MEDICAR. But some providers complained that the prices on the site were inaccurate, and some cards are not listed at all.

For many retirees, it is too much.

''I'm 85, do I have to go through this nonsense?'' asked Florence Daniels, a retired engineer who said she received less than $1,000 a month from Social Security, of which she paid $179 a month for supplemental medical insurance. She gets drugs through a New York State program, which provides any prescription for $20 or less. To make ends meet and afford her drugs, she said she bought used clothing and put off buying new glasses. Some of her friends travel by bus to Canada to buy drugs; others do without, she said.

Ms. Daniels did not use the government Web site to compare drug cards, in part because she cannot afford a computer. ''I'm trying to absorb all the information, but it's ridiculous,'' she said. ''Not just ridiculous, it's scary. If there was a single card and it was administered by Medicare, and it got the cost of drugs down—wonderful, marvelous. But with these cards, the only thing we know is that we'll have to pay money to other people to administer what we can get and can't get.''

The discount program, which is financed largely by the cards' sponsors, reflects the Bush administration's desire to open Medicare to market principles without allowing participants to import drugs from other countries, which many Democrats favored.

Mark B. McClellan, an administrator at the Center for Medicare and Medicaid Services, said the complexity of the plan encouraged competition. ''We're seeing more plans offering better benefits,'' he said, estimating that people will be able to save 15 percent or more using the cards.

But the complexity of choices will keep many people away from the program, said Marilyn Moon, director of health at the American Institutes for Research, a nonprofit research organization in Washington.

Often, the discount provided by the cards is not as good as what people can get from existing state programs, union plans or consumer groups, said Robert M. Hayes, president of the Medicare Rights Center, a nonprofit organization that helps individuals with Medicare problems.

Sydney Bild, 81, a retired doctor in Chicago, compared the discount cards with the prices he paid ordering his drugs by mail from Canada. Dr. Bild pays $4,000 to $5,000 a year for five medications. When he checked the government Web site, he said the best plans were about 50 percent to 60 percent higher than what he was paying.

But Dr. Bild said his main objection to the new plans was that companies could change prices on drugs, or change the drugs covered. Medicare requires plans to cover only one drug in each of 209 common categories. Consumers can change cards only once a year. Committing to a card is ''like love—it's a something thing,'' Dr. Bild said. ''What if I chose one? They could drop my drugs two weeks later.''

Companies began soliciting customers for their discount drug cards last week. When the first pamphlets arrived at Beverly Lowy's home in New York City, Ms. Lowy said, she looked at them carefully. She does not have drug coverage and last year spent about $3,000 on prescription drugs. But the more brochures she reads, Ms. Lowy said, the less clear things became.

''You really have to be a rocket scientists,'' Ms. Lowy, 71, said. ''It takes time, energy, and you don't even save money. I thought, 'This one is offering this, this one is offering that.' Finally I decided this isn't for me.''

At the Leonard Covello Senior Center in East Harlem, the new cards seemed opaque. Ramon Velez, 72, a retired taxi driver, said he had watched AARP advertisements in which people read the dense language on the federal Medicare bill.

''I was laughing at the people in the ads, but it's true,'' Mr. Velez said. ''Everyone's confused.''

Mr. Velez received $763 a month from Social Security, and often skips his psoriasis medication because he cannot afford the $45 co-payment under this Blue Cross/Blue Shield plan. He wondered if the new drug cards could save him money.

''But it's very confusing,'' he said. ''I'd go to the Social Security office to ask about the cards, but I don't think they'd know.''

Alejandro Sierra, 67, a retired barber, paced around the center's pool table. Mr. Sierra takes six medications for diabetes and complications from cataracts and colon cancer, and sometimes skips a medication because he cannot afford it.

''I'm interested in the cards,'' he said. ''But I can't figure it out on the computer, because I can't see.''

Carlos Lopez, the director of the center, said the cards had so far produced little but anxiety. Mr. Lopez asked participants to bring any applications to him before signing them, and warned them about people selling phony cards.

''They're not nervous, but concerned,'' he said. ''They feel, why now? Why do I suddenly need a card for medications?''

