employment of individuals with disabilities.

["Sec. 607. Requirements for prescribing regulations.

["Sec. 608. State administration.

["Sec. 609. Report to Congress

["PART B—ASSISTANCE FOR EDUCATION OF ALL CHILDREN WITH DISABILITIES

["Sec. 611. Authorization; allotment; use of funds; authorization of appropriations.

["Sec. 612. State eligibility.

["Sec. 613. Local educational agency eligibility.

["Sec. 614. Evaluations, eligibility determinations, individualized education programs, and educational placements.

["Sec. 615. Procedural safeguards.

["Sec. 616. Monitoring, technical assistance, and enforcement.

["Sec. 617. Administration.

["Sec. 618. Program information.

["Sec. 619. Preschool grants.

["PART C—INFANTS AND TODDLERS WITH DISABILITIES

["Sec. 631. Findings and policy.

["Sec. 632. Definitions.

["Sec. 633. General authority.

["Sec. 634. Eligibility.

["Sec. 635. Requirements for statewide system.

["Sec. 636. Individualized family service plan.

["Sec. 637. State application and assurances.

["Sec. 638. Uses of funds.

["Sec. 639. Procedural safeguards.

["Sec. 640. Payor of last resort.

["Sec. 641. State Interagency Coordinating Council.

["Sec. 642. Federal administration.

["Sec. 643. Allocation of funds.

["Sec. 644. Authorization of appropriations.

["PART D—NATIONAL ACTIVITIES TO IMPROVE EDUCATION OF CHILDREN WITH DISABILITIES

["Sec. 650. Findings and purpose.

["SUBPART 1—STATE PERSONNEL PREPARATION AND PROFESSIONAL DEVELOPMENT GRANTS

["Sec. 651. Purpose; definition; program authority.

["Sec. 652. Eligibility and collaborative process.

["Sec. 653. Applications.

["Sec. 654. Use of funds.

["Sec. 655. Authorization of appropriations.

["SUBPART 2—SCIENTIFICALLY BASED RESEARCH, TECHNICAL ASSISTANCE, MODEL DEMONSTRATION PROJECTS, AND DISSEMINATION OF INFORMATION

["Sec. 660. Purpose.

["Sec. 661. Administrative provisions.