ENERGY AND NATURAL RESOURCES

Mr. BURNS. Mr. President, today I join Senators DOMENICI, BINGAMAN, TALENT and DORGAN in sponsorship of legislation instructing the Secretary of the Interior to develop an oil and gas leasing program for Lease Area 181, located 100 miles off the coast of Florida in the Gulf of Mexico.

As oil and natural gas prices continuously increase, many Americans, especially Montanans, are feeling the strain of increased prices for energy use in their homes and businesses. Montana ag producers are particularly hard hit because the costs of fuel and fertilizer have skyrocketed. While I strongly support the idea of renewable energies, it will take years of research and development before there are practicable and affordable alternatives to oil and natural gas. Development of the American-owned offshore Lease Area 181 would provide nearly 5 trillion cubic feet of natural gas as a near term solution for our country's growing energy needs. That amount would be enough to heat 5 million homes for 15 years.

In order to strengthen American energy security, it is our obligation to use our own domestic resources whenever we can. Offshore drilling has proven to be a safe, reliable, and valuable technology for oil and gas production. Lease Area 181 is a phenomenal resource, and time after time in energy committee hearings when we ask expert witnesses for their opinions on how to best stabilize and lower natural gas prices, the answer is, ''Open Lease Area 181.'' It is not the entire answer to our energy challenges, but it is an important step forward. I applaud the leadership of the chairman and ranking member of the Energy and Natural Resources Committee for acting on this important issue. Next, I hope we examine the potential for additional onshore resource development. I come from an energy producing state, and I can tell you, without reservation, that Montana stands ready to serve the energy needs of this country. We have oil, natural gas, more coal than any other state, and a great potential for wind energy.

I am confident that my fellow Senators will see the value in providing a supply of affordable energy from our domestic resources, and hope the Senate acts quickly on this important legislation.

LOCAL LAW ENFORCEMENT ENHANCEMENT ACT OF 2005

Mr. SMITH. Mr. President, today, I speak about the need for hate crimes legislation. Each Congress, Senator KENNEDY and I introduce hate crimes legislation that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society. Likewise, each Congress I have come to the floor to highlight a separate hate crime that has occurred in our country.

On January 11, 2006 in Stuart, FL, two men allegedly beat and robbed John Sprunger, a mentally handicapped man for $150. Earl Shanks called his friend Raymond Lee Dawson to the home of the victim, after trying to get Sprunger to give him money. When Dawson entered the home, he pistol-whipped Sprunger, and, assisted by Shanks, got his wallet before both men left the trailer.

I believe that the Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

RECOGNITION OF TOBEY SCHULE

Mr. BAUCUS. Mr. President, I rise today to recognize Mr. Tobey Schule, of Kalispell, MT, for his valuable testimony today before the Senate Finance Committee.

The Senate Finance Committee played a key role in enacting Medicare drug benefits. We must be diligent in overseeing their implementation. In 2003, after years of debate, Congress added prescription drug coverage to Medicare. I was proud to help pass that law. The law was not perfect. But it has the potential to do some good.

The Medicare drug bill has the potential to make prescription drugs available to millions who could not otherwise afford them. It has the potential to make drugs available that will lessen pain. It has the potential to save lives.

Unfortunately, the administration has implemented the new law poorly. After Congress passed the law, the Centers for Medicare and Medicaid Services—CMS—had the duty to ensure that Medicare drug benefits were up and running by January 1, 2006. I appreciate CMS's efforts to implement the new law. It is a huge task. CMS worked hard. But CMS's efforts have come up short, in two major areas.

First, CMS made the new drug benefit needlessly confusing.

As part of the new law, Congress passed a temporary drug discount card, available in 2004. The card was supposed to give temporary relief from high drug costs. Seniors of modest means were eligible for a $1,200 Federal subsidy for their drug purchases.

But most Medicare beneficiaries did not sign up for the drug card. Why? They were paralyzed by the choices. CMS approved 40 Medicare drug cards in my State of Montana alone. Instead of celebrating their choices, most seniors in my State decided not to sign up.

Less than a year later, CMS was approving drug plans for the new drug benefit. I urged CMS not to repeat the mistakes that they made with the drug card. I urged CMS to approve only plans meeting the highest standards.