S. 2413

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 ''Medicare Assurance of Rx Transitional Assistance Act of 2004''.

SEC. 2. AUTOMATIC ENROLLMENT OF MEDICAID BENEFICIARIES ELIGIBLE FOR MEDICARE PRESCRIPTION DRUG BENEFITS.

(a) AUTOMATIC ENROLLMENT OF BENEFICIARIES RECEIVING MEDICAL ASSISTANCE FOR MEDICARE COST-SHARING UNDER MEDICAID.—Section 1860D–14(a)(3)(B)(v) (42 U.S.C. 1395w–114(a)(3)(B)(v)) is amended to read as follows:

''(v) TREATMENT OF MEDICAID BENEFICIARIES.—Subject to subparagraph (F), the Secretary shall provide that part D eligible individuals who are—

''(I) full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or who are recipients of supplemental security income benefits under title XVI shall be treated as subsidy eligible individuals described in paragraph (1); and

''(II) not described in subclause (I), but who are determined for purposes of the State plan under title XIX to be eligible for medical assistance under clause (i), (iii), or (iv) of section 1902(a)(10)(E), shall be treated as being determined to be subsidy eligible individuals described in paragraph (1).''.

(b) ASSURANCE OF TRANSITIONAL ASSISTANCE UNDER DRUG DISCOUNT CARD PROGRAM.—

(1) IN GENERAL.—Section 1860D–31(b)(2)(A) of the Social Security Act (42 U.S.C. 1395w–141(b)(2)(A)) is amended by adding at the end the following new sentence: ''Subject to subparagraph (B), each discount card eligible individual who is described in section 1860D–14(a)(3)(B)(v) shall be considered to be a transitional assistance eligible individual.''.

(2) AUTOMATIC ENROLLMENT OF MEDICAID BENEFICIARIES.—Section 1860D–31(c)(1) of the Social Security Act (42 U.S.C. 1395w–141(c)(1)) is amended by adding at the end the following new subparagraph:

''(F) AUTOMATIC ENROLLMENT OF CERTAIN BENEFICIARIES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall—

''(I) enroll each discount card eligible individual who is described in section 1860D–14(a)(3)(B)(v), but who has not enrolled in an endorsed discount card program as of August 15, 2004, in an endorsed discount card program selected by the Secretary that serves residents of the State in which the individual resides; and

''(II) notwithstanding paragraphs (2) and (3) of subsection (f), automatically determine that such individual is a transitional assistance eligible individual (including whether such individual is a special transitional assistance eligible individual) without requiring any self-certification or subjecting such individual to any verification under such paragraphs.

''(ii) OPT-OUT.—The Secretary shall not enroll an individual under clause (i) if the individual notifies the Secretary that such individual does not wish to be enrolled and be determined to be a transitional assistance eligible individual under such clause before the individual is so enrolled.''.

(3) NOTICE OF ELIGIBILITY FOR TRANSITIONAL ASSISTANCE.—Section 1860D–31(d) of the Social Security Act (42 U.S.C. 1395w–141(d)) is amended by adding at the end the following new paragraph:

''(4) NOTICE OF ELIGIBILITY TO MEDICAID BENEFICIARIES.—Not later than July 15, 2004, each State or the Secretary (at the option of each State) shall mail to each discount card eligible individual who is described in section 1860D–14(a)(3)(B)(v), but who has not enrolled in an endorsed discount card program as of July 1, 2004, a notice stating that—

''(A) such individual is eligible to enroll in an endorsed discount card program and to receive transitional assistance under subsection (g);

''(B) if such individual does not enroll before August 15, 2004, such individual will automatically enrolled in an endorsed discount card program selected by the Secretary unless the individual notifies the Secretary that such individual does not wish to be so enrolled;

''(C) if the individual is enrolled in an endorsed discount card program during 2004, the individual will be permitted to change enrollment under subsection (c)(1)(C)(ii) for 2005; and

''(D) there is no obligation to use the endorsed discount card program or transitional assistance when purchasing prescription drugs.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2071).

