The preamble, as modified, was agreed to.

The resolution, with its preamble, as modified, reads as follows:

S. RES. 19

Whereas Gerald Rudolph Ford, the 38th President of the United States, was born on July 14, 1913, in Omaha, Nebraska;

Whereas Gerald Ford was raised in Grand Rapids, Michigan, where he was active in the Boy Scouts, achieving the Eagle Scout rank, and where he excelled as both a student and an athlete during high school;

Whereas after graduating from high school, Gerald Ford attended the University of Michigan at Ann Arbor, where he played on the university's national championship football teams in 1932 and 1933, and was honored as the team's most valuable player in 1934, before graduating with a B.A. degree in 1935;

Whereas Gerald Ford later attended Yale Law School and earned an LL.B. degree in 1941, after which he began to practice law in Grand Rapids;

Whereas Gerald Ford joined the United States Naval Reserve in 1942 and served his country honorably during World War II;

Whereas upon returning from his service in the military, Gerald Ford ran for the United States House of Representatives and was elected to Congress;

Whereas Gerald Ford served in the House of Representatives from January 1949 to December 1973, winning reelection 12 times, each time with more than 60 percent of the vote;

Whereas Gerald Ford served with great distinction in Congress, in particular through his service on the Defense Appropriations Subcommittee, of which he rose to become ranking member in 1961;

Whereas in addition to his work in the House of Representatives, Gerald Ford served as a member of the Warren Commission, which investigated the assassination of President John F. Kennedy;

Whereas, in 1965, Gerald Ford was selected as minority leader of the House of Representatives, a position he held for 8 years;

Whereas after the resignation of Vice President Spiro Agnew in 1973, Gerald Ford was chosen by President Richard Nixon to serve as Vice President of the United States;

Whereas following the resignation of President Nixon, Gerald Ford took the oath of office as President of the United States on August 9, 1974;

Whereas upon assuming the presidency, Gerald Ford helped the nation heal from one of the most difficult and contentious periods in United States history, and restored public confidence in the country's leaders;

Whereas Gerald Ford's basic human decency, his integrity, and his ability to work cooperatively with leaders of all political parties and ideologies, earned him the respect and admiration of Americans throughout the country;

Whereas the John Warner National Defense Authorization Act for Fiscal Year 2007 recommended that America's next nuclear-powered aircraft carrier, designated as CVN-78, be named as the U.S.S. Gerald R. Ford, in honor of our 38th President; and

Whereas Gerald Ford was able to serve his country with such great distinction in large part because of the continuing support of his widely admired wife, Elizabeth (Betty), who also has contributed much to the nation in many ways, and of their 4 children, Michael, John, Steven, and Susan: Now, therefore, be it

*Resolved,* That the Senate notes with deep sorrow and solemn mourning the death of President Gerald Rudolph Ford.

*Resolved,* That the Senate extends its heartfelt sympathy to Mrs. Ford and the family of President Ford.

*Resolved,* That the Senate honors and, on behalf of the nation, expresses deep appreciation for President Ford's outstanding and important service to his country.

*Resolved,* That the Senate directs the Secretary of the Senate to communicate these resolutions to the House of Representatives and transmit a copy thereof to the family of the former President.

The PRESIDING OFFICER. The majority leader is recognized.

## MORNING BUSINESS

Mr. REID. Mr. President, I ask unanimous consent that there now be a period for the transaction of morning business, with Senators allowed to speak therein for up to 10 minutes each.

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

Mr. REID. Mr. President, I further ask unanimous consent that Senator SALAZAR be recognized for up to 5 minutes, followed by Senator ALLARD for up to 5 minutes.

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

The Senator from Colorado.

Mr. SALAZAR. I thank the Chair.

(The remarks of Mr. SALAZAR and Mr. ALLARD pertaining to the introduction of S. 194 are printed in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

The PRESIDING OFFICER. The Senator from Maine is recognized.

Ms. COLLINS. Mr. President, I ask unanimous consent that I be permitted to proceed for 17 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Ms. COLLINS. Mr. President, before the two Senators from Colorado leave the floor, let me just indicate that the legislation they introduced to honor former President Ford would be referred to the Homeland Security and Governmental Affairs Committee, and as the ranking member of that committee, I wish to pledge my cooperation to them in moving this legislation. It is a fitting tribute.

Mr. ALLARD. I thank the Senator from Colorado. I appreciate all her fine work on that committee, and I really appreciate it for all the people of Colorado.

## ACCESS TO AFFORDABLE HEALTH CARE ACT

Ms. COLLINS. Mr. President, last week, on the very first day of this new Congress, I joined with my colleague from Louisiana, Senator MARY LANDRIEU, in introducing the Access to Affordable Health Care Act. This is a comprehensive plan which builds on the strengths of our current public programs and private health care system to make affordable health care available to millions more Americans. It is similar to legislation we introduced in the last Congress. I hope, given the urgency of dealing with the cost of health care and health insurance, that this will be the year this legislation moves forward.

