

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 Madam President, I ask unanimous consent that the order for the quorum call be rescinded.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

tion 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

the Medicare Modernization Act, and we were successful. Congress reformed how Medicare pays for these drugs under Part B as opposed to the drug program Part D. Medicare now based its payments for many of these drugs on what it ought to, a market-based price. This change is already saving taxpayers and beneficiaries, but it took years to get fixed. All that time Medicare and taxpayers paid too much for these drugs. Billions and billions of dollars were wasted.

I compliment President Clinton for trying to do something about it, but he couldn't get it done. Congress had to act. But when we had all of this track record, as we were writing the prescription drug bill, I, for one, didn't want to repeat that experience under the Medicare drug benefit. We also knew that Medicare overpays for a lot of other services and equipment. The bookshelves are full of other reports from the Government Accountability Office, from the Inspector General, from the Medicare Payment Advisory Commission, from the Congressional Budget Office, and others, about how Medicare is paying too much in too many areas where the Government pays for health care through Medicare.

For example, Medicare overpaid for durable medical equipment for years until the Republican-led Congress made changes in 2005 in what we called the Deficit Reduction Act. In fact, just 12 months ago, now, that was a big issue before the Congress.

Each year, the Office of Inspector General issues its Red Book which presents cost-saving recommendations. The books are usually 50 or more pages long, and the recommendations span all aspects of Medicare—hospitals, physicians, home health, the Medicare Part D plans, among others. And this is more evidence on many areas where Medicare doesn't get the best deal, where the Government doesn't get the best deal. So Government doesn't always know best. In fact, the situation is so bad that several years ago, Congress created what is called the Medicare Payment Advisory Commission, also known as MedPAC, to provide advice to us in Congress and to the Center for Medicare Services on what we ought to pay for services. And every year Congress hears recommendations from MedPAC addressing Medicare overpayments; yes, trying to do something about wasting the taxpayers' money, paying more than we should for health care for our senior citizens.

But even though we have MedPAC, experts studying this, coming out with recommendations, it takes Congress or the Secretary of Health and Human Services far too many years to make the changes to save the taxpayers money—more evidence that Government doesn't always know best when it sets prices.

In making recommendations, MedPAC looks at profit margins as an example. One type of provider had been found to have a margin of 16 percent off

of Medicare payments. Congress has been able to act on many MedPAC recommendations, but it is not easy. There is always some special interest out there fighting saving the taxpayers money. As chairman of the Finance Committee, I received letters from Members saying, "Please don't cut benefits for this provider group or that provider group." So as the Clinton administration found, letters like that, where they come to Congress or to the administration, can make it difficult in very short order to solve a lot of these overpayment problems, despite compelling evidence of overpayment, despite the high profit margins, despite the fact that the proposed change could save the taxpayers billions of dollars.

The architects of the drug benefit—and I am one of them—were concerned that this same kind of dynamic would happen again. So 3 years ago, when we wrote the bill, we tried to deal with that problem. Political pressures on the Medicare drug benefit would tie the hands of the Secretary of Health and Human Services. If that happened, the program would be unmanageable, and the costs would skyrocket, just as they have in many of these other instances where the Government is setting the price. So, instead, Congress put competing private plans in charge of negotiating; again, following on the pattern of 40 years of the Federal Employees Health Benefits Program. So under the Part D Medicare prescription drug program, these health plans and their pharmacy benefit managers, because they have years of experience in this arena—it is what they do—they negotiate, and Health and Human Services has had very little experience and a very dismal track record in doing it.

These plans and managers have powerful bargaining clout in the market. They manage the drug coverage for tens of millions of people. There are plans that cover upwards of 50 million people—75 million in one case—far more than the 41 million Medicare beneficiaries. So, clearly, Medicare beneficiaries account for a large number of all prescriptions filled each year. Some might argue that 41 million beneficiaries have more clout than 75 million nonbeneficiaries. But numbers alone do not necessarily translate into lower cost. It is what is done to leverage those numbers that leads to lower costs.

That leverage comes from the plan being able to say to a drug company something like: I can get a better deal on a different drug that has the same clinical effect made by manufacturer Y. So thank you for your offer, but I am leaving the table.