But CMS repeated the mistakes of the drug card. CMS approved dozens of plans for participation in the new drug program. CMS approved more than 40 drug plans in Montana. I support choice, competition, and the free market. It is great that Americans can choose from hundreds of different models when buying a new car. But when people don't know what they are buying, choice can lead to confusion. That is particularly true of health care.

Ask elderly Americans whether they prefer a four-speed automatic or a five-speed manual, and they will probably choose the automatic. Ask them whether they prefer a drug plan with a four-tiered formulary to a plan with five, and they will probably look at you with a mixture of confusion and anger.

My second concern relates to the warnings that CMS ignored. Last year, I asked the independent Government Accountability Office to report on CMS's plans for seniors eligible for both Medicaid and Medicare. I asked: What were CMS's plans for seniors whose drug coverage was moving from Medicaid to Medicare? In December 2005, GAO reported that CMS's plans were insufficient to avoid big disruptions in coverage.

CMS disagreed. CMS said: ''[We have] worked diligently on the transition from Medicaid to Medicare drug coverage . . . and . . . these individuals will get effective, comprehensive prescription drug coverage . . . on January 1, 2006.''

That did not happen. GAO was right. Data systems failed. Pharmacists and States were stuck with the bill for copays that should never have been charged. And some vulnerable seniors left the pharmacy without the medicines that they needed.

Today the Finance Committee heard from Tobey Schule, an independent pharmacist from Kalispell, MT. Mr. Schule is one of thousands of pharmacists who have been burdened with the failed transition from Medicaid to Medicare. I will ask that his testimony from today's hearing be submitted in the CONGRESSIONAL RECORD, next to my remarks.

Last month, Secretary Leavitt and Doctor McClellan briefed members of this committee on problems implementing the new drug program. They outlined seven specific problems. And they outlined plans to fix them. I appreciate CMS's attempts to fix the problems. But some problems remain unsolved. Dr. McClellan, I look forward to hearing how and when CMS plans to fix the problems.

In addition to ensuring that the implementation flaws are fixed, Congress should also address the problem of confusion. We can do that by learning the lessons of Medigap. In 1980, Congress enacted amendments that I offered to fix marketing abuses and consumer confusion with Medigap. The reforms

required Medigap issuers to meet minimum standards and have minimum loss ratios.

Ten years later, Congress again took up Medigap reform, passing legislation to standardize Medigap policies. Ten different Medigap options would be offered, each with a basic set of benefits. This gave consumers an apples-to-apples comparison of Medigap coverage.

We should do the same with the new drug program. We should standardize the drug plans. We should make it easier for people to make good choices about which plan is best for them. I intend to introduce legislation to do just that.

I understand that the drug benefit is young. But I want this benefit to work. We simply cannot afford another round of confusion. We need broad participation. And that's not going to happen unless we make the program more accessible and understandable. I supported enactment of the Medicare drug benefit in 2003. I still support it. Health insurance needs to cover prescription drugs. But we need to make it work. And I look forward to hearing from our witnesses on how we can do so.

I thank Mr. Schule for taking time from his important work to tell the committee about his experiences with the new Medicare drug benefit.

Mr. President, I ask unanimous consent that Mr. Schule's testimony be printed in the RECORD.

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

Chairman GRASSLEY, Senator BAUCUS, members of the Committee, I appreciate the privilege and opportunity to speak about Medicare Part D and how it is affecting my patients and pharmacy.

I am the co-owner of a small independent pharmacy in Kalispell, Montana that was established in 1981. There are about 32,000 people in Kalispell and the surrounding areas; we are 200 miles from the state capitol in Helena. Our pharmacy employs two pharmacists, my son and me, and two pharmacy technicians. There are five senior apartment buildings within three blocks of the pharmacy, and we serve primarily geriatric patients. In addition, we provide weekly medication box exchange for three assisted living facilities and the mental health center in our community. About ninety percent of our walk-in patients are elderly.

Medicare Part D has become a major factor in my pharmacy. I contracted with every company offering drug plans in Montana, so I could continue to serve my patients. I would like to address my concerns with this new benefit, in the following four areas: confusion among patients and pharmacists, education and outreach, coverage of dual-eligibles, and burden on pharmacists.