One of my priorities in the Senate has long been to expand access to affordable health care. There are still far too many Americans without health insurance or with woefully inadequate coverage. As many as 46 million Americans are uninsured, and millions more are underinsured. The State of Maine is in the midst of a growing health insurance crisis, with insurance premiums rising at alarming rates. Whether I am talking to a self-employed fisherman, a displaced mill worker, the owner of a struggling small business, or the human resources manager of a large company, the soaring costs of health insurance are a common concern. These cost increases, double digit this past year, have been particularly burdensome for small businesses, the backbone of the Maine economy.

Maine's small business owners want to provide coverage for their employees, but they are caught in a cost squeeze. They know that if they pass on premium increases to their employees, more and more of them will decline coverage altogether because they simply can't afford their share. Yet these small businesses cannot continue to simply absorb the double-digit increases in their health insurance premiums year after year. The problem of rising costs is even more acute for individuals and families who must purchase health insurance on their own. Monthly health insurance premiums in my State often exceed a family's mortgage payment. Clearly, we must do more to make health insurance more available and more affordable.

The legislation Senator LANDRIEU and I are introducing is a seven-point plan that combines a variety of public and private approaches. The legislation's seven goals are, first, to expand access to affordable health care for small businesses; second, to make health insurance more affordable for individuals and families purchasing coverage on their own; third, to strengthen the health care safety net for those without coverage; fourth, to expand access to care in rural and underserved areas; fifth, to increase access to affordable long-term care, a major challenge as our population continues to age; sixth, to promote healthier lifestyles; and seventh, to provide more equitable Medicare payments to Maine providers to reduce the Medicare shortfall which has forced hospitals, physicians, and other health care providers to shift costs on to other payers in the form of higher charges, which, in turn, drives up the cost of health care premiums.

Let me discuss these points in greater detail.

First, expanding access for small businesses by helping small employers cope with rising health insurance costs. Since most Americans get their

health insurance through the workplace, it is a common assumption, but a false one, that people without health insurance are unemployed. In fact, as many as 83 percent of Americans who do not have health insurance are in a family with a worker or are working themselves. Uninsured working Americans are most often the employees of small businesses. In fact, some 63 percent of uninsured workers are employed by small firms. Smaller firms generally face higher costs for health insurance than larger companies, which makes them again less likely to offer coverage.

The legislation we have introduced will help these employers cope with rising costs by creating a new tax credit for small businesses to make health insurance more affordable. It will also encourage small businesses that do not offer health insurance to start doing so with the help of this tax credit, and it will help employers that do offer insurance to continue coverage in the face of escalating premiums.

Our legislation would also provide grants to provide startup funding to States to help businesses join in purchasing co-ops. These co-ops would enable small businesses to band together to purchase health insurance jointly, but this part of the bill does not preempt State law, so it is a different approach than some have taken.

The legislation would also authorize the Small Business Administration grant program for States, local governments, and nonprofit organizations to provide information about benefits of health insurance to small employers, including tax benefits, increased productivity of employees, and decreased turnover. These would also be used to help make employers aware of current incentives under State and Federal laws. It is an interesting fact that one survey showed that 57 percent of small employers did not know they could deduct 100 percent of their health insurance premiums as a business expense. I want to change that into a tax credit which is far more valuable, but many small businesses don't realize that there is a tax incentive even in our current tax laws.

The legislation would also create a new program to encourage innovation by awarding demonstration grants in up to 10 States conducting the innovative coverage expansions such as pooling arrangements or group market reforms, or subsidies to employers or individuals. We know the States are the laboratories for reform. Insurance is regulated at the State level. This would provide for some assistance in conducting some innovative projects to expand coverage.

The Access to Affordable Health Care Act would also expand access to affordable health insurance for individuals and families. One of the first bills I sponsored when I first came to the Senate in 1997 was legislation introduced by Senator HATCH and Senator KENNEDY to create the State Children's Health Insurance Program, the SCHIP program, which provides insurance for children of low-income parents who cannot afford health insurance yet make too much money to qualify for the Medicaid Program. Since that time, this program has contributed to a one-third decline in the number of uninsured children in this country. Today, over 6 million children—including approximately 14,500 in Maine—are receiving health care coverage through this remarkably effective program.

Our legislation would shore up the looming shortfalls in the SCHIP program in 17 States, including Maine. We want to ensure that children currently enrolled in the program do not lose their coverage, and in order to achieve that goal, we need to make up that shortfall. Just prior to adjournment last month, Congress approved legislation which partially addressed that shortfall, but that provides only about one-fifth of the funds needed. Our legislation would help close that gap.

