

acknowledge that the employer-based system of health coverage that worked back in 1945 no longer makes sense for 2007. We can acknowledge, as I have done today, that I think Democrats are right about making sure that everybody gets covered and Republicans are right about promoting personal responsibility and more personal involvement in making health care choices. We can end 13 years of ducking on health care, 13 years of slapping Band-Aids on health care, and roll up our sleeves and go to work. A lot of it—and I know the distinguished President of the Senate has been to many community meetings in his home State of Virginia—simply means following up on what constituents say at home.

Every time health care comes up when I have community meetings somebody usually says, “Well, I guess we ought to go to what is called a single payer system. You know, one where the Government essentially runs it and you don’t have these private insurance companies.”

After somebody at a town meeting says we ought to have a single payer system, somebody else says, “No, we already voted on that.” In fact, Oregonians did. They voted against a single payer system by more than 3 to 1 just a few years ago.

But the other speakers say, “We don’t want all that Government. We don’t want the Government to make all the decisions.”

So after a bit, somebody raises their hand at one of my townhall meetings and says, “Ron, what we want is what you Members of Congress have. We want health care coverage like you have.”

Then everybody in the room shakes their head in agreement.

So much of what I propose in the Healthy Americans Act comes from those townhall meetings that I hold in all of Oregon’s 36 counties. I have an approach that guarantees benefits like Members of Congress have; that is delivered in the same way; and that can actually be implemented with the very first paycheck that a worker gets under the new system.

Part of the reason I have written this legislation as I have has been to ensure that the Congress and the Federal Government could pick up some lost credibility on health care. My sense is that after the debate of 1994 on health care in America a lot of Americans said: The United States Congress can’t figure out how to put together a two-car parade let alone a reform that involves one-seventh of the American economy.

That is why I have written this legislation so it can be understood and the effects can be seen from the time the very first paychecks go out under the legislation. The legislation works in a way that will be attractive to both workers and employers.

So I have spent a lot of time listening to my constituents as I brought together the various principles that are contained in the Healthy Americans

Act. I know colleagues in this body have other ideas.

I would like to wrap up by simply saying I think health care has been studied enough. It has been commissioned. It has been blue-ribboned. It has been the subject of white papers, blue papers, pink papers, papers of every possible description. It is time for the Senate to act. The Senate has ducked on health care for almost 13 years. Health care and Iraq are the driving issues that our citizens care about most. It is time to fix health care, and I think with the Healthy Americans Act, this body can get the job done.

Mr. President, I yield the floor, and I note the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

ORDER OF PROCEDURE

Mr. WYDEN. Mr. President, I ask unanimous consent that the time today from 4:30 to 5:30 be equally divided and controlled between the two leaders or their designees, and that 10 minutes of the majority’s time be allocated to Senator FEINGOLD.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. WYDEN. Mr. President, I ask unanimous consent that the majority leader be recognized at 12:30 p.m. today.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

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

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

PRESCRIPTION DRUGS

Mr. GRASSLEY. Mr. President, I am going to proceed in morning business, but I want to welcome the new Senator from Virginia to the Senate. I look forward to serving with him. I am sorry that maybe the Senator’s first time being in the chair he has to listen to my speech, but I am very glad to have the opportunity to speak to you and Members of the body and the people of the United States about a very important issue that is going to be coming before us. This is an issue that I have been speaking about for the last sev-

eral days on the floor. In fact, I think 4 days last week I did. I talked about the Medicare prescription drug benefit and the so-called prohibition on Government negotiation with drugmakers for low prices. I spent time doing that because people need to understand that some proposals could have drastic consequences, not only for Medicare and the beneficiaries of Medicare but also for anyone else who buys prescription medicine.

I want to make this very clear because when you are talking about seniors and the disabled on Medicare, and on prescription drugs, you might get the impression that we make a decision here, and the only people it is going to affect are those on Medicare. But I hope I made it very clear last week, and I am going to go over this again today.

In other words, if we change Medicare in this instance dealing with the prices of prescription drugs, it will increase prices of prescription drugs for everybody. It is not going to impact just those on Medicare, the decisions we make. I have said it before, and I say it again: Having the Government negotiate drug prices for Medicare might be a good sound bite, but it is not sound policy if it is going to increase the price of prescription drugs for everybody regardless of age in the United States.