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 357—DESIGNATING THE WEEK OF AUGUST 8 THROUGH AUGUST 14, 2004, AS ''NATIONAL HEALTH CENTER WEEK''

Mr. CAMPBELL (for himself, Mr. DURBIN, Mr. BOND, Mr. HOLLINGS, Mr. KERRY, Mr. BUNNING, Mr. BIDEN, Mrs. MURRAY, Mrs. LINCOLN, Ms. LANDRIEU, Mr. GRASSLEY, Mr. DOMENICI, Ms. COLLINS, Mr. BURNS, Mr. INHOFE, Mr. TALENT, Mr. BENNETT, Mr. JOHNSON, Mr. LUGAR, Ms. CANTWELL, Mr. CRAPO, Mr. DASCHLE, Mr. DAYTON, Mr. CORZINE, Mr. KENNEDY, Mrs. FEINSTEIN, Mr.

COCHRAN, Mr. SMITH, Mr. FEINGOLD, Mr. ALLEN, Mr. INOUYE, Mr. ENZI, Mr. LIEBERMAN, Mr. WYDEN, and Mr. DODD) submitted the following resolution; which was referred to the Committee on the Judiciary:

Whereas community, migrant, public housing, and homeless health centers are nonprofit, community owned and operated health providers and are vital to the Nation's communities;

Whereas there are more than 1,000 such health centers serving 15,000,000 people in over 3,500 communities in every State and territory, spanning urban and rural communities in all 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands;

Whereas these health centers have provided cost-effective, high-quality health care to the Nation's poor and medically underserved (including the working poor, the uninsured, and many high-risk and vulnerable populations), acting as a vital safety net in the Nation's health delivery system, meeting escalating health needs, and reducing health disparities;

Whereas these health centers provide care to individuals in the United States who would otherwise lack access to health care, including 1 of every 8 uninsured individuals, 1 of every 9 Medicaid beneficiaries, 1 of every 7 people of color, and 1 of every 9 rural Americans;

Whereas these health centers and other innovative programs in primary and preventive care reach out to over 621,000 homeless individuals and more than 709,000 migrant and seasonal farm workers;

Whereas these health centers make health care responsive and cost effective by integrating the delivery of primary care with aggressive outreach, patient education, translation, and enabling support services;

Whereas these health centers increase the use of preventive health services such as immunizations, Pap smears, mammograms, and glaucoma screenings;

Whereas in communities served by these health centers, infant mortality rates have been reduced between 10 and 40 percent;

Whereas these health centers are built by community initiative;

Whereas Federal grants provide seed money that empowers communities to find partners and resources and to recruit doctors and needed health professionals;

Whereas Federal grants on average form 25 percent of such a health center's budget, with the remainder provided by State and local governments, Medicare, Medicaid, private contributions, private insurance, and patient fees;

Whereas these health centers are community oriented and patient focused;

Whereas these health centers tailor their services to fit the special needs and priorities of communities, working together with schools, businesses, churches, community organizations, foundations, and State and local governments;

Whereas these health centers contribute to the health and well-being of their communities by keeping children healthy and in school and helping adults remain productive and on the job;

Whereas these health centers engage citizen participation and provide jobs for over 70,000 community residents; and

Whereas designating the week of August 8 through August 14, 2004, as ''National Health Center Week'' would raise awareness of the health services provided by health centers: Now, therefore, be it

Resolved, That the Senate—

(1) designates the week of August 8 through August 14, 2004, as ''National Health Center Week''; and

(2) requests that the President issue a proclamation calling upon the people of the United States to observe the week with appropriate ceremonies and activities.

Mr. CAMPBELL. Mr. President, today I am submitting a resolution declaring the week of August 8, 2004, as a National Health Center Week dedicated to raising awareness of health services provided by community, migrant, public housing, and homeless health centers. I am pleased to be joined in this effort by Senator DURBIN and 31 of our colleagues.

The resolution expresses the sense of Congress that these health centers contribute to the health and well-being of their communities by keeping children healthy and in school and helping adults remain productive and on the job.

The resolution also recognizes health centers for providing cost-effective, high-quality health care to the Nation's poor and medically underserved, and by acting as a vital safety net in the Nation's health delivery system. These nonprofit, community-based centers are performing a vital service to our country's more vulnerable populations and they are to be commended for their efforts.