The implementation of Part D has caused confusion and frustration for my patients. And it has caused confusion and frustration for me. This program doesn't need to be so complicated.

The frustration and confusion for my patients began last summer, when they started receiving information from insurance companies offering Medicare Part D coverage. With over 40 plans to choose from in Montana, my patients said they were scared and intimidated by all of the options. Many of my patients were not fortunate enough to have a family member help them through the process of deciding which plan was best for them. I work with the elderly every day, and this has been overwhelming for them. Bewildered by the complexity, some patients are choosing not to enroll.

Those patients who could make sense of the Medicare mailings faced new obstacles. They were instructed to check the internet to see if the coverage was appropriate for their individual situation. I question this approach, since the vast majority of my elderly patients do not have computers and cannot use the internet. Access to the information through the 1–800 Medicare number was not much better. The phone systems are automated, and many of my elderly patients are unable to navigate through them. Others had the ability to use the phone system but gave up because of long hold times.

Despite this enormous confusion, there were few opportunities for Kalispell patients and pharmacists to get answers. Several meetings were sponsored by the state of Montana, by insurance companies and by senior citizen advocates to help the elderly make their choices and explain Medicare Part D. After attending these sessions, many patients came back to my pharmacy saying they were even more confused. Patients received different answers from different people. They had trouble understanding the literature that they received, and felt a lawyer was necessary to make heads or tails out of it.

On top of this complexity, elderly patients feared they would select the wrong plan. At educational events, patients were instructed to focus on the formularies and pick one that had their medications on the list. But patients found only some of their drugs listed on formularies, requiring patients to choose between medications.

Education for pharmacists wasn't much better. I heard of only one event sponsored by CMS to educate pharmacists, and that was in Billings, nearly 500 miles from my store. I could not attend this meeting, although I did send a pharmacy technician to a local educational event sponsored by an insurance counselor. This seminar did not help us serve our patients enrolling in Part D. But it did help us understand why our patients were so frustrated.

With little information coming from CMS or the insurance plans, I relied on my drug wholesaler to learn how to handle patient in Part D. For instance, in mid-December I called my software vendor to ask how I would determine patients' Part D drug coverage. It was only through this call that I learned about the E–1 transaction, which shows patient plan eligibility. I now use this system many times a day when trying to figure out a patient's coverage, but I had to learn about it on my own.

Over the last few weeks, drug plans have been my only source of information describing the administrative procedures that I must follow to provide drugs and submit claims. But this information is often incomplete. I recently received a notice that patients enrolling in Part D in late January wouldn't be in the system on February 1st. So the problems we heard about at the beginning of January are happening again.

Many of my patients have both Medicaid and Medicare. These ''dual-eligibles'' were automatically enrolled into the new drug plans as their drug coverage was shifted from Medicaid to Medicare. Unfortunately, these plans did not always meet patients' medical needs. I found many patients' medications were not covered by their plans.

Further complicating matters, information systems did not recognize these patients as dually-eligible. They could not afford the high co-pays that the system said they should be charged. I handled each patient on a case-by-case basis, and it required a huge time commitment to sort out problems in drug plan data and information systems. Fortunately, we are a small pharmacy and we know all of our patients. So we were able to give them their medications on the spot. I cannot help but think of how many patients across the country must have gone without their medications. Now we are working through billing issues, trying to determine how we will be reimbursed.

I am very concerned for my patients because we are being forced to change their medications to match the formulary for their plan. By changing medication, I expect to see increases in physician visits, labs, and hospitalizations. This will increase costs to the program. Medicare should have a plan to track the costs associated with medication changes.

Some of the plans are offering the mail-order pharmacy, and I do not think that mail-order should even be an option for Medicare Part D. If patients are getting some medications from mail-order and others from local pharmacies there is no continuity of care. This lack of coordination between mail-order and bricks-and-mortar pharmacies increases the likelihood of adverse events and noncompliance. If a patient using mail-order pharmacy is hospitalized, it is very difficult for doctors at the hospital to get drug information when prescriptions are not filled locally. If patients need drug information about a medication and are using mail order, they must attempt to use automated phone systems. In contrast, local pharmacists are readily available to answer questions. The ordering process of mail-order is also difficult for the elderly. These patients have trouble remembering to order a medication before they run out, but if they order too soon the script will not be processed.