I think the House bill, which is numbered H.R. 4 and passed the House last week, very definitely falls into that category. It may be a good sound bite. It may be very politically beneficial. But a good sound bite is not good policy. It will be bad for Medicare beneficiaries and other consumers of prescription drugs.

That outcome was voiced by witnesses just last week when they appeared before the Senate Finance Committee, chaired by the Senator from Montana, Senator BAUCUS.

At that hearing, one of the witnesses, Dr. Fiona Scott Morton, a professor of economics at Yale University, made a key point about the size of the Medicare market and when you deal with the price that Medicare recipients pay for drugs, the fact that it has negative consequences for everybody else in America.

She pointed out that of course we all want to obtain discounts for drugs for seniors. But she said:

With close to half of all spending being generated by those seniors, whatever price they pay will tend to be the average price in the market.

Her point is, if you are half of the market, the math makes it virtually impossible for your prices to be below average. Dr. Scott Morton said that because Medicare is so large, if drugmakers had to give it the lowest price they give any customer, they would have a strong incentive to increase their prices for everybody else.

Professor Scott Morton also stated:

This approach to controlling prices harms all other consumers of pharmaceuticals in the United States and is bad policy.

I pointed out how Part D has already given seniors, on the 25 drugs most used by seniors, 35-percent lower prices than we anticipated when we wrote the bill. While it is great to be doing things for seniors, there is no free lunch. Everybody, regardless of age, will pay more for prescription drugs. Do you want that to happen? Do you want those unintended consequences to happen?

Then we had another witness at the hearing held by Senator BAUCUS before the Senate Finance Committee last week. It was a representative of the Government Accountability Office who talked about its Year 2000 report on this very issue, and echoed Professor Scott Morton's view. Remember, in 2000 the General Accounting Office concluded:

Mandating that federal prices for outpatient prescription drugs be extended to a large group of purchasers such as Medicare beneficiaries could lower the prices they pay, but raise prices for others.

That is from a nonpartisan Government agency working for the Congress of the United States called the Government Accountability Office.

One thing we keep hearing is that Medicare should not pay more than the Veterans' Administration pays. We had another witness, Professor Richard Frank of Harvard University, who said that if Medicare got the same prices the Veterans' Administration gets for drug prices—if that happened—it would likely raise Veterans' Administration prices for our veterans for all drugs. Do you want to hurt veterans with these unintended consequences of some of these ideas that are floating around this new Congress?

Then we had other panelists. As they listened to Dr. Frank's response, other panelists nodded in agreement. Talk about unintended consequences, do you know who else agrees with these professors who have been testifying before our committee? I point to the Military Order of the Purple Heart. In a letter to Members of Congress, the Military Order of the Purple Heart expressed its concern about the impact that extending Veterans' Administration prices to Medicare could have on veterans. In fact, they stated that several veterans organizations passed formal resolutions opposing legislation to extend the Veterans' Administration prices to Medicare because it would threaten Veterans' Administration's current discounts.

What is the end result? Higher drug prices for those who get their drugs from the Veterans' Administration.

Another key point made at last week's hearing before the Senate Finance Committee was that it is not simply about the number of people for whom you are buying drugs. In response to a question I asked Professor Scott Morton, the professor said it doesn't matter whether you negotiate on behalf of 1 million people or 43 million people—which is the number of senior citizens in this country. What

matters is what leverage you have and how you use that leverage. And if you don't have a fundamental tool, and that would be the formulary, you have no leverage over drugmakers. A formulary is a list of drugs that a plan will cover.

Here is what Professor Scott Morton said would happen if someone negotiating drug prices couldn't have a formulary:

Each manufacturer would know that, fundamentally, Medicare must purchase all products. The Medicare "negotiator" would have no bargaining leverage, and therefore, simply allowing bargaining on its own would not lead to substantially lower prices.

That is the end of the quote from Professor Scott Morton.

Then we had a Mr. Edmund Haislmaier, a fellow at the Heritage Foundation, talk about the limits of bulk purchasing power alone. In his written testimony he said:

... volume purchasing encourages manufacturer discounting, it is not, in and of itself, sufficient to extract large discounts. Manufacturers will only offer substantial discounts if the buyer combines the "carrot" of volume with the "stick" of being able to substitute one supplier's goods with those of another.

In drug negotiation, that stick he is talking about—Mr. Haislmaier is talking about—is the formulary.

