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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable JOHN F. KERRY, a Senator from the State of Massachusetts.

PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

Gracious God, our prayer is not to overcome Your reluctance to help us to know You and to do Your will, for You have created us to love, and serve, and obey Your guidance. Rather, our prayer is to lay hold of Your willingness to accomplish Your plans through us. You have told us to call on You, to trust You completely, to put You first in our priorities, and to express our devotion to You in our patriotism. Sometimes, pride blocks our response, and we find it difficult to turn the control of our lives over to You. When we are self-sufficient, we do not pray; when we are self-satisfied, we will not pray; and when we are self-righteous, we cannot pray. And yet, Father, when we are honest with ourselves, we know that, by ourselves, we are insufficient. We admit our profound need for Your presence, Your wisdom, and Your solutions to our problems. Continue to guide the discussion of the crucial issue of affordable prescription drugs for America. May this be a great day, lived to the fullest, trusting You each step of the way. Through our Lord and Saviour. Amen.

PLEDGE OF ALLEGIANCE

The Honorable JOHN F. KERRY led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, July 18, 2002.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable JOHN F. KERRY, a Senator from the State of Massachusetts, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. KERRY thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The distinguished assistant majority leader is recognized.

SCHEDULE

Mr. REID. I thank the Chair. The Chair will announce very briefly that there will be a period for morning business until 10:30 a.m., at which time we will take up the military construction bill with 15 minutes of debate. All Members are advised this should be a busy day. We have many things we need to accomplish on legislation now before the Senate.

We have a number of other issues we need to have resolved. I have notified staff for the minority that I am going to again propound a unanimous consent request to appoint conferees on the terrorism insurance bill. We have been held up doing this for weeks and weeks. The business community is going deeper and deeper into trouble because of our not coming forward with legislation. We cannot do that until the minority allows us to appoint conferees.

Mr. President, the first half of the time under the order of last evening is under the control of the majority. Senator STABENOW is here, but also Senator SPECTER is here. Senator SPECTER has a conference at 10 o'clock. We are entitled to the time. If Senator STABENOW has a time situation, she should proceed. I do not know if she would have time to give the Senator from Pennsylvania 10 minutes or so. I know he asked for 15 minutes. Maybe that is a little too much.

Mr. President, will Senator STABENOW tell me how she feels?

Ms. STABENOW. Mr. President, I will be pleased to yield some time to my friend from Pennsylvania. I am not sure what he is asking for at this point. I need to preside at 10 a.m., and I know we have other colleagues coming, but I will be happy to yield.

Mr. REID. Mr. President, I ask unanimous consent that the order be changed and that the Republican time begin with Senator SPECTER now taking 15 minutes. Is that what he wants?

Mr. SPECTER. Mr. President, I will try to abbreviate my remarks.

Mr. REID. If the Senator can do it in 10 minutes, that will allow Senator STABENOW time to speak before she takes the chair.

Mr. SPECTER. I thank my distinguished colleague from Nevada, and I will endeavor to limit myself to 10 minutes.

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

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be a period for the transaction of morning business according to the unanimous consent agreement just entered into, and time shall not extend beyond the hour of 10:30 a.m., with Senators permitted to speak for up to 10 minutes each. The control will be as the distinguished acting majority leader just described.

The Senator from Pennsylvania is recognized.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

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Mr. SPECTER. I thank the Chair and the Senator from Michigan and the Senator from Nevada.

(The remarks of Mr. SPECTER pertaining to the introduction of S.J. Res. 41 are printed in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

The ACTING PRESIDENT pro tempore. The Senator from Michigan is recognized for a period of 10 minutes.

PRESCRIPTION DRUGS

Ms. STABENOW. Mr. President, I appreciate very much being recognized and having an opportunity this morning to speak regarding the situation I believe we are in and the challenges right now as they relate to moving forward on addressing prices and cost containment in the pharmaceutical industry.

We heard a lot of discussion yesterday. We had the opportunity to debate whether to open the border to Canada to have more competition between the prices that American companies charge in the United States and those in Canada. I was pleased we were able to move forward and come together on a plan to open the border, and now we place it in the hands of the Secretary of Health and Human Services to certify the difference in prices which we know are there and the fact that there is no safety risk, which we know is the case. So I look forward to moving ahead.

A lot came up during that debate and I did want to, as we set the stage to debate additional efforts today to lower prices, speak as to how I view the situation in our country right now with our most profitable industry. I welcome the fact that we have a very profitable, successful prescription drug industry. There are new lifesaving drugs being created that keep people out of the hospital and living longer. We celebrate that.

Over the last several years, we have seen more and more of a focus on selling and marketing and promotion than creating the next generation of lifesaving drugs. That is of great concern to me. When we talk about reducing prices, we hear that means reducing research and development. Yet there is nothing today that indicates that is factually accurate.

Yesterday, Family USA produced another study showing the companies are spending 2.5 times more on advertising, promotion, marketing and administration than they do on research and development. The blue on my chart is R&D and the gold is advertising and marketing. For each of the top drug companies, the gold line is much higher than the blue line. We know there is more being spent in this effort.

We also know when you look overall at the profits versus R&D, we see stark numbers. Merck is a successful company in the United States. Their profit was three times more than what they spent on R&D last year. I do not begrudge that profit margin, but if we are going to have the next generation of new lifesaving medications, we need to see that R&D is the focus and that prescriptions are affordable. If they are not affordable, they are not available. That is not acceptable. This is about trying to get some balance in the system. Pfizer had 1.5 times more in profit last year than what they spent on R&D. They spent more on advertising than on R&D.

In the context of what we are talking about right now with corporate responsibility, and companies where executives take the dollars and run, leaving the shareholders or employees holding the bag, my concern is that while we are talking about the need to stop prescription drug prices from rising three times the rate of inflation, which is the average right now—the average drug used by seniors last year went up three times the rate of inflation. Our seniors do not have insurance coverage and are paying the highest prices in the world—but these companies are making top profits in the world today, and we find astounding salaries in compensation for the CEOs. I do not begrudge it, but I do when our average senior is deciding this morning: Do I eat breakfast or do I take my medicine? Companies are saying, no, they cannot lower prices; they could not possibly have more competition, they cannot open to Canada, they cannot allow more generics on the market, they cannot possibly handle more competition, or lowering prices without cutting R&D.

I am offended when I look at the numbers, when we are seeing more on promotion and advertising, more on the sales machine than on research and developing new drugs, more in profits, way more in profits than R&D, and more in the compensation for those at the top.

I will not name individuals, but we see the five highest paid executives in the industry, and the top at Bristol-Myers, with a salary of almost $75 million last year in direct compensation, not counting unexercised stock options. Compare that to the average senior who is either not getting their medicine, cutting their pills in half, or taking them every other week; families who are struggling; small businesses whose premiums are skyrocketing and are having trouble affording health care for their employees because of 30 to 40 percent premium increases, mostly because of prescription drugs, and employees are told they cannot get a pay raise next year because the company has to cover more in medical premiums. I believe that company is sincere in having to struggle with those benefits, those prices.