Our bill also builds on the success of the SCHIP program by giving States a number of new tools to increase participation. I won't go through all of the changes we would make, but let me mention one. We would allow the parents of those children enrolled in the SCHIP program to enroll in the health insurance program on a subsidized rate, depending on their income, if the State wants to take advantage of that option. The experts tell us that would help provide coverage for about 6 million more low-income Americans.

So what I am trying to do is take advantage of some existing programs such as SCHIP, expanding them, providing new tax incentives such as the tax credit for small businesses to help piece together a program that builds on the strengths of the existing program that still has a private sector approach and yet fills in the gaps in coverage and helps make health insurance more affordable. Part of that is providing for more funding for community health centers which operate in underserved urban as well as rural communities. They provide critical primary care services to millions of Americans regardless of their ability to pay.

We also know we need to deal with the problem of not enough physicians, physician assistants, nurse practitioners, and other primary care providers in underserved areas. We need to revamp the National Health Service Corps, which helps supply doctors, dentists, and other clinicians who serve in rural and inner-city areas. We want to revamp that program to make it more flexible. I was talking to physicians in Holten, ME, just recently who said that program used to be a source of physicians for rural Maine, but over the years it has become rigid and encrusted and not flexible enough and is no longer nearly as valuable as it once was. We would revamp that program.

As Senate cochair with Senator CLINTON of the bipartisan Congressional Task Force on Alzheimer's Disease, I am particularly sensitive to the long-term needs of patients with chronic diseases such as Alzheimer's and of the impact on their families. Long-term care is the major catastrophic health expense faced by older Americans today, and these costs will only increase with the aging of the baby boomer generation—our generation.

I have been surprised that many Americans mistakenly believe that Medicare or their private health insurance policy will cover the cost of long-term care should they develop a chronic illness or a cognitive impairment such as Alzheimer's. Unfortunately, far too many do not discover they do not have coverage until they are confronted with the difficult decision of placing a much loved parent or spouse in a long-term care facility and facing the shocking realization that unless they have long-term care coverage, they have to cover the costs themselves. We need to encourage people to purchase long-term care insurance, to plan for this need.

The bill we are introducing provides a tax credit for long-term care expenses of up to $3,000 to provide some help to families struggling with that cost, and it would encourage more Americans to plan for their future long-term care needs by providing a tax deduction to help them purchase long-term care insurance.

Health insurance alone is not going to ensure good health. As noted author and physician Dr. Michael Crichton has observed, ''The future in medicine lies not in treating illness but in preventing it.'' Many of our serious health problems are directly related to unhealthy behaviors: Smoking, the lack of regular exercise, poor diet. These three major risk factors alone have made my State the State with the fourth highest death rate, due to four largely preventable diseases—or at least you can delay their onset—cardiovascular disease, cancer, chronic lung disease, and diabetes. These diseases are responsible for 70 percent of the health care problems in Maine.

Our bill, therefore, contains a number of provisions designed to promote healthy lifestyles. It includes, for example, grants to allow States to assist small businesses in establishing worksite wellness programs for their employees. It also authorizes a grant program to support new and existing community partnerships. There is a great one in Franklin County, in Maine. It is the Healthy Community Coalition, and it has made a difference in promoting healthy lifestyles.

Finally, the Access to Affordable Health Care Act will promote greater equity in Medicare payments and help to ensure that the Medicare system rewards, rather than punishes, States such as Maine that deliver high-quality, cost-effective Medicare services to our elderly and disabled citizens. The Medicare Modernization Act of 2003 and subsequent legislation did take some significant steps toward promoting

greater fairness by increasing Medicare payments to rural hospitals and by modifying geographic adjustment factors that discriminated against physicians and other providers in rural areas. Our legislation would build on these improvements by establishing pilot programs that reward providers of high-quality, cost-effective Medicare services.

The Access to Affordable Health Care Act outlines a blueprint for reform based on principles upon which I am hopeful that a bipartisan majority of Congress could agree. The plan takes significant strides toward the goal of access to health care coverage by bringing millions more Americans into the insurance system and by strengthening the health care safety net. Most of all, it helps address the No. 1 obstacle to health insurance—and that is its cost—through a variety of incentives.

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

The PRESIDING OFFICER (Ms. CANTWELL). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

## EXTENSION OF MORNING BUSINESS

Mr. GRASSLEY. Madam President, I ask unanimous consent to add time to the order for morning business so I can speak for 25 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

## MEDICARE PRESCRIPTION DRUG BENEFIT

Mr. GRASSLEY. Madam President, it is a very important issue that is going to be coming before the Senate very shortly, and it deals with the Medicare prescription drug benefit and whether the Government ought to negotiate prices as opposed to what is in the Medicare Part D bill. I wish to speak on that subject because this issue is very important to the seniors of America. It is important for the public and for Medicare beneficiaries to fully understand these proposed changes. It is equally important we explore in depth the effects these changes are going to have on this program and particularly the negative impact on the senior citizens of our country. So I am going to spend some time this week dealing with this issue.