Here is what is wrong with the House bill that just passed. It prohibits the Secretary of Health and Human Services from using a formulary. Thus the stick that is necessary, that the Veterans' Administration uses to drive down the price of drugs, is not even in the bill that passed the House that is supposed to guarantee senior citizens lower drug prices.

For all of their talk about getting savings from Government negotiations, the House Democrats took away a key tool to get lower prices. That was a key lesson we also learned from last week's Finance Committee hearing that Senator BAUCUS chaired.

Here is what the Congressional Budget Office said about H.R. 4. Here I have a chart. The bottom line of it is that it would have negligible effect on Federal spending. To emphasize that, I want to read it all. For the benefit of new Members, I point out we will soon find out that when you refer to the Congressional Budget Office, it is like God on Capitol Hill. When the Congressional Budget Office says something costs something—and you might have intellectually honest, good reasons for disagreeing with it—the Congressional Budget Office is always right. If there is a point of order against it, then you get 60 votes. The 60-vote requirement around here almost makes anything or anybody or any agency a god, because it is difficult to get 60 votes. So CBO generally stands. Sometimes they are overridden but not very often. So this god of CBO:

CBO estimates that H.R. 4—

I want to emphasize, that is the bill that just passed the House last week, a Democratic bill—

would have negligible effect on Federal spending because we anticipate that the Secretary—

meaning the Secretary of HHS—

would be unable to negotiate prices across a broad range of covered Part D drugs that are more effective than those obtained by PDPs under current law.

You heard it during the campaign. You heard it a long time before the campaign. If we do away with this noninterference clause, we are going to get drugs cheaper for the citizens. This is supposedly on top of the 35 percent of the average reduction in the price of the 25 drugs most often used by senior citizens, and the god of Capitol Hill says there is not going to be the savings. That is not only for the people who pay out of their pockets some portion for drugs, but also saving the taxpayers money.

I am going to quote another thing from the Congressional Budget Office that gets back to this carrot and stick, the stick being the formulary that is used by the Veterans' Administration to get the low prices they get—the same pattern that proponents of doing away with the noninterference clause want to follow, to get lower prices for senior citizens, and that is the formulary. The Veterans' Administration has a formulary, but the House bill passed last week does not have a national formulary, so you do not have a stick to accomplish the goals.

Without the authority to establish a formulary, we believe the Secretary would not be able to encourage the use of particular drugs by Part D beneficiaries, and as a result would lack the leverage to obtain significant discounts in his negotiations with drug manufacturers.

It is pretty clear that what we are being told you are going to get as a result of the House-passed bill is not happening. So I would quote another independent actuary—maybe not quite the god that CBO is, but the actuaries at the Center for Medicare Services, the agency that oversees the Medicare drug benefit. They said about the same thing about H.R. 4 not having a formulary.

Although the bill would require the Secretary to negotiate with drug manufacturers regarding drug prices, the inability to drive market share via the establishment of a formulary or development of a preferred tier significantly undermines the effectiveness of negotiations.

Whether you are CBO, responsible to the Congress of the United States, working for the Congress of the United States, or whether you are the actuaries downtown at the Center for Medicare Services working for the President of the United States—and maybe actuaries are fairly independent—but the point being they came to the same conclusion, that the tool that is necessary to accomplish what Democrats say they want to accomplish by doing away with the noninterference clause to negotiate prices with drug companies isn't going to be effective because the tool to be effective is not in their legislation.

Let me point out the key downside of having the Secretary establish a national formulary in my next chart. Fewer drugs would be covered. I have made a point about keeping the Government bureaucrat out of the medicine cabinet, not to be the person between the doctor and the patient. We set up, as a principle in the Medicare bill, to do it differently than the Veterans' Administration because the Veterans' Administration did not allow every therapy to be available to a veteran. A bureaucrat makes a decision that a veteran can have this, but a veteran cannot have that, the Government will not buy this. We did not want the senior citizens to be treated that way, so every therapy has to be available.

This chart shows only 30 percent of the drugs covered by Medicare will be available to seniors if done the way the Veterans' Administration does it. Do you want to get the complaints from the seniors of America, as I sometimes get from veterans? They come to my town meetings saying: My doctor says I should not take this pill because there are side effects, I should take this one. Why won't the Veterans' Administration let me buy this pill? The doctor said I ought to have it.