Put that picture together with that of the drug companies, one of the most highly subsidized industries in the world: $23.5 billion we as taxpayers put into the National Institutes of Health this year. So the companies can take that basic research, and I support that—I would support more—they take that basic research, and they then develop their drugs. We give them tax credits and tax writeoffs to develop through research. We also give them tax writeoffs for their administration, their sales, their marketing. We give them a 20-year patent so they are protected from competition for their name brand so they can recover their costs for R&D. What do we get at the end? The highest prices in the world, and an effort to fight everything we are trying to do in the Senate—to increase competition and to lower prices and to provide Medicare benefit.

Then to add insult to injury, we see those at the top of the companies that who are fighting us earning $75 million a year, $40 million a year, $28 million, $23 million, $15 million a year. We see unexercised stock options. At the top is Merck, $93 million in unexercised stock options; $76 million; $60 million; $56 million; $46 million.

I could live on that. I think everybody within the sound of my voice together could live on that. I don't begrudge that. But I do begrudge people in that category heading companies that fight everything we do. They have put more money into their lobbying corporation than anybody else. For every one Senator there are six drug company lobbyists who spend their time more on sales and marketing than anything else.

Let me speak from the standpoint of our future health care discoveries. In Money and Investing, the Wall Street Journal, there was an article about a merger this week, and one of the disturbing parts of that was this:

After falling for 5 years, new drug applications to the Food and Drug Administration are expected this year to slide further. Through the first 5 months of this year, the FDA had received just two new applications for new drugs. Last year, total new drug applications dropped to 24, less than half the 53 received in 1996. Many in the industry say that past mergers may be among these reasons for these drops in new drug discoveries.

What I see is an effort more and more to focus on the fast, easy money, the quarterly report. Eighty percent of the new applications for patents now at FDA are not for new lifesaving discoveries that increase our longevity and deal with health challenges, but they are, instead, what are called ''me too'' drugs; 80 percent of the patents. A purple pill becomes a pink bill, a daily dose becomes a weekly dose, or maybe, to add insult to injury, the packaging changes.

I urge, as I draw to a conclusion, that as we look at the issues before the Senate on increasing competition and lowering prices, we do so understanding there is a lot of room to bring down prices without ever touching R&D. I argue we need to do everything possible to change the incentives to a longer view, to more research and development. This industry is out of

whack, just as the other industries we were talking about, the system of accounting and auditing, the whole process that has now put us in a position where the incentives are to run right up to the line or over the line, to push for the quarterly profit statement, to look for the intermediate gain, the immediate cash rather than the long-term view.

Unfortunately, this is not a pair of shoes. It is not even a new car—and I want everybody to buy a new car. This is not an optional buy. This is lifesaving medicine. The research is heavily subsidized and paid for by taxpayers, and I think we deserve better. I think that is what this debate is about.

We want a healthy industry, we want R&D, but we want the American taxpayers to get their money's worth and be able to afford the medicines they have invested in and helped to create, medicines that will help them and their families be able to be healthy.

The ACTING PRESIDENT pro tempore. The Senator from New Jersey.

Mr. CORZINE. Madam President, I ask to speak for 10 minutes in morning business.

The PRESIDING OFFICER (Mrs. STABENOW). The Senator has that right and is recognized for a period of 10 minutes.

Mr. CORZINE. Madam President, I rise today to support passage of a Medicare prescription drug benefit and express my strong belief that the time has come when a Medicare prescription drug benefit that provides affordable and meaningful coverage for all our Nation's seniors should be implemented. We have a historic opportunity to reform our Medicare programs and put in place something that I think we all know is necessary and important for our Nation's well-being.

I particularly also thank Senator STABENOW, the Presiding Officer, for her extraordinary leadership in raising the level of awareness, the level of concern and consideration, not only inside the Chamber but across the country. She has done a remarkable job of elevating the quality of debate on the subject.

Furthermore, and equally so, I thank my colleagues, Senator BOB GRAHAM, Senator KENNEDY, and Senator MILLER, for their efforts to bring forward a real and meaningful prescription drug program. It is one that I think all of us should get behind and support. It is measured but certain.

I have yet to speak out on specific programs. As the Chair knows, the industry which you just so eloquently spoke about is an important part of the community which I represent. It has been important, in my view, to find a response to this great need in our Nation that also does not undermine all the elements that I think make the industry so important to our Nation and so entrepreneurial. In fact, I think the Graham-Kennedy-Miller program has found that balance. It is for that reason I also want to make sure I am on record expressing my support.

All of us know it is time to act. We need to ensure that seniors can afford their prescription drugs. We have heard the refrain that we should not be forcing people into these hard choices, and it is a reality. Anyone who is in public life, who interfaces with our senior citizens around our country—just as much in New Jersey as anyplace else—knows that these are real world choices for people: Whether they can afford their lifesaving, quality-of-life-producing prescription drugs or whether they have to choose between that and other aspects of quality of life, including the simple things such as house and home, and their ability to have quality of life in general, which our Nation can afford, absolutely, including putting food on the table.

The fact is, this is a choice far too many of our seniors are having to make, and it is time for us to move to make these costly drugs available so our seniors can lead that independent, productive life that I think all of us hope for, for our families, our parents, and certainly we want for our generation as well.

That is why I support this bill. I will be very aggressive in getting out and trying to promote it, not only here in the Chamber but actually among those in the industry so we can move forward.

This effort truly does guarantee prescription drug coverage for every senior—it is universal—rather than relying on the private insurance industry to provide that coverage. That is what the alternative House bill is all about. I think many of us think that is going to leave a lot of folks out of the system.

The Democratic package also ensures that seniors will have coverage all year. It does not have to deal with so-called doughnut holes, or black holes, two-thirds of the calendar year where people are left out of any kind of coverage. That is certainly the case with the proposal that is coming out of the House, the Republican proposal.

Under that proposal, a senior would pay $400 a month for her or his prescriptions, but they would essentially be out of coverage for nearly two-thirds of the calendar year. I think that is a major flaw that needs to be addressed. I think it is very effectively done in the Graham-Kennedy proposal.

Furthermore, the Republican proposal threatens to undermine the private insurance market. This is really a perverse economic impact. Their proposal would have the effect of encouraging employers to drop prescription drug coverage from employer-provided health plans. In 10 minutes I am not going to go through this, but the fact is, individual workers facing catastrophic drug costs would not have their drugs provided by the Government if their employer paid for some portion of those drug costs. It is a really serious flaw about which I think almost anyone who has analyzed the proposal coming from the House is concerned. It needs to be addressed under any circumstances.

I also ask those who have criticized the cost of the Democratic package that they consider the high cost of not providing comprehensive drug coverage. They call that a cost-benefit analysis. It is well known that prescription drugs reduce the number of hospital admissions, surgical procedures, and doctor visits. They also can reduce costly admissions to nursing homes, helping seniors to stay home longer. Those are real savings that will come. I do not think we have fully appreciated that or explained those or factored those into our thinking.

Needless to say, this is not just about saving money, it is about improving the quality of life for our seniors, allowing them to lead longer, healthier, and more productive lives. This is reform that Medicare needs. It is one we cannot afford not to address, not to deal with, not to move on.

In my own State of New Jersey, we recognized this need about 25 years ago when we created a pharmaceutical benefit for seniors—probably the best in the Nation. By the way, we have to make sure that as we legislate here, we engineer this legislation in a way that it is supportive of the prescription drug program we have in New Jersey, which is designed to serve the low- and middle-income seniors in an extraordinary way.