As a pharmacist I want to know how certain medications were picked for the formularies. An example is why is one plan using Zocor and another is using Lipitor. I would like to know why some formularies use a branded drug when a generic is available. This appears costly to the program.

As the program began on January 1st, it became apparent that the insurance companies were not prepared for the start. Patients had not received their cards or enrollment letters. When this documentation had been received, the information was often incomplete. Missing data included BIN numbers, group numbers, ID numbers and processor control numbers. When I tried to access through the E–1 system, patients would come back as not enrolled. I was not able to bill the appropriate plan.

We have spent a tremendous amount of time on the phones with the different companies getting patient billing information or prior authorization to fill. We have been on hold to talk to a representative for as long as four hours before we were able to get through. In other cases, we were simply disconnected after hours on the phone. This is unacceptable.

Drug plans are sending out lists of the pharmacies associated with their plan. While I have contracted with every plan offered in Montana, my pharmacy is not on every company's list. As a result, several of my patients have come in very upset because they think they will have to change pharmacies. I tell my patients that I can fill for them even though I am not on the list. Insurance companies should not send only a partial list of in-network pharmacies. It should be all or nothing. Also, I think that it is totally unacceptable for the drug plans to co-brand patient insurance cards with Wal-Mart, Walgreens, or other chain drug stores. It is

confusing to the patient, leading them to think that they can only go to those pharmacies.

The insurance companies have created problems on the business side of my practice. There is no ''negotiation'' between pharmacists and drug plans on reimbursement rates. If I am going to continue serving my patients, I am forced to accept the low rates offered by insurance companies. Plans are slow to pay claims, and my drug wholesaler requires that I pay for drugs much more quickly than the plans pay me. My pharmacy has over $45,000 in unpaid claims from Medicare Part D.

Pharmacist and pharmacy technician salaries are climbing because of the shortage of available personnel. I am not sure how long independent pharmacies will be able to stay in business with the low reimbursement rates.

I wish that before this program started on January 1st that Medicare and the insurance companies would have taken the time to truly consider the elderly. If the people setting up the program had thought about the needs of their own elderly parents, I am sure this plan would be different.

Chairman GRASSLEY, Senator BAUCUS and Members of the Committee, thank you again for inviting me to appear before you here today. I will now answer any questions you may have.

ADDITIONAL STATEMENTS

RECOGNITION OF THE CALIFORNIA TEAMSTERS HISPANIC CAUCUS

● Mrs. BOXER. Mr. President, I rise to recognize the important work and accomplishments of the California Teamsters Hispanic Caucus. I am also pleased to commend International Brotherhood of Teamsters, IBT, General President James P. Hoffa, and General Secretary-Treasurer C. Thomas Keegel for their continued support of the California Teamsters Hispanic Caucus's efforts in awarding educational scholarships and conducting community improvement and community education programs.

The California Teamsters Hispanic Caucus, formed in 1989 as a nonprofit organization, has experienced phenomenal growth and success. Since the Hispanic Caucus' early beginnings, membership has grown to include more than 250 active members. The support that the caucus has provided to its members has also grown throughout the years. In nearly two decades of service, the Hispanic Caucus has increased the number of its educational scholarships from 3 to nearly 20 and has distributed more than $200,000.

Both General President Hoffa and General Secretary-Treasurer Keegel have shown tremendous support for the California Teamsters Hispanic Caucus through their involvement in increasing the availability of educational scholarship funding and participation in annual Hispanic Caucus events. Their work, in combination with the fine work of the Hispanic Caucus, has allowed the children of Teamsters to continue their education and pursue their dreams.

I invite all of my colleagues to join me in commending the California Teamsters Hispanic Caucus, International Brotherhood of Teamsters General President James P. Hoffa and General Secretary-Treasurer C. Thomas Keegel for their continued support for education, for strong communities, and for all working people.●

IN MEMORIAM OF CORETTA SCOTT KING

● Mr. CARPER. Mr. President, I rise today to honor the life of Coretta Scott King, who peacefully left this world on Monday, January 30, 2006, at the age of 78.