I can go to the Veterans' Administration and advocate for this veteran, but it is not a sure thing. We do not have to worry about that with seniors.

Let me sum up two important points from the Senate Committee on Finance hearing we had last week and from the experts from the Congressional Budget Office and the chief actuary of Medicare.

First, giving Medicare the lowest price a drugmaker gives any purchaser, whether that is a private plan or the Veterans' Administration, will increase prices of prescription drugs for everyone else in America. That means higher prices for working Americans and for small businesses. Second, in summary, the ability to use a formulary to negotiate means you have to be able to tell a drugmaker: If you do not give me a good price, I will pick another drug to put in my formulary. If you do not believe all the experts, if you do not believe all of the people that have studied this over a long period of time, whom are you going to believe?

I remind everyone from where the prohibition on negotiations came. We have 10 new Members of the Senate, and a lot of them will not be familiar with the genesis of the noninterference clause. The opponents of the drug benefits seem to conveniently forget their own bills had the same language and that they supported a benefit run by private plans. My next chart demonstrates this better.

The prohibition of Government negotiation—what is referred to as a noninterference clause—first appeared in Democratic bills; in total, seven bills introduced and supported by 34 Senate Democrats and more than 100 House Democrats had the prohibition in these legislation. On top of that, many of the

Members who are now twisting that language cosponsored that very legislation.

I will not emphasize every Democratic Congressman or Senator who introduced these seven bills, but I will emphasize President Clinton, in 1999, when he proposed from the White House a plan for prescription drugs for seniors. The plan proposed by President Clinton took the same approach. President Clinton said so many good things that I didn't have to think up new things, just repeat what President Clinton said about saving money and the ability of plans to negotiate and save money, and to make sure there was a wide range of drugs available for our seniors.

We have a good basis for including in our bipartisan bill that passed in 2003 things that Democrats had in their bills before we passed our bill. I don't see any of them embarrassed about that fact even while they go on talking about how bad the provision is now that it's in a bipartisan bill. Plans are negotiating for seniors, and those negotiations are reducing the cost of the 25 most often used drugs by seniors on an average of 35 percent. President Clinton said so many good things that I don't have to say them. I wish Members would read some of the things President Clinton said about this.

Continuing to summarize, the Secretary does not need the authority to negotiate and a national formulary is a bad idea. Competition among these plans that seniors are now joining—91 percent of the seniors have prescription drug coverage; the Medicare prescription drug benefit is a voluntary program; they do not have to get in it if they don't want to—had led to lower drug prices for beneficiaries and, more importantly, lower costs for taxpayers and the States. This is saving taxpayers \$189 billion. I will cover that in a minute.

Premiums are lower than they were estimated to be. I talked of lower drug prices, but now I am talking about the premiums to join the plans. Before 2006, the Medicare chief actuary estimated the average monthly premium would be \$37. In fact, we struggled to make sure, when we wrote the Medicare bill, that the premium would be between \$35 and \$40 a month because we felt above that there would be resistance to joining, and we would not have 91 percent of the people in. We planned on \$35 to \$40. The chief actuary said \$37. But because of competition, it ended up being only \$23 in 2006. In the year 2007, premiums are going to average \$22. Competition is working.

The net cost to the Federal Government is also lower than expected. This is that \$189 billion. Last week, the official Medicare actuary announced the net 10-year cost has dropped by \$189 over the original budget window used when the Medicare Modernization Act was enacted. That is a 30-percent drop in the actual costs compared to what was projected. Competition is working.

I ask any Member how often a Federal program comes in under cost. We always speak of overruns. Every Federal program is costing more than we anticipate when we pass it. Overruns do not seem to be the sin they ought to be. We have a program \$189 billion under what we thought it would cost, so we have an underrun. We never hear of that. We could not get the lower prices and lower costs unless the prescription drug plans are, in fact, what we anticipate they would be—strong negotiators with the drugmakers. Competition is working.

I know the opponents of the drug benefit will likely keep up their attacks on the program. They have pandered through the last election and they have to deliver. What are they delivering? They are delivering a pig in a poke. They may be delivering something very negative for the seniors of America. I have been working hard this week to give people important facts that have been left out of the debate on negotiation of drug prices.

The plain and simple fact is that competition among the plans is working. The Medicare plans are delivering the benefits to Medicare beneficiaries. These private sector plans have the experience in negotiating better drug prices. As I pointed out last week, for 50 years, Federal employees, under the Federal Employee Health Benefit Program, have been doing it this way. It has successfully worked. That is why we adopted it for seniors.