Some plans get a better deal on drug A and put it on their formulary. Some plans get a better deal on drug B. But many experts agree, and experience suggests, that it would be difficult for Medicare itself to walk away from the table; in other words, the Government people doing the negotiating. There would be enormous pressure to cover

everything and, if it did, the negotiating power lies then with the manufacturers and not with Medicare.

In fact, in a November 2 Wall Street Journal editorial, Dr. Allen Enthoven, an economist at Stanford University, wrote:

When the government negotiates its hands are tied because there are few drugs it can exclude without facing political backlash from doctors and the Medicare population, a very influential group of voters.

Yesterday's New York Times quoted Dr. Alan Garber, the director of the Center for Health Policy at Stanford University, on the same subject. Dr. Garber said:

To obtain drugs at low prices, a purchaser must be able to say no to covering a particular drug.

He went on to say:

[I]f you cannot walk away from a deal, there's no way you can be sure of obtaining [the lowest possible] price.

Dr. Garber's point is exactly on point. The Medicare drug benefit recognizes that the Government would be a weaker negotiator. So as we set it up, it relies upon private sector plans to do the negotiating, as has been done for 40 years under the Federal Employees Health Benefits Program. We believed then that the private sector could be a tough negotiator, and we had a way to make competition work.

When Congress finished work on the new drug benefit in 2003, we knew it was an experiment. Nothing like this had been tried on this scale. Here is what we learned: Private competition works. It has been very successful in keeping costs down. These plans that negotiate their bids have come in lower than we even expected. This year they were down 10 percent from last year's bids. How many commodities do you see in America where you are going to find something 10 percent less this year than last year?

It happens that premiums are lower for people joining these plans; the premiums that they pay are lower than they were estimated to be. Before 2006, Medicare's chief actuary estimated that the average monthly premium would be \$37 a month. But because of competition, it was actually \$23 in 2006. That is 38 percent lower than expected. And because of the strong competition between plans, the average premium for beneficiaries is expected to be about \$22. That is \$1 cheaper this year than in 2006. The net cost to the Federal Government is also lower than expected. Just today the official Medicare actuaries are announcing that the net 10-year cost of Part D has dropped by \$189 billion over the original budget window used when the Medicare Modernization Act was enacted in 2003. That is, in fact, a 30-percent drop in actual cost compared to what was projected when the bill was being written.

Cost overruns is the name of the game with most people doing business with the Federal Government. In this particular case, this is an exception to cost overruns. This is where things are

coming in \$189 billion less than bureaucrats projected they would cost when the bill was written. Of course, States are involved in this as well because they had a lot of senior citizens on what we call Medicaid for low-income people. States are saving money in lower contributions. These are referred to as clawback payments. So State payments are now projected to be \$37 billion less over a 10-year period, and that is 27 percent lower than what we thought they would be when the legislation was written.

Just in the year 2006, the 50 States saved \$700 million. The plans are negotiating lower prices for drugs. Let's take the top 25 drugs used by seniors. Using them, the Medicare prescription drug plans have been able to negotiate prices that are, on average, 35 percent lower than the average cash price at the retail pharmacies. That is 35 percent lower. Some examples: Lipitor is 15 percent lower; Anetol, 63 percent lower; Norvas, 28 percent lower; Fosamax, 30 percent lower.

When the drug benefit was signed into law, we believed it would work. We believed it would hold down costs. That is certainly happening today, now going into the second year of experience with this legislation. At the time it was signed into law, we also said that if it did not work, if the negotiating model we wrote into the legislation did not hold costs down, then Congress would need to reexamine the whole setup. That makes sense. But if costs grew too fast, then the whole idea, obviously, would have to be revisited. Maybe we would have to restrict access to drugs. Maybe we would have to rely more on mail-order pharmacies, instead of liberal access to local retail pharmacies. Maybe more drastic cost-cutting measures would be needed. We thought of all those things as we were writing this legislation.

But as it turns out now, 3 years later, since the President signed the bill, that is not the case. Everyone has heard the old saying, "If it ain't broke, don't fix it." That certainly applies here, and the evidence shows it. I would be the first one to say the Medicare drug benefit is not perfect. There are improvements that can be made. The Senate version of the drug bill had some important features that I hope we can revisit at some point. Congress should look at ways to make it easier for low-income beneficiaries to get the additional assistance they need by eliminating the low-income subsidy asset tax. We need to look at payments to pharmacies and make some reforms in that area. We need to look at ways to simplify the enrollment process. And there are other areas, too, where we can make improvements.