Health centers throughout the country have a 30-year history of success. Studies continue to show that the centers effectively and efficiently improve our Nation's health.

Last year, the community health centers in my State of Colorado provided care to 372,000 patients, and 41 percent of those patients were children under the age of 19. Of the patients seen in Colorado in 2003, 45 percent had no health insurance, 30 percent were Medicaid recipients and 87 percent had family incomes less than $36,200 a year for a family of four. Community health centers are truly America's healthcare safety net.

I believe it is important that we support and honor this nationwide network of community based providers. That is why I urge my colleagues to act quickly on this legislation. Let's show our community health center network that we value its significant contribution to the health of our citizens by declaring the week of August 8, 2004, a National Health Center Week.

SENATE RESOLUTION 358—EXPRESSING THE SENSE OF THE SENATE THAT NO LATER THAN DECEMBER 31, 2006, LEGISLATION SHOULD BE ENACTED TO PROVIDE EVERY INDIVIDUAL IN THE UNITED STATES WITH THE OPPORTUNITY TO PURCHASE HEALTH INSURANCE COVERAGE THAT IS THE SAME AS, OR IS BETTER THAN, THE HEALTH INSURANCE COVERAGE AVAILABLE TO MEMBERS OF CONGRESS, AT THE SAME OR LOWER RATES

Mr. DASCHLE (for himself, Mr. GRAHAM of Florida, Mr. KENNEDY, Ms. STABENOW, Mr. KERRY, Mr. DURBIN, Mr. CORZINE, Mr. LAUTENBERG, Mrs. MURRAY, Mr. INOUYE, Mr. DAYTON, Mr. JOHNSON, Mr. LEVIN, Mr. WYDEN, Mr. EDWARDS, Mrs. BOXER, Mr. FEINGOLD, Mr. JEFFORDS, Mr. BINGAMAN, and Mr. LEAHY) submitted the following resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. RES. 358

Whereas the number of uninsured people in the United States has grown to 43,600,000, an increase of 3,800,000 since 2000;

Whereas nearly 20 percent of uninsured Americans are children;

Whereas 8 out of 10 uninsured people in the United States come from working families;

Whereas members of racial and ethnic minority groups at all income levels are more likely to be uninsured than their white counterparts;

Whereas the United States is the only major industrialized country that does not guarantee health care to all of its citizens;

Whereas the United States has the highest health care spending per capita, but consistently scores near the bottom in infant mortality and life expectancy when compared with other developed, high-income countries;

Whereas those without insurance are more likely to go without necessary medical care and preventive services;

Whereas millions of Americans who have insurance coverage are underinsured;

Whereas the Institute of Medicine has estimated that the lost economic value of uninsurance is between $65,000,000,000 and $130,000,000,000 each year, and the Kaiser Family Foundation has concluded that uninsured Americans could incur nearly $41,000,000,000 in health care treatment in 2004;

Whereas the financial consequences of uninsurance are disastrous for families, as demonstrated by a recent study that found medical problems were a factor in 45 percent of all non-business bankruptcy filings;

Whereas employer-based insurance premiums grew 13.9 percent between 2002 and 2003, the third consecutive year of double-digit increases;

Whereas a recent study by the Commonwealth Fund concluded that small employers that provide health insurance to their employees pay more but receive less for their money while suffering faster increases in premiums and steeper jumps in deductibles than large firms;

Whereas public programs such as medicare, medicaid, the State Children's Health Insurance Program, the Indian Health Service, the Veterans Health Administration, and TRICARE, play a critical role in providing coverage for millions of Americans, but are often underfunded;

Whereas the market for individual insurance policies is extremely expensive and allows for discrimination based on health status, age, and gender; and

Whereas members of Congress and their families have the opportunity to select among many benefit choices and to purchase high quality, group health insurance coverage at reasonable rates: Now, therefore, be it

Resolved, That it is the sense of the Senate that no later than December 31, 2006, legislation should be enacted to provide every individual in the United States with the opportunity to purchase health insurance coverage that is the same as, or is better than, the health insurance coverage available to members of Congress, at the same or lower rates.