These Medicare negotiators have proven their ability to get lower drug prices. The Medicare plans are negotiating with drug companies using drug formularies within the rules set by law. These plans have to be approved by the Centers for Medicare & Medicaid Services. Medicare beneficiaries have access to the drugs they need and 70 percent of the drugs that are out there under the Medicare prescription drug benefit are not offered by the Veterans' Administration to veterans.

I have an example from the ALS Association, better known as the association dealing with Lou Gehrig's disease. Here is what they said about repealing the noninterference clause in a January 4 letter to Members of Congress:

The elimination of the noninterference provision will have particularly cruel consequences for people with ALS. It means that even if a new drug is developed to treat ALS, many patients likely will not have access to it. That's because price controls can limit access to the latest technologies.

The letter continues to say that individuals with ALS:

... will either be forced to forego treatment, or only have access to less effective treatment options—ones that may add a few months to their lives but not ones that will add years to their lives.

Just for the record, drugs to treat ALS are covered under the Medicare drug benefit right now.

I end with a statement I have so often used in the last week: If it ain't broke, don't fix it.

I ask unanimous consent to have these letters printed in the RECORD.

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

THE AMYOTROPHIC LATERAL
SCLEROSIS ASSOCIATION,

Washington, DC, January 4, 2007.

DEAR MEMBER OF CONGRESS: I am writing on behalf of the ALS Association to express our strong opposition to legislation that would eliminate the noninterference provision of the Medicare Modernization Act (MMA). Legislation that authorizes the federal government to negotiate Medicare prescription drug prices will significantly limit the ability of people with ALS to access the drugs they need and will seriously jeopardize the future development of treatments for the disease—a disease that is always fatal and for which there currently are no effective treatment options.

The ALS Association is the only national voluntary health organization dedicated solely to finding a treatment and cure for amyotrophic lateral sclerosis (ALS). More commonly known as Lou Gehrig's disease, ALS is a progressive neurodegenerative disease that erodes a person's ability to control muscle movement. As the disease advances, people lose the ability to walk, move their arms, talk and even breathe, yet their minds remain sharp; aware of the limitations ALS has imposed on their lives, but powerless to do anything about it. They become trapped inside a body they no longer can control.

There is no cure for ALS. In fact, it is fatal within an average of two to five years from the time of diagnosis. Moreover, there currently is only one drug available to treat the disease. Unfortunately, that drug, Rilutek, originally approved by the FDA in 1995 has shown only limited effects, prolonging life in some patients by just a few months.

The hopes of people with ALS—those living today and those yet to be diagnosed—are that medical science will develop and make available new treatments for the disease; treatments that will improve and save their lives.

However, The ALS Association is deeply concerned that the elimination of the MMA's noninterference provision will dampen these hopes and will result in unintended consequences for the thousands of Americans fighting this horrific disease. The potential impacts are significant and include:

LIMITS ON INNOVATION

While reducing the cost of prescription drugs is an important goal, it should not be done at the expense of innovation. Unfortunately, eliminating the MMA's noninterference provision will limit the resources available to develop new breakthrough medicines. This is especially troubling for a disease like ALS, for the development of new drugs offers patients their best, and likely only, hope for an effective treatment.

Additionally, by establishing price controls, Congress will undermine the incentives it has established to encourage drug development in orphan diseases, like ALS. As resources available for research and development become more scarce, there will be even less incentive to invest in orphan drug development.

LIMITS ON ACCESS

The elimination of the noninterference provision will have particularly cruel consequences for people with ALS. It means that even if a new drug is developed to treat ALS, many patients likely will not have access to it. That's because price controls can limit access to the latest technologies. Proponents of government negotiated prices cite the Department of Veterans Affairs as a

model for how the government should negotiate prices for Medicare prescription drugs. Yet under that system, patients do not have access to many of the latest breakthrough treatments. For example, two of the most recently developed drugs to treat Parkinson's and Multiple Sclerosis, neurological diseases like ALS, are not covered by the VA due to the government negotiated price. Ironically, those drugs currently are covered by Medicare Part D.

Given this scenario, we are deeply concerned that any new drug that is developed for ALS will not be available to the vast majority of patients who need it. Instead they either will be forced to forgo treatment, or only will have access to less effective treatment options ones that may add a few months to their lives, but not ones that will add years or even save their lives.