Coretta Scott King was born on April 27, 1927, in Marion, AL, during a time of great social injustice. Despite the many barriers that society had placed in front of her, she refused to let hate and prejudice stand in the way of her dreams. She was valedictorian of her graduating class at Lincoln High School and went on to receive a B.A. in music and education from Antioch College in Yellow Springs, OH. She also earned a degree in voice and violin at Boston University's New England Conservatory of Music. It was during this time that she met Martin Luther King, Jr., who was then studying for his doctorate in systematic theology at Boston University. They married on June 18, 1953, and began their lives together in Montgomery, AL.

As Dr. Martin Luther King, Jr., began his civil rights work, Mrs. King worked closely with him by organizing marches and arranging sit-ins at segregated restaurants to draw attention to the unfairness of Jim Crow laws. She also played a central role behind the scenes of many of the major civil rights campaigns of the 1950s and 1960s. She was by her husband's side when he received the Nobel Peace Prize in 1964 and walked by his side during the infamous march from Selma to Montgomery in 1965 that eventually led to the passage of the Voting Rights Act. Mrs. King also performed in ''Freedom Concerts'' where she would sing songs and read poetry to help raise money for the Southern Christian Leadership Conference, the organization that Dr. King led during the civil rights movement.

Following her husband's death on April 4, 1968, Mrs. King demonstrated remarkable strength and courage by continuing the struggle to bring equality to all Americans. She established the Atlanta-based Martin Luther King, Jr. Center for Nonviolent Social Change as a living memorial to her husband and his dream of social equality. During the 1980s, Mrs. King participated in a series of sit-in protests to highlight the inequality of South Africa's racial policies.

Mrs. King also led the campaign to establish Dr. King's birthday as a national holiday. In 1983, Congress instituted the Martin Luther King, Jr. Federal Holiday Commission, which she chaired during its duration. And on January 20, 1986, the Nation celebrated the first Martin Luther King, Jr. Federal holiday.

Mrs. King has received honorary doctorates from more than 60 colleges and universities, has authored three books and has served on, and helped found, dozens of organizations including the Black Leadership Forum, the National Black Coalition for Voter Participation, and the Black Leadership Roundtable.

I rise today to celebrate the life and accomplishments of Mrs. Coretta Scott King. As wife, mother, social activist, musician, and author, she used her words and actions to spread the message of racial equality and justice throughout the world. I hope that her vision, as well as the vision of her late husband, Dr. Martin Luther King, Jr., will continue to live on in all of us through our work and our deeds.●

A TRIBUTE TO GEORGE WEEKS

● Mr. LEVIN. Mr. President, for the past 22 years, George Weeks' column for the Detroit News has been required reading for anyone interested in Michigan politics. It has been the gold standard for fair, insightful commentary, and I am proud to have known and worked with George over these years. Our mornings—and our public life—won't be the same without him.

George Weeks' life and career have been spent in service to the people of Michigan. In a journalism career that took him to Lansing, MI; to Washington, DC; and around the world, George Weeks always put his responsibility to his readers first. And although we are honoring him today for his legendary accomplishments as a reporter and columnist, George also served his State as chief of staff to Governor William Milliken and his country in the U.S. Army.

In his work as a political columnist, it has seemed at times that George knows everything that is happening or has ever happened in Michigan. He reports on which candidate wowed the crowd—or otherwise—at a recent dinner, what issues are resonating with voters, and who he thinks has the right stuff to go all the way—or the other kind of stuff. His column is a treasure trove of political information. And not only does he have great information, he is also able to put it into perspective. George has a deep knowledge of history. He has written a history of Michigan through the lens of its governors as well as several works on Michigan's Native Americans. Although I admire his trove of knowledge, I do wish he would quit reminding me—and his readers—of how many years I have served in the Senate, a metaphor for the aging process.

George has earned both the loyalty of his readers and the respect and admiration of those he covers. His approach is impartial, issue-oriented, and assumes good faith on the part of public figures. He starts from a belief that public officials of both parties are motivated