SENATE RESOLUTION 359—DESIGNATING THE WEEK OF APRIL 11 THROUGH APRIL 17, 2004, AS ''FREE ENTERPRISE EDUCATION WEEK''

Mr. COLEMAN submitted the following resolution; which was considered and agreed to:

S. RES. 359

Whereas the United States values the free enterprise system as its basic economic system;

Whereas the elementary schools and secondary schools of the United States should strive to educate their students about the importance of the free enterprise system;

Whereas an understanding of the free market system by the youth of the United States is necessary to the United States' long-term economic growth;

Whereas companies, student organizations, and teachers in the United States are willing and able to participate in educating young people about free markets and opportunities; and

Whereas many organizations, such as Students in Free Enterprise, have developed programs to teach and encourage entrepreneurship among students: Now, therefore, be it

Resolved, That the Senate—

(1) designates the week of April 11 through April 17, 2004, as ''Free Enterprise Education Week'';

(2) encourages schools and businesses in the United States to educate students about the free enterprise system; and

(3) requests that the President issue a proclamation calling on the people of the United States and interested groups to observe the week with appropriate ceremonies, activities, and programs.

SENATE CONCURRENT RESOLUTION 107

Mr. LIEBERMAN submitted the following concurrent resolution; which was considered and agreed to:

Whereas Congress hosted the first American Association for the Advancement of Science (AAAS) Congressional Science and Engineering Fellows in 1973;

Whereas the AAAS Congressional Science and Engineering Fellowship Program was the first to provide an opportunity for Ph.D.-level scientists and engineers to learn about the policymaking process while bolstering the technical expertise available to members of Congress and their staff;

Whereas members of Congress hold the AAAS Congressional Science and Engineering Fellowship Program in high regard for the substantial contributions that AAAS Congressional Science and Engineering Fellows have made, serving both in personal offices and on committee staff;

Whereas Congress is increasingly involved in public policy issues of a scientific and technical nature, and recognizes the need to develop additional in-house expertise in the areas of science and engineering;

Whereas more than 800 individuals have held AAAS Congressional Science and Engineering Fellowships since 1973;

Whereas the AAAS Congressional Science and Engineering Fellows represent the full range of physical, biological, and social sciences and all fields of engineering;

Whereas the AAAS Congressional Science and Engineering Fellows bring to Congress new insights and ideas, extensive knowledge, and perspectives from a variety of disciplines;

Whereas the AAAS Congressional Science and Engineering Fellows learn about legislative, oversight, and investigative activities through assignments that offer a wide array of responsibilities;

Whereas AAAS Congressional Science and Engineering Fellowships provide an opportunity for scientists and engineers to transition into careers in government service; and

Whereas many former AAAS Congressional Science and Engineering Fellows return to their disciplines and share knowledge with students and peers to encourage more scientists and engineers to participate in informing government processes: Now, therefore be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) recognizes the significance of the 30th anniversary of the American Association for the Advancement of Science Congressional Science and Engineering Fellowship Program;

(2) acknowledges the value of over 30 years of participation in the legislative process by the AAAS Congressional Science and Engineering Fellows; and

(3) reaffirms its commitment to support the use of science in governmental decisionmaking through the AAAS Congressional Science and Engineering Fellowship Program.

SENATE CONCURRENT RESOLUTION 108—SUPPORTING THE GOALS AND IDEALS OF TINNITUS AWARENESS WEEK

Mr. LIEBERMAN (for himself, Mrs. LINCOLN, and Mr. WYDEN) submitted the following concurrent resolution; which was considered and agreed to:

Whereas 50,000,000 individuals in the United States have experienced tinnitus, the perception of noises or ringing in the ears and head when no external sound source is present;

Whereas 12,000,000 individuals in the United States experience tinnitus to an incessant and debilitating degree, such that the sounds in their ears and heads never abate, forcing them to seek assistance from a health care professional;

Whereas tinnitus is frequently caused by exposure to loud noises in the workplace, where an estimated 30,000,000 individuals in the United States are exposed to injurious levels of noise each day, and where noise-induced hearing loss is the most common occupational injury;

Whereas tinnitus is also caused by exposure to loud noises in recreational settings, where levels of sound can reach traumatic levels, and where individuals frequently are not aware that temporary ringing in the ears can become permanent after continued exposure to loud levels of sound;