But I have to say it is almost unconscionable that States such as New Jersey and Pennsylvania—I think it has a similar program—have stepped to the plate to provide this important health care benefit to seniors while the Federal Government has failed to do it. As a matter of fact, it makes New Jersey a magnet for seniors—a positive element in our society. But people have recognized this fundamental need and have voted with their feet with respect to the follow-through on this.

The Democratic plan will help States such as New Jersey expand, if we are careful about how we write this legislation, and improve that prescription drug program for everyone. By contrast, the Republican proposal does nothing. As a matter of fact, it will increase—if we are to meet the constraints that are put down in the bill—co-pays and coverage under our PAAD Program, which is what our benefit program is called. That is simply unacceptable and will require a lot of resistance from those of us who care about our seniors—in New Jersey specifically.

Last year, the Senate passed a Patients' Bill of Rights to ensure that Americans with private health insurance have access to prescription drugs and medical procedures they need to maintain their health. Should we not offer the same protection to our seniors, millions of whom currently lack access to essential medicines? It is a fundamental flaw of Medicare. It is one we need to deal with, particularly because Medicare was designed before the explosive growth of medications, so the

use of medicines is not covered where they are now being applied.

We have an opportunity and a responsibility to correct this flaw by enacting a prescription drug benefit.

I want to work with my colleague in the Chair, my friend from New York, and all of those who truly care about making our society one where access to quality of life that America can offer is made available to all citizens. It is absolutely essential that we move forward.

Lastly, it concerns me that we are willing to spend $4 trillion to make last year's tax cuts permanent, which essentially goes to a lot of those people the Chair was talking about who are making $70 million and $40 million, the well off in our society, and we don't think we have the resources to pass a $100 billion prescription drug benefit for senior citizens in our Nation.

It is time for us to act. Those people have worked hard, paid their taxes, and supported our Nation in all kinds of ways. It is time to get a prescription drug benefit, get it through this Chamber, get it to the House and to the President's desk.

I thank the Chair. I look forward to working with you and all my colleagues to make sure this comes to pass as soon as possible.

The PRESIDING OFFICER. The Senator from New York.

Mrs. CLINTON. Madam President, I commend my colleague from New Jersey for his statement, which I think all of us recognize was arrived at after considerable study and thought since he does represent a State which has a concentration of our finest pharmaceutical companies. His statement today, which shows a balance and a very thoughtful approach to policies that affect us, is a great addition to this debate.

Madam President, I ask unanimous consent to speak for up to 12 minutes as in morning business.

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

Mrs. CLINTON. Thank you, Madam President.

Madam President, I wish to pick up on a comment that you made at the end of your remarks before assuming the Chair.

I, as all of our colleagues, deeply respect the leadership you have provided on this issue. You are down here on the floor day after day making the case on behalf of the need for prescription drug coverage and reform that would provide the lifesaving quality-of-life drugs to our seniors and open the doors to others who are not yet of Medicare eligibility but who have very high prescription drug costs.

At the end of your remarks you said this was connected to the debate that we finished last week concerning the serious issues about accounting and corporate governance to which we have to pay special attention. I agree with that. We may be debating prescription drug coverage, but it is in the larger context of what kind of country we want to be. What kind of values do we espouse? How are we going to ensure that people not only have the perception but the reality that our system works for everybody, not just for the rich and the powerful, not just for the big companies but for the small businesses and for the average citizen? There is a connection. I think that connection deserves to be drawn. I thank you for doing so.

The legislation we are discussing this week addresses not just a top health priority but a fundamental value of who we are as Americans. Will we or will we not provide access to affordable prescription drugs for our seniors? Will we or will we not make equivalent generic drugs available for all Americans? Simple question; complicated answer. That is what we are attempting to work out today.

The prescription drug issue is well known to any of us who have had to fill a prescription in the last several years. Prescription drug costs have been rising at an annual rate of 20 percent, far outpacing inflation and more than doubling in the last 5 years.

We set a goal a couple of years ago to double NIH funding within 5 years, but instead we have seen the doubling of drug industry costs.

Costs have increased for a number of reasons. People have begun to use more of these so-called lifestyle drugs in addition to the lifesaving drugs. Costs are also increasing because of drug company marketing efforts to shift patients away from older, less expensive drugs to newer, costlier, so-called ''me too'' drugs which have had an impact. ''Me too'' drugs are copycat drugs that actually do little or nothing more than the existing drugs we already have, but they are more expensive because they are new. It is like when you go to the supermarket and they say new and improved, new and different. These are new but not necessarily improved drugs. They are copycat drugs.

We have recently heard examples of Vioxx and Celebrex, expensive, new, heavily advertised drugs that doctors now tell us may be no better than the kinds of drugs you get across the counter for which you don't need a prescription.

Drug companies are also spending up to $13,000 per doctor annually trying to influence research results and prescribing patterns. Think about it. Every doctor in America has a $13,000 allocation from drug companies that flood his or her offices with salespeople with all kinds of inducements—with trips and dinners and the like in order to convince the doctor to use this different drug than the doctor has been using or to try the new and improved copycat drug. This is going on despite the ethics and gift guidelines that the American Medical Association has developed and that the pharmaceutical association—known as PhRMA—has agreed to follow.

Many of my physician constituents continue to complain to me that, despite these ethical guidelines, drug company representatives have attempted to circumvent and flout them.

With the multibillion-dollars that drug companies spend annually on drug promotion and on physicians, this shocks me, I have to tell you. I said to my staff: You have to go and triplecheck this. I couldn't believe it. But with the money they spend on drug promotion mostly directly to physicians, their spending exceeds the amount of money that we spend as a nation educating all medical students and medical residents in our Nation.

That just isn't right. We have a voluntary set of guidelines that are supposed to control it, but, unfortunately, as with a lot of human nature, those voluntary guidelines don't have enough teeth in them to make it happen.

I am also concerned about the erosion of privacy. Drug companies are doing everything they can to convince patients—that is you and me—to try the drug. In addition to convincing physicians with all of their money, they are spending a heck of a lot of money trying to convince us to try something.

A friend of mine said she didn't even know she had a problem until she saw an advertisement. And all of a sudden, she now thinks she has a problem. She talked to her doctor. Her doctor said she really didn't need it. She said: I am not sure. She said: Should I listen to the doctor or should I listen to the advertising? I said: For Heaven's sake, you wouldn't do that on anything else. Why would you do it on this?

Advertising really works. It gets into our psyche. It kind of convinces us of things and makes us feel that we are not doing what we should unless we go out and buy a new product. That is the same with new drugs.

The privacy aspect is different than going out and being convinced that you need a different car or that you should try a different detergent.

Under the Bush administration, privacy regulations previously issued by the Secretary of Health and Human Services have been changed. These changes make it easier for drug companies to acquire patient information about us and then to use that patient information they get from doctors, pharmacists, or health provider organizations without our full knowledge, and certainly without our prior consent.

Several weeks ago, we heard about a woman in Florida who received an unsolicited prescription drug, Prozac, in the mail. She believes her privacy was violated. I think she is right. It was violated. Can you imagine, all of a sudden, into your mailbox come drugs that you never asked for, that were never prescribed for you? I do not think any drug company should have access to a patient's records or be able to use that kind of intimate information without a patient's full agreement and consent.