First, everyone should recognize that political opponents of the drug benefit have, in every way, done everything they can to tear apart and denigrate this new benefit that the vast majority of seniors find to their liking, based upon a lot of different polls that have been taken over the last 7 or 8 months. In fact, the opponents of this legislation have done this ever since the ink was barely dry on the bill we called the Medicare Modernization Act of 2003.

First they said that no plan would offer—meaning no benefit plan; the people, the administrators of the program—that none of these plans would offer the new drug benefit in the first place, that eventually the Government was going to end up doing it. Of course, we know that is not the fact. The plan is up and running, and the plans are offering so many.

Then, after it was up and running, these opponents of the legislation said, well, there were too many plans. They said it was too confusing, seniors would not be able to choose a plan. But 91 percent of seniors are covered by some plan that has prescription drugs in it, and surveys show overwhelming satisfaction by seniors with their plans.

Opponents suggested plans could change their prices and the drugs they cover at the drop of a hat without even almost any notice. This did not turn out to be the case. The opponents tainted beneficiaries' views of the benefits before it even got off the ground. You wondered whether the millions of people who signed up would ever sign up, hearing so much negative stuff about it. But they did sign up.

And, as we have heard from the opponents over and over again, one of the biggest criticisms about the drug benefit is that the Government does not negotiate with drugmakers for lower prices. So they have gone to great lengths to make it sound as if nobody is negotiating with the drug companies. It is, of course, correct that the Secretary of Health and Human Services does not do negotiation with drug companies. But it is absolutely not true there are not negotiations going on with drug companies. People who say that are completely nonsensical in their understanding of the legislation or maybe they have some ulterior motive of wanting to continue to degrade and denigrate a piece of legislation that seniors have accepted.

The idea behind the drug benefit is that multiple drug plans would compete with each other to get the lowest prices from manufacturers, to be the best negotiator, and to offer beneficiaries the best possible drug plan.

The pattern for this was the 40-year-old Federal Employees Health Benefit Plan that has worked so well for Federal employees. We patterned this program, Part D, after that: plans negotiating for Federal employees, getting a good price; plans that have membership of senior citizens negotiating with drug companies to get the best possible price for senior citizens who are in a particular plan.

But the opponents of this legislation do not like plans negotiating. They think the Government directly can do a better job of negotiating because they have a belief about Government always doing good, Government always doing the best. Their faith is in big Government because they lack faith in the American people. They find it very hard to believe anybody other than the Government could do a better job of negotiating.

Last week on the Senate floor, the senior Senator from Illinois said the law ''took competition out of the program so that [the drug companies] could charge what they want.'' Well, it did not take competition out of the program. Competition is what this program is all about.

In fact, the competition is working. Plans have no restrictions on the tools they can use to negotiate with drug companies. And, remember, these plans must be approved by the Secretary of Health and Human Services. Not every Tom, Dick, and Harry can go out and offer a plan and hoodwink seniors. There is control over these plans. But once the plan is approved, there are no restrictions on the tools they can use to negotiate. And, of course, this is very important because one thing we had learned is that Government is not actually a very good entity at figuring out what it should pay for drugs.

I have a chart in the Chamber with a quote from the Washington Post. They recognized this fact, that the Government cannot do a very good job of negotiating, where they said: ''Governments are notoriously bad at setting prices. . . .'' And then, as a matter of emphasis, it said: ''and the U.S. government is notoriously bad at setting prices in the medical realm.'' I will add to that: especially when it comes to medicine policy.

Now, we knew this because of the Government's experience for paying for drugs under another Medicare program, not Part D as in ''Donald,'' but Part B as in ''Bob,'' the one that pays for doctors. Those drugs are given during a physician's office visit, and they could be drugs such as oral cancer drugs.

Medicare payments for these drugs were based on what is called the average wholesale price. ''AWP'' is the moniker that is used for that. AWP is a little bit like the sticker price of a car. The sticker price on a car is not what you pay for the car. And the average wholesale price, AWP, is not what you pay for drugs. The joke was that AWP actually stood for ''Ain't What's Paid.''

Over the past decade, reports issued by the Office of the Inspector General, the Department of Justice, and the Government Accountability Office found that by relying on AWP, Medicare was vastly overpaying for these drugs.

So the Federal Government sets the price, and we end up wasting a lot of taxpayer money under Part B with the few drugs that Medicare was paying for before we passed Part D.

Recommendations were made to change payments so that they reflected actual market cost. The Clinton administration tried to make some of these changes, but after push-back from providers, it backed off. Congress took another run at this issue in 2003 in