Whereas in many cases, simply wearing proper hearing protection would protect individuals from damaging their hearing;

Whereas many individuals with tinnitus are told that the only solution to their condition is to learn to live with it, even though treatments for tinnitus are available that can help reduce the stress of the incessant ringing and increase the coping skills and quality of life for individuals who experience this condition; and

Whereas the American Tinnitus Association has designated the week beginning May 15, 2004, as the first National Tinnitus Awareness Week, in order to raise public awareness and to further its mission to silence tinnitus through education, advocacy, research, and support: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) supports the goals and ideals of National Tinnitus Awareness Week, as designated by the American Tinnitus Association;

(2) encourages interested groups and affected persons to promote public awareness of tinnitus, the dangers of loud noise, and the importance of hearing protection for all individuals; and

(3) commits to continuing its support of innovative hearing health research through the National Institutes of Health, particularly through the National Institute on Deafness and Other Communication Disorders, so that treatments for tinnitus can be refined and a cure for tinnitus can be discovered.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3144. Mr. HARKIN (for himself, Mr. HAGEL, Mr. KENNEDY, Ms. COLLINS, Mr. JEFFORDS, Mr. COLEMAN, Mrs. CLINTON, Mr. ROBERTS, Ms. MIKULSKI, Mr. DODD, Mr. REED, Ms. STABENOW, Mr. LEVIN, Mr. ROCKEFELLER, Mr. CORZINE, Mr. SCHUMER, Mr. WARNER, Ms. MURKOWSKI, Mr. JOHNSON, Mrs. LINCOLN, and Mr. PRYOR) proposed an amendment to the bill S. 1248, to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

SA 3145. Mr. GREGG proposed an amendment to the bill S. 1248, supra.

SA 3146. Mrs. CLINTON proposed an amendment to the bill S. 1248, supra.

SA 3147. Mr. GREGG (for himself, Mr. ENZI, and Mr. GRASSLEY) proposed an amendment to the bill S. 1248, supra.

SA 3148. Mrs. MURRAY (for herself, Mr. DEWINE, and Mr . FEINGOLD) proposed an amendment to the bill S. 1248, supra.

SA 3149. Mr. GREGG (for Mr. SANTORUM) proposed an amendment to the bill S. 1248, supra.

TEXT OF AMENDMENTS

SA 3144. Mr. HARKIN (for himself, Mr. HAGEL, Mr. KENNEDY, Ms. COLLINS, Mr. JEFFORDS, Mr. COLEMAN, Mrs. CLINTON, Mr. ROBERTS, Ms. MIKULSKI, Mr. DODD, Mr. REED, Ms. STABENOW, Mr. LEVIN, Mr. ROCKEFELLER, Mr. CORZINE, Mr. SCHUMER, Mr. WARNER, Ms. MURKOWSKI, Mr. JOHNSON, Mrs. LINCOLN, and Mr. PRYOR) proposed an amendment to the bill S. 1248, to reauthorize the Individuals with Disabilities Education Act, and for other purposes; as follows:

In section 611 of the Individuals with Disabilities Education Act (as amended by section 101 of the bill) strike subsection (i) and insert the following:

''(i) FUNDING.—

''(1) IN GENERAL.—For the purpose of carrying out this part, other than section 619, there are authorized to be appropriated—

''(A) $12,268,000,000 or the maximum amount available for awarding grants under subsection (a)(2), whichever is lower, for fiscal year 2005, and, there are hereby appropriated $2,200,000,000 for fiscal year 2005, which shall become available for obligation on July 1, 2005 and shall remain available through September 30, 2006, except that if the maximum amount available for awarding grants under subsection (a)(2) is less than $12,268,000,0000, then the amount appropriated in this subparagraph shall be reduced by the difference between $12,268,000,000 and the maximum amount available for awarding grants under subsection (a)(2);

''(B) $14,468,000,000 or the maximum amount available for awarding grants under subsection (a)(2), whichever is lower, for fiscal year 2006, and, there are hereby appropriated $4,400,000,000 for fiscal year 2006,