So I worry about the combination of the Bush administration weakening

privacy regulations and the drug companies using that information, which is extremely personal, to try to sell us something.

I do not have any argument with the lifesaving benefits that are provided to all of us because of the work done by pharmaceutical manufacturers. Their role in the American health system is not only vital but should be rewarded through exclusive patents on their discovery for the full patent term of up to 20 years, as set forth by one of our colleagues and a colleague from the House in the Hatch-Waxman bill passed years ago.

However, Hatch-Waxman represented a carefully crafted balance designed to make the American consumer—the American patient—the ultimate beneficiary. On the one hand, Hatch-Waxman established full restoration of the monopoly patent time for a brand name drug as an incentive for real innovation. On the other hand, Hatch-Waxman ensured that after the monopoly term ended, the consumer would get the benefit of competition because there would no longer be an exclusive right to manufacture and market that drug.

We know the consumer will get benefits with lower drug prices and generic versions which are just as good as the brand name patented versions. Generic drugs share the same active ingredients as the brand name drugs but, as this chart shows, the generics are usually considerably less expensive. Generic drugs have also increased in price but at a much slower rate than brand name drugs have.

Generic drugs help keep prices down, particularly for our seniors. If you look at this next chart, it is a chart showing the costs that are involved in manufacturing and advertising drugs. It is very clear that the amount of money that is spent to market these drugs goes right into the cost of them. That $13,000 per doctor, that has to be paid by somebody, and we are the ones who end up paying for it.

It is important to protect innovation. Nobody wants to undermine innovation. But in recent years, drug companies have clearly taken advantage of these loopholes to keep generics off the market. What we have found is that the brand name manufacturers are frivolously listing patents not because the generics will infringe on the patents but simply to force generics to certify that those patents are invalid in order to get the lower priced generic drugs to market. The reason is that forcing this certification gives the brand name drug an automatic 2½-year extension, called a 30-month stay, on their monopoly, regardless of the merits of the patent.

Let me give you a few quick examples.

There is a medication called Pulmicort, which is an asthma medication. In addition to all the patents on the compound—in other words, the active ingredients that are in the drug that makes it work for asthma—in addition to all the patents on the compound, on its use, and on its formulation, they have a patent on the container, which is in what is called the Orange Book. The container may be a really nice container, it may look great inside your medicine chest, but when a generic company is seeking to make a pill for asthma, it is not trying to make the bottle, it is trying to make the pill. So a patent on the bottle should not prevent the generic version of the drug from coming to market.

In addition, we know that some drug companies make sweetheart deals with generic companies, literally paying them—I would say bribing them—to stay off the market, which under one of the loopholes in the current law means that other generics also have to stay out of the market.

So generic X comes and says, we are going to the market with this drug, and the big drug company says, we will pay you not to; and they say, OK, we will not. That means nobody can come with a competitive drug that will do the same thing at a lower price.

I support adequate patent terms for pharmaceutical manufacturers to conduct research and development, which all of us know is high risk and high stakes, but the best way to encourage that research and development is a prospective approach rather than a patent extension after the fact.

Companies, as we know, have been maneuvering at the 11th hour just as their patents are about to expire. This legislation, the underlying Schumer-McCain legislation, is intended to prevent that.

So let's do the right thing. Let's get our generic manufacturers a level playing field. Let's get a prescription drug benefit for our seniors. And let's send a message to America that we want to treat people fairly in this great country of ours.

Thank you, Madam President.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. THOMAS. Madam President, how much time is remaining on the division in morning business?

The PRESIDING OFFICER. Five minutes is remaining in morning business.

Mr. THOMAS. That is the share the Republicans have?

The PRESIDING OFFICER. That is the current share, yes.

Mr. THOMAS. I wish we could have divided the time up if we say we are going to.

The PRESIDING OFFICER. The Senator from Pennsylvania was accorded, I believe, 15 minutes.

Mr. THOMAS. And we were accorded 30 minutes, and we didn't get 30 minutes.

PRESCRIPTION DRUGS

Mr. THOMAS. Madam President, I will take just a short time to talk a little bit about pharmaceuticals. Obviously, there are different ideas about that. Indeed, there should be. We are on the floor again, however, without having a committee suggestion to follow, so it will be difficult for us. But certainly we need to do that.

I suggest that the tripartisan bill that is before us is probably the one that is most likely to get support. Indeed, it is the only bipartisan plan in the Senate.

We truly talk about finding common ground traditionally between the views. I think that is a good idea. This bill reforms Medicare and provides prescription drug benefits which will ensure that seniors do have coverage.

The proposal, if it had been debated, I think would have come out of the committee as the one selected. The tripartisan bill spends about $330 billion over 10 years for drugs, which is more than some of the bills, but is considerably less than the one the Democrats have put forth. So this, perhaps, is a reasonable compromise between those proposals.

I think the Democrat bill is unofficially scored at $500 billion for 5 years, and then it expires. So I think that is one of the difficulties, the idea that it expires.

The tripartisan bill also spends $40 billion to make some long overdue changes in Part B and Part A so seniors will have health coverage. So there seems to be quite more available there than in the alternatives. I hope we do something.

Just to comment, one of the things that, of course, we are dealing with—we have talked about, and I think has merit—is the idea of reimportation. That is kind of what is on the floor at the moment. I think there is some merit in that. I do not believe it is the final solution. Indeed, as it gets into operation, we may find it more difficult than it has been.

I think the Cochran amendment, that was passed yesterday, is very useful in terms of safety as it relates to the bill. I do think we ought to go a bit further; that is, I think there ought to be some labeling so that consumers have the opportunity to choose whether or not they want to take on the reimported drugs that have gone through Canada, that may or may not have come from the United States in the beginning. So I do think perhaps we ought to consider the idea, which can be very simple, to have it labeled that it is imported from Canada so people can, in fact, make those kinds of choices.

Mr. President, since our time has been used, I will yield the floor.

I suggest the absence of a quorum.

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

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. McCAIN. Mr. President, may I ask what the parliamentary situation is at this time?

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

MILITARY CONSTRUCTION APPROPRIATIONS ACT, 2003

The PRESIDING OFFICER. Under the previous order, the Senate will now resume consideration of H.R. 5011, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 5011) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2002, and for other purposes.

The PRESIDING OFFICER. The Senator from Arizona controls 5 minutes of debate on this pending measure.

Mr. McCAIN. Mr. President, I ask to be recognized for my 5 minutes.

The PRESIDING OFFICER. The Senator is recognized.

Mr. McCAIN. Mr. President, I regret that the managers are not in the Chamber, but I will proceed with my statement.

Regretfully, I rise yet again to address the Senate on the subject of military construction projects added to an appropriations bill that were not requested by the Department of Defense and are strongly opposed by the Office of Management and Budget.

This bill contains over $1 billion in unrequested military construction projects and includes hundreds of millions of dollars for Army and Air Force infrastructure projects relating to Interim Brigade Combat Teams, IBCTs, and C–17 Globemaster aircraft bed-down military construction projects that the Senate Armed Services Committee has neither approved nor authorized for this purpose.

There are 29 members of the Appropriations Committee. Only one committee member has not added projects to this appropriations bill. Those numbers, needless to say, go well beyond the realm of mere coincidence. Of 116 projects added to this bill, 91 projects, representing 80 percent of all projects, are in the States represented by the Senators on the Appropriation Committees, totaling over $728.1 million.