PEOPLE WITH ALS RELY ON MEDICARE

A significant percentage of people with ALS rely on Medicare, and the newly established prescription drug benefit, to obtain their health and prescription coverage. In fact Congress recognized the importance of Medicare coverage for people with ALS by passing legislation to eliminate the 24-month Medicare waiting period for people disabled with the disease. This law helps to ensure patients have timely access to the health care they need. With the establishment of the Part D benefit, Congress also has now, helped to ensure that people with ALS have access to coverage for vital prescription drugs.

Yet this improved access is threatened by short-sighted and inappropriately cost driven efforts to remove the noninterference provision. If Congress makes this change, they will undo what the MMA sought to ensure: access to needed prescription drugs.

While The ALS Association appreciates attempts to improve access to affordable prescription drugs, we believe that Congress must consider the implications of its actions on coverage, access and the advancement of medical science. We fear that in an effort to control costs, Congress may limit treatment options, discourage innovation, and extinguish the hopes of thousands of Americans whose lives have been touched by ALS and who are fighting to find a treatment and cure. On behalf of your constituents living with Lou Gehrig's disease, we urge you to oppose legislation to eliminate the noninterference provisions of the Medicare Modernization Act.

Sincerely,

STEVE GIBSON,

Vice President, Government Relations
and Public Affairs.

MILITARY ORDER OF THE PURPLE HEART,
Springfield, VA, January 10, 2007.
Speaker NANCY PELOSI
Washington, DC.

DEAR MADAM SPEAKER: In the coming days the House will take up legislation that, if enacted will repeal the noninterference clause of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The Medicare Prescription Drug Price Negotiation Act of 2007, H.R. 4, will require the Secretary of Health and Human Services to negotiate lower covered part D drug prices on behalf of Medicare beneficiaries. While there is no specific mention of the Department of Veterans Affairs (VA) and the favorable pricing they receive on pharmaceutical products through the Federal Supply Schedule (FSS), I would like to share with you the concerns of The Military Order of the Purple Heart (MOPH) as you consider H.R. 4.

As you know, Federal law currently enables the Department of Veterans Affairs (VA) to purchase pharmaceutical products

for veterans through the Federal Supply Schedule (FSS). Because of the Veterans Health Care Act of 1992, the prices the VA pays through the FSS are substantially discounted from the prices private sector purchasers pay. Extending access to the FSS pharmaceutical discounts to larger groups would cause FSS prices to rise and would dramatically increase the VA's pharmaceutical costs. The Government Accounting Office and the VA have documented the magnitude of this effect in 1995, 1997 and 2000 in response to previous proposals to extend FSS prices to other entities. The studies estimate that the VA would incur many hundreds of millions of dollars in additional expenses.

Our concerns about such proposals were expressed in The Independent Budget of 2006 sent to every Member of Congress. Sixty-two veteran and allied organizations endorse The Independent Budget. Additionally, several veteran organizations have passed formal Resolutions opposing legislation extending FSS prices to Medicare or other programs because it would threaten discounts the VA currently receives.

MOPH is on record as supporting lower prescription drug prices for all Americans, but not at the expense of those veterans enrolled in the VA health care system and the favorable pricing that the VA receives through the FSS.

Respectfully,

THOMAS A. POULTER,
National Commander.

Mr. GRASSLEY. I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. SANDERS). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

RECENT TRIP TO INDIA, SYRIA,
AND ISRAEL

Mr. SPECTER. Mr. President, I have sought recognition to report on the recent trip I made from December 13 to December 30 to India, Syria, and Israel.

The trip to India was a revelation to me—to see the vast economic progress that this gigantic nation of 1.1 billion people has made. For a long time, the nation of India resisted foreign investment, perhaps as a result of the colonialization by the British. But for most of the past two decades, India has been open for investment and trade. During the course of my travels there, which are detailed in a lengthy statement that I will include for the RECORD at the conclusion of my extemporaneous remarks, I have detailed the many U.S. plants we visited, such as GE and IBM, all showing a remarkable aptitude for the technology of the 21st century.

I recall, several years ago, being surprised when I sought a number from information and found out that the answering person was in India. I have since learned that this is a common practice because, whereas, it used to cost about \$3.50 for a minute conversation between the United States and India, it now costs about 7 cents.