But to emphasize one area that is working very well, it is the negotiating power of the Medicare drug plans. They have shown their ability to hold down costs, so it is working. The pleas from the drug plans' opponents to put the Government—because they believe in

big Government—in charge of negotiating are, quite frankly, about politics, not policy. These voices want to score political points with the drug benefit. It saddens me that we are going to start off this year with a new Democratic-controlled Congress playing politics with Medicare and raising issues that could harm our senior citizens as opposed to benefiting them.

But that is what this issue is all about; it is about politics. It is not about saving money because this program, through negotiations by the drug plans, is already saving money. It is surely not about improving the program. In fact, the Congressional Budget Office looked at the proposals made last year to have the Secretary negotiating drug prices, and they concluded they would not achieve any savings. So around here the Congressional Budget Office is like God. If they say something costs something and you don't have an offset for it, they are so much of a god around here, if you try to get it done, you have to have 60 votes to get it done. Now we have the Congressional Budget Office saying there are no savings, because the Government negotiates instead of having the plans negotiate. During the debate on the Deficit Reduction Act of 2005, Senators SNOWE, WYDEN, MCCAIN, and STABENOW offered an amendment to give the Secretary authority to negotiate with drug companies.

Here is what CBO said about that amendment: It would produce zero savings. So what is this amendment all about? If you are going to save senior citizens some money by having Government negotiate instead of the plans, you should not get a big zero out of the CBO.

I want to have a second chart observed by my colleagues. This is a person a lot of people 3 years ago were expressing was competent when he was judging that this bill would cost more than the CBO said it would cost, and that somehow the administration was playing games with these figures. All these figures ended up being too high because they are \$189 billion lower than they were saying they were going to be. There are no cost overruns in this program as in every other program. I am going to refer to the chief actuary for Medicare who examined these proposals we are talking about and having the Government negotiate. He came up with the same conclusion: Direct price negotiations by the Health and Human Services Secretary would be unlikely to achieve prescription drug discounts of greater magnitude than those negotiated by the Medicare prescription drug plans responding to competitive forces.

Competition in the marketplace is what getting the consumer the best buy for the money is all about. Every day consumers benefit from competition. We wrote competition into this program 3 years ago, and that competition is working for the seniors. Now we have people who want to come out here

and screw it all up for the senior citizens of America.

I hope we can put politics aside here and focus on some of the real improvements we could be making in the drug benefit program that I pointed out today that need to be made, and not deal with things that are working. "If it ain't broke, don't fix it."

Madam President, since no other Members are here, 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.

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

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

TRIBUTE TO LINDA HAWKER

Mr. DURBIN. Madam President, I rise today to pay tribute to a great friend of mine, an amazing woman in Springfield, IL, a dedicated public servant, Linda Hawker.

After nearly 30 years in public life, Linda is retiring as Secretary of the Illinois State Senate and starting a new chapter in her life. Those who worked with Linda in the Illinois State capitol can tell you what an amazing difference she made in the office of the Secretary of the Senate. The job is a tough one. The hours are long. But Linda has worked tirelessly to serve the people of the Senate and the people of my State.

Linda is going to be missed. Linda and I started together working in the Illinois State Senate. I was fresh out of law school. She had just started as a secretary to one of the State senators back in the early 1970s. She was born and raised in Springfield. Linda is one of eight children. She worked hard throughout her life to raise her daughter. She graduated from Sangamon State University, now known as the University of Illinois-Springfield, with a degree in political studies.

Linda has worked so hard not only for the Senate but for many candidates for the Illinois State Senate over the years. She was the first woman to serve as Secretary of the Illinois Senate, the guardian of the public records of that institution. Before serving in that position, she was assistant secretary. Prior to that, she worked for the Senate Democratic leadership staff and served as special assistant to former Illinois Senate president Phil Rock.

As Secretary of the Senate, Linda is best known as the chief administrative and fiscal officer of the Senate. But those terms don't tell the whole story. She brought a state-of-the-art computer system into the Illinois State Senate to make it easier to track bills and debate them. She was also instrumental in the creation and development of the Illinois Women in Government Organization. In 2004, she was