Every year, I come to the Senate floor to highlight programs and projects added to spending bills for primarily parochial reasons. While I recognize that many of the projects added to this bill may be worthwhile, the process by which they were selected is not.

By adding over $1 billion above the President's request, the Appropriations Committee is further draining away funds desperately needed for transformation. But such short-sightedness is pretty much the norm for Congress. Common-sense reforms—closing military bases, consolidating and privatizing depot maintenance, ending ''Buy American'' restrictions, and ending pork-barrel spending—that I have long supported would free up nearly $20 billion per year which could be used to begin our long-needed military transformation.

But all too often Congress fights these reforms because of home-State politics. As a result, the Defense Department looks elsewhere to find the resources. For example, according to a Baltimore Sun article, ''Pentagon To Consider Large-Scale Troop Cuts,'' the Department is considering cutting nearly 100,000 troops ''to free up money'' for transformation. I would oppose this and we will debate this another day, but I certainly understand the pressure that Secretary Rumsfeld and the Joint Chiefs are under because of Congress' continuing parochialism as evidenced once again by the military construction bill before us.

Included in the Senate Appropriations Committee's report are the words: ''The Committee strongly supports the authorization-appropriation process.'' That is news to many of my colleagues. If that statement is true why would over $550 million in military construction projects be added without prior Senate Armed Services Committee authorization. It could be that many of these projects would be acceptable after going through the normal, merit-based prioritization process. But the Appropriations Committee decided to do otherwise.

Two rather large additions—totaling $200 million—for large military construction projects for Interim Brigade Combat Teams, IBCTs, facilities and the C–17 Air Mobility Modernization Program are examples of the committee's disregard for the authorization process. The committee report justifies these add-ons on the grounds that ''the war on terror has placed new demands on all elements of the military'' and ''military construction timetables developed prior to September 11 are no longer sufficient.'' War profiting is what it is all about. Because of this, the report continues, ''the committee believes that it is imperative to accelerate the Army and Air Force transformation programs.'' There is no mention of Navy and Marine Corps transformation programs. The committee report leads one to ask how the Navy and Marine Corps got it right and the Army and Air Force missed the boat.

The committee's justification for adding $200 million for the IBCTs facilities and new hangars for C–17s, C–5s and C–130s under the Air Force Air Mobility Modernization program is at odds with the facts. The President's budget was sent to the House and the Senate in February—a full 5 months after September 11. Since September 11, the President and his Secretary of Defense have officially forwarded to Congress the Fiscal Year 2002 Supplemental Appropriations bill—which we have not passed—and recently a formal description of how the Defense Department will spend the $10 billion war reserve fund set-aside in the Defense Emergency Response Fund that the President requested for the war on terrorism. Let me ask: did anyone on the Appropriations Committee inform the President that his budget proposal was not ''sufficient''? I know the answer is no.

Let me share some critical facts that were left out of the committee report related to the $200 million in additional funding added for these key programs. It is common knowledge that nearly all the IBCTs will initially be stationed in Alaska and Hawaii and will require a significant increase of infrastructure. General Shinseki has supported testing the IBCT concept in Alaska and Hawaii and then expanding the concept elsewhere. However, in putting together the Army budget, the Chief of Staff of the Army, the Secretary of the Army, and the Secretary of Defense weighed all the other Army priorities and decided that their were more critical funding issues than to accelerate an already robust IBCT program and adding $100 million more for facilities construction.

Likewise, other facts left out of the Appropriations report related to the $100 million in accelerated funding for the Air Force Air Mobility program should be known:

The Air Force did not request this funding;

The requirement for accelerating funding is not on the Air Force Chief of Staff's ''Unfunded Requirements List'';

Nor does it appear in the Secretary of Defense's Wartime Fiscal Year 2002 Emergency Supplemental Appropriations request;

Nor does the requirement to accelerate funding for C–17 hangars show up on the war reserve fund set-aside in the Defense Emergency Response Fund (DERF) that the President recently submitted to Congress as an Fiscal Year 2003 budget amendment for the Department of Defense for expenses relating to the war against terrorism; and

Moreover, over 80 percent of the total $1.6 billion military construction projects under the Air Force C–17 Air Mobility Modernization program will be built in just 4 states: surprise, surprise California, West Virginia, Alaska, and Hawaii—how surprising.

Funding $200 million for IBCTs and C–17, C–5 and C–130 hangars—as part of a larger 4-5 billion dollar program—was simply not authorized by the Armed Services Committee in its recently passed bill. I attended more than 10 hearings on Armed Services this year, and I cannot remember a single instance in which an argument was made in support of accelerating this funding.

Separately, I am at a loss as to the rationale for including in this bill certain site-specific earmarks and directive language. For example, in time-

honored fashion, the Appropriations Committee continues to earmark projects under the heading ''Unspecified Minor Construction.'' According to Title 10, Section 2805 of the United States Code, these ''military construction projects are intended solely to correct a deficiency that is life-threatening, health-threatening, or safety-threatening.'' However, I believe that certain earmarks in this Appropriations bill are in violation of this statute, including provisions that would provide:

Up to $1.5 million in funding for a storage facility for military police emergency vehicles in Fort Wainwright, AK;

Up to $1.5 million in funding for a similar storage facility in Fort Richardson, AK;

$1.5 million in funding for a Kinetic Energy Missile Complex at the White Sands Missile Range in New Mexico;

$1.5 million in funding for a force protection facility at the Naval Air Station in Corpus Christi, TX;

$1 million in funding for a training facility at the Corpus Christi Army Deport in Texas;

$1.5 million in funding for a UAV facility at the Fallon Naval Air Station in Nevada;

$1 million in funding to replace and bury electrical infrastructure at Lackland Air Force Base in Texas;

$1.5 million in funding for a barracks for the Army National Guard in Chillicothe, OH;

$1.5 million in funding for Federal Scout Readiness Centers/Armories for the Army National Guard in Alakanuk, Quinhagak, and Kwigillingok, AK;

$1.5 million in funding for a maintenance facility for the Army National Guard at Fort Harrison in Montana;

Up to $2.5 million in funding for various facilities for the Army National Guard Weapons of Mass Destruction/Civil Support Teams;

Up to $1 million in funding for a warehouse for the Air Force Reserve at the Lackland Air Force Base in Texas;

$1 million in funding for a Multiple Threat Emitter System, MUTES, Facility for the Army National Guard at the Smoky Hill Range in Kansas;

$1.5 million in funding for a Bachelor Officer/Enlisted Quarters for the Army National Guard at Fort Meade in South Dakota; and

$1.5 million in funding for an ammunition supply plant for the Army National Guard at Camp Grafton in North Dakota.

I could go on and on. Without a doubt, each of these provisions unabashedly expands the definition of unspecified minor construction. Sadly, yet significantly, the American taxpayer is once again at the losing end of such reckless congressional action.

I also find objectionable language in this bill requiring that only American firms, or American firms in joint venture with host nation firms, be eligible for architecture and engineering contracts for all overseas projects exceeding $500,000. Similarly restrictive language bans the awarding of any contract over $1 million to any foreign contractor in U.S. territories and possessions in the Pacific, on Kwajalein Atoll, and in countries bordering the Arabian Sea. American firms are among the best in the world; advocating a level playing field for them to compete overseas is appropriate. However, it is both inappropriate and harmful to the best interests of our Armed Forces to mandate that construction projects overseas not be subject to the kind of competitive process that best serves the taxpayer and the service member by providing the best product at the lowest cost.

We are waging war against a new enemy and at the same time undertaking a long-term process to transform our military from its Cold War structure to a force ready for the challenges of tomorrow. A lack of political will had previously hamstrung the transformation process, but the President and his team have pledged to transform our military structure and operations to meet future threats.

The reorganization of our armed services was, of course, an extremely important subject before September 11, and it is all the more so now. The threats to the security of the United States, to the very lives and property of Americans, have changed in the last decade.

In the months ahead, no task before the administration and the Congress will be more important to require greater care and deliberation than making the changes necessary to strengthen our national defense in this new, uncertain era. Needless to say, this transformation process will require enlightened, thoughtful leadership, and not the pork-barreling of military funds if we are to best serve America in this time of rapid change in the global security environment.

I thank the President for this opportunity to address the Senate. I ask unanimous consent that the list of unrequested military construction projects that were added by the Appropriations Committee be printed in the RECORD.

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

In an effort to contain the wasteful spending inherent in member requested construction projects, I sponsored, and the Senate adopted, merit based criteria for evaluating member adds as a part of the fiscal year 1995 Defense Authorization Act. The criteria are: (1) The project is in the service's future years defense plan; (2) the project is mission essential; (3) the project can be put under contract in the current fiscal year; (4) the project does not conflict with base re-alignment proposals; and (5) the service can offset the proposed expenditure within that year's budget request.

FY2003 MILITARY CONSTRUCTION ADD-ONS

Alabama:	
Army: Fort Rucker Physical Fitness Center	$3.5
UH–60 Parking Apron	3.1
Alaska:	
Army: Fort Richardson: Community Center	15.0
Air Force: Eielson AFB Blair Lakes Range Maintenance Complex	19.5
Arkansas:	
Defense-Wide: Pine Bluff Arsenal Non-Stockpile Ammunition Demolition Shop	18.0
Air National Guard, Little Rock AFB: Operations And Training Facility	5.1
California, Navy:	
Camp Pendelton Marine Corps Base: Child Development Center	8.2
Port Hueneme: Seabee Training Facility	10.2
Colorado:	
Defense-Wide, Pueblo Depot: Ammunition Demilitarization Facility (Phase IV)	36.1
Air National Guard: Buckley AFB Control Tower	5.9
Florida, Navy: Panama City Naval Surface Warfare Center: Special Operations Facility	10.7
Georgia, Air Force, Robins AFB: Corrosion Paint/De-paint Facility	24.0
Hawaii:	
Army: Pohakuloa Training Area Access Road (Saddle Road) Phase I	13.0
Navy:	
Ford Island Site Improvements (Utility System)	19.4
Marine Corps Base/OAHU Religious Ministry Facility (Chapel)	9.5
Idaho:	
Army National Guard, Gowen Field/Boise: Readiness Center	1.5
Air National Guard: Gowen Field/Boise Air Support Squadron	6.7
Iowa, Air National Guard, Des Moines: Airfield Facilities Upgrade	9.2
Kansas, Army: Fort Riley Combined Arms Collective Training Facility, PH 1	13.8
Kentucky:	
Army, Fort Knox: Child Development Center	6.8
Defense-Wide, Bluegrass Army Depot:	
Ammunition Demilitarization Facility (Phase II)	9.8
Ammunition Demilitarization Support (Phase III)	7.9
Louisiana:	
Air Force: Barksdale AFB Parking Apron	12.0
Air National Guard: New Orleans Joint Reserve Base Belle Chasse Vehicle Maintenance Support Equipment Shop	5.5
Maine, Navy: Brunswick Naval Air Station Control Tower Upgrade	9.8
Maryland:	
Navy: Carderock (NSWC): National Maritime Technical Information Center	12.9
Defense-Wide, Aberdeen Proving Ground: Ammunition Demilitarization Facility (Phase V)	29.1
Massachusetts, Air Force: Fourth Cliff Recreation Area: Erosion Control/Retaining Wall	9.5
Michigan:	
Army National Guard: Joint/Multi-Unit Readiness Center, Phase 1	17.0
Air National Guard, Selfridge ANGB: Joint Dining Facility	8.5
Mississippi:	
Navy:	
Meridian Naval Air Station: Control Tower and Beacon Tower	2.9
Pascagoula Naval Air Station Bachelor Enlisted Quarters	10.5
Defense-Wide, Special Operations Command: Stennis Space Center, Land/Water Ranges	5.0

Missouri:	
Army National Guard, Fort Leonard Wood: Aviation Support Facility	14.8
Air National Guard, St. Louis/Lambert Field: Base Relocation/Facilities upgrade	4.0
Montana, Air National Guard: Gore Hill/Great Falls: Load Crew Training Facility	3.5
Nebraska, Air Force: Offutt AFB: Fire Crash/Rescue Station	11.0
Nevada, Air Force: Nellis AFB Land Acquisition	19.5
New Hampshire, Air National Guard: Pease Air Base Fire Station	4.5
New Jersey, Navy: Lakehurst Naval Air Warfare Center Structural and Aircraft Fire Rescue Station	5.2
New Mexico, Air Force:	
Holloman AFB: Survival Equipment Shop	4.7
Kirtland AFB: Visiting Airmen Quarters	8.4
New York, Air Force Reserve: Niagra Falls Air Reserve Station Visiting Airmen Quarters, Phase I	9.0
North Carolina, Air Force: Seymour Johnson: Fire/Crash Rescue Station	10.6
North Dakota, Air Force: Minot AFB Cruise Missile Storage Facility	18.0
Ohio, Air Force, Wright-Patterson AFB:	
After Graduate Education Facility	13.0
Consolidate Materials Computational Research Facility	15.2
Oklahoma:	
Army: Fort Sill Logistics Maintenance Facility, Phase I	10.0
Air Force:	
Altus AFB: Consolidate Base Engineer Complex, Phase I	7.7
Vance AFB: Road Repair (Elam Road)	4.8
Pennsylvania, Air National Guard, Pittsburgh: Squadron Operations and Support Facility	7.7
Rhode Island, Navy: Newport Naval Station: Consolidated Police/Fire/Security Facility	9.0
South Carolina:	
Air Force, Shaw AFB: Fighter Squadron Maintenance Facilities	6.8
Air National Guard, McEntire Air National Guard Base: Replace Operations and Training Facility	10.2
South Dakota:	
Air Force: Ellsworth AFB Operations Facility	13.2
Army National Guard, Camp Rapid: Barracks/Dining/Administration and Parking, Phase I	10.6
Texas:	
Navy: Ingleside Mine Warfare Training Center	5.5
Air Force: Goodfellow AFB: Wing Support Complex	10.6
Utah, Air Force: Hill AFB: Consolidated Software Support Facility	16.5
Vermont, Army National Guard: South Burlington Readiness Center, Phase I	11.2
Virginia, Navy: Norfolk Naval Shipyard: Ship Component Service Facility	16.8
Washington, Army National Guard: Spokane Readiness Center (Phase I)	11.6
West Virginia, Air National Guard: Martinsburg Airbase Site Improvement and Utilities	12.2
Wyoming, Air Force: Warren AFB Stormwater Drainage System	10.0
Worldwide Unspecified:	
Army: IBCT Transformation, various facilities	100.0
Air Force: C–17 Transformation, various facilities	100.0
Defense-Wide:	
Planning and Design:	
Tricare Management Activity	3.0
Special Operations Command	0.1
Undistributed	8.6
Base Realignment and Closure Account	100.0
MINOR CONSTRUCTION	
Alaska:	
Army:	
Fort Wainwright: Military Police Emergency Storage Facility	1.5
Fort Richardson: Military Police Emergency Vehicle Storage Facility	1.5
Army National Guard: Federal Scout Readiness Centers	1.5
Kansas, Air National Guard: Smoky Hill Range Threat Emitter System	1.0
Montana, Army National Guard: Fort Harrison Engineer Maintenance Facility Construction	1.5
Nevada, Navy: Fallon Naval Air Station: UAV Facility	1.5
New Mexico, Army: White Sands Missile Range: Kinetic Energy Missile Complex	1.5
North Dakota, Army National Guard: Camp Grafton Ammunition Supply Point Construction	1.5
Ohio, Army National Guard: Chillicothe Barracks Construction	1.5
South Dakota, Army National Guard: Fort Meade Bachelor Quarters	1.5
Texas:	
Army: Corpus Christi Army Depot: Training Facility	0.9
Navy: Corpus Christi: Force Protection Facility	1.5
Air Force:	
Laughlin AFB: Railroad Crossing Gates	0.2
Lackland AFB: Replace and Bury Electrical Infrastructure	0.9
Air Force Reserve: Lackland AFB Warehouse Renovations	0.8
Army National Guard Wide: Weapons of Mass Destruction Civil Support Teams Facilities	2.5
PLANNING AND DESIGN	
Alabama, Army National Guard: Haleyville Joint Readiness Center Design	1.1
Alaska:	
Army, Donnelly Training Area: Training & UAV Maintenance Support Facility	1.5
Air Force, Elmendorf AFB: Wide-Body Aircraft Hangar	2.7
Army National Guard: Bethel Readiness Center Design	0.5
Air National Guard: Kulis ANG Base Pararescue Training Complex Design	0.7
California:	
Navy: North Island Naval Air Station	0.4
Air Force, Travis AFB: Replace C–5 Squadron Operations Facility/Aircraft Maintenance Facility	0.9
Connecticut, Army National Guard: New Haven Readiness Center Design	1.4
Delaware, Air Force, Dover AFB: Control Tower	0.7
Hawaii, Army National Guard: Barbers Point Naval Air Station Relocation Design	2.0
Massachusetts:	
Air Force, Otis ANG: Fire/Crash Rescue Station/Control Tower	1.7
Army Reserve: Hanscom AFB Armed Forces Reserve Center Design	2.6
Mississippi, Army National Guard:	
Clarksdale Readiness Center Design	0.3
Gulfport Munitions Complex Design	0.7
Missouri:	
Army, Forest Leonard Wood: WMD First Responder Training Facility	0.5
Army National Guard:	
St. Peters Readiness Center Design	0.3
Springfield Aviation Classification Repair Depot Design	1.2
Nevada:	
Army National Guard: Henderson Readiness Center Design	0.9
Air National Guard: Reno Security Complex Design	0.9
New York, Army National Guard: Fort Drum Equipment Maintenance Site Design	1.5
Pennsylvania, Army: Letterkenny Depot: Storage Igloo Upgrade	0.4
South Dakota, Army National Guard: Rapid City Readiness Center STARC Design	1.2
Pierre Organizational Maintenance Shop Consolidation Design	0.3
Texas:	
Army, Camp Bullis: Vehicle Maintenance Facility	0.9
Navy, NAS Kingsville: Replace Fuel Farm	1.0
Air Force, Brooks AFB: Tri-Service Research Facility	1.0
West Virginia, Air National Guard: Martinsburg Air National Guard Base, C–5 Support Facilities Design	3.0
Wisconsin, Army Reserve: Eau Claire Armed Forces Reserve Center Design	0.9
Total MILCON Members Add-Ons= $1.1 Billion	

Mr. McCAIN. Mr. President, I regret that at a time when our defense dollars need to be spent efficiently, we now continue the pork-barreling of the military construction appropriations bill.

I yield the floor.

Mr. WELLSTONE. Mr. President, the 2003 Military Construction Appropriations bill provides over $10 billion in funding for planning, design, construction, and improvements for military bases around the world. A long neglected priority, the bill would provide $4.2 billion for family housing, much of which is substandard right now. Many armed forces personnel have suffered a declining quality of life in recent years despite rising Pentagon budgets. The pressing needs of dedicated men and women in uniform and their families must be addressed, especially as they continue to be mobilized for duty in response to the attacks of September 11.

I want to highlight two provisions in this bill that are of particular importance to my home State of Minnesota. For a very long time, I have said that there would be an increased reliance by the Defense Department on the National Guard as budget pressures and force structure realignments continued. Since the attacks on America on September 11, the men and women of the National Guard have flown air missions to secure our skies, and they have protected airports and other vulnerable public facilities. I am pleased that we were able to include in this bill $15 million for the Duluth Air National Guard Base for an airport maintenance facility at the 148th Fighter Wing, which will provide maintenance and repair of 15 F–16 fighter aircraft. Further, the bill contains $1.45 million for the Harden Naval Reserve Center in Duluth. I am pleased that these projects

are receiving the funds they deserve, and I appreciate the opportunity to work in this area with my colleague from Minnesota, Senator DAYTON, who, as a member of the Armed Services Committee, is especially attentive to such needs. The bill goes far in addressing many vital national needs, and I am voting for it today.

The PRESIDING OFFICER. Who seeks time?

The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I rise as the ranking Republican on the committee that has the bill before us for military construction, and I am pleased to have worked with Senator FEINSTEIN, chairman of the subcommittee, to bring out a bill that does address the priorities of the Defense Department.

I noticed that the Senator from Arizona targeted the Appropriations Committee, saying that a large percentage of the Appropriations Committee were taken care of, as if this were some pork-barrel spending.

The fact is, the Senate Armed Services Committee has authorized every project in this bill. We don't have projects in the appropriations bill that have not been authorized by a completely different committee that focuses totally on defense and has determined that these projects should be authorized.

I am very pleased to support this bill. It provides new mission facilities for the Department of Defense consistent with the Department's request. The priorities are articulated by the military departments. It also enhances quality of life for servicemembers and their families—a commitment we made to these people who are representing our country and fighting for our freedom on the plains of Afghanistan and in Kuwait today, based there for us. We are going to take care of them. Finally, it makes a significant downpayment on renewing the Department of Defense aging infrastructure.

Every project in the military construction appropriations bill is authorized in the Defense authorization bill, a completely separate bill. Two committees have looked at these priorities. Every project in the bill is on the Pentagon's future year defense plan, and every project the committee added was the base commander's highest priority.

The committee added funds to the military construction bill because we were concerned with the sharp drop in funding, particularly for the Guard and Reserve forces. That is where much of the funding we have added is focused. Our Guard and Reserve forces are fighting side by side with our active-duty forces in Afghanistan and providing the bulk of our homeland security forces here at home.

Adequate training and readiness facilities are essential for the Guard and Reserve, particularly during this time of increased demand on their skills and services. The bill provides greatly needed facilities for the Guard and Reserve and will help them prepare for and execute their missions.

The bill also provides funding for two key transformation initiatives in support of President Bush's strategic vision for transforming the Department of Defense: $100 million for Army transformation, and $100 million for Air Force mobility transformation.

Earlier this year, both the Army and the Air Force identified unfunded transformation military construction requirements to the Congress. Many of these requirements were refined after development and presentation of the 2003 President's budget, so we added them because they are critical to the Army and the Air Force to make them more mobile and capable to face the 21st century battle conditions.

The committee funded another initiative, the BRAC environmental cleanup initiative, which provides $100 million to accelerate the cleanup of dangerous environmental contaminants at closed and realigned bases throughout the Nation. Until the cleanup of these bases is completed, the properties cannot be returned to productive use in these communities.

In my own State of Texas, we have terrible environmental bills, both at the former Kelly Air Force Base in San Antonio and the former Navy Air Station in Dallas. There are reports like this across the country, and we are trying to address those concerns wherever they may be, so that these closed bases can be returned to productive use, as we have promised these communities they would be.

Mr. President, this is a good bill. It is a bill that stresses the priorities of the Department of Defense and the President. It also has added areas that were not able to be added earlier because the Department of Defense wasn't ready, and we certainly added more than the President's budget allowed for Guard and Reserve units.

I think the priorities are right, and I urge my colleagues to support this bill so we can get on with the business of revamping our aging military infrastructure and increasing the quality of life for those who are fighting for us as we speak on this floor.

I yield the floor.

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. FEINSTEIN. Mr. President, as chairman of the subcommittee, I thank the ranking member, the distinguished Senator from Texas, for her help on this bill. She has been a wonderful colleague with whom to work, and I am very grateful for that.

Mr. President, essentially, this bill, as Senator HUTCHISON said, provides $10.6 billion in new budget authority. That is a tenth of 1 percent over last year's appropriation. It is 10 percent over the President's appropriation. The reason for this is that the President cut the Guard and the Reserve 52 percent from last year's budget request. We do not believe they can sustain their infrastructure requirements with that kind of a funding shortfall.

As Senator HUTCHISON mentioned, every project is in the 5-year defense plan. Every project has been authorized. Every project is the base commander's priority. With respect to the transformation initiative, we didn't decide the locations, the services decided the locations. Both the Army and the Air Force have identified the locations for their transformation initiatives. The Army involved 13 active and Guard installations in six States, plus Germany. The Air Force's transformation involves 53 active, Guard, and Reserve bases in 32 States, plus Germany, Japan, and Puerto Rico.

The Appropriations Committee is not—and I stress that—attempting to divert funding from any of these planned locations or to influence where the money will go. These decisions have been and will be made by the services. The purpose of the transformation initiative is to accelerate the process. Infrastructure is a long lead time item, and we need to start investing more in this transformation infrastructure now to meet the service requirements.

Essentially, 53 percent of this bill is for military construction for the active and Reserve components. It is $610 million for the Guard and Reserve, $1.1 billion for barracks, $26 million for child development, $137 million for medical facility, and $159 million for chemical demilitarization. The remaining 40 percent—$4.23 billion—is for family housing, including new housing, housing improvements, and operation and maintenance of units.

At the BRAC cleanup, as Senator HUTCHISON stated, I can tell you that we have one closing base—McClellan Air Force Base—in northern California, where plutonium has badly contaminated the ground. Senator HUTCHISON, in her State, has toxic materials that are seeping into residential areas from Kelly Air Force Base. There is no question in either of our minds that the BRAC rounds we have completed were not sufficiently funded with environmental remediation dollars. The proof is in the pudding, and that pudding is that many bases still cannot be transitioned into productive civilian use because of the absence of the ability to clean them up.

Mr. President, the MilCon bill is important to the men and women in uniform who serve our Nation at home and overseas. We believe it is a good bill, it is a bipartisan bill, and I strongly urge my colleagues to approve it.

How much time do I have left?

The PRESIDING OFFICER. The Senator has 40 seconds.

Mrs. FEINSTEIN. I yield back the remainder of my time.

The PRESIDING OFFICER. The bill having been read the third time, the question is, Shall the bill pass?

The yeas and nays have been ordered, and the clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from North Carolina (Mr. HELMS) is necessarily absent.

I further announce that if present and voting the Senator from North Carolina (Mr. HELMS) would vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas, 96, nays 3, as follows:

[Rollcall Vote No. 181 Leg.]

YEAS—96

Akaka	Domenici	Lugar
Allard	Dorgan	McConnell
Allen	Durbin	Mikulski
Baucus	Edwards	Miller
Bayh	Ensign	Murkowski
Bennett	Enzi	Murray
Biden	Feinstein	Nelson (FL)
Bingaman	Fitzgerald	Nelson (NE)
Bond	Frist	Nickles
Boxer	Graham	Reed
Breaux	Gramm	Reid
Brownback	Grassley	Roberts
Bunning	Gregg	Rockefeller
Burns	Hagel	Santorum
Byrd	Harkin	Sarbanes
Campbell	Hatch	Schumer
Cantwell	Hollings	Sessions
Carnahan	Hutchinson	Shelby
Carper	Hutchison	Smith (NH)
Chafee	Inhofe	Smith (OR)
Cleland	Inouye	Snowe
Clinton	Jeffords	Specter
Cochran	Johnson	Stabenow
Collins	Kennedy	Stevens
Conrad	Kerry	Thomas
Corzine	Kohl	Thompson
Craig	Landrieu	Thurmond
Crapo	Leahy	Torricelli
Daschle	Levin	Voinovich
Dayton	Lieberman	Warner
DeWine	Lincoln	Wellstone
Dodd	Lott	Wyden

NAYS—3

Feingold	Kyl	McCain

NOT VOTING—1

Helms

The bill (H.R. 5011) was passed, as follows:

Mrs. FEINSTEIN. I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Under the previous order, the Senate insists on its amendment, requests a conference with the House on the disagreeing votes of the two Houses, and that the Chair be authorized to appoint conferees on the part of the Senate.

The Presiding Officer (Mr. BINGAMAN) appointed Mrs. FEINSTEIN, Mr. INOUYE, Mr. JOHNSON, Ms. LANDRIEU, Mr. REID, Mr. BYRD, Mrs. HUTCHISON, Mr. BURNS, Mr. CRAIG, Mr. DEWINE, and Mr. STEVENS conferees on the part of the Senate.

PRESCRIPTION DRUGS

The PRESIDING OFFICER (Ms. LANDRIEU). The Senator from Missouri is recognized.

Mr. BOND. Madam President, I rise today to comment on the overall policies we are working on today. While this bill we are debating, the underlying bill, is a generic drug bill that came out of the Committee on Health, Education, Labor, and Pensions, we all know that ultimately we are going to be talking about Medicare and prescription drug coverage.

We all recognize the lack of prescription drug coverage demonstrates clearly Medicare has not kept up with the rapid advances in medical care, placing ultimately the health care security of too many seniors at risk.

When Medicare was created in 1965 to provide health care for our Nation's elderly and disabled, prescription drugs were not included as part of the program's benefits. At that time, that made sense because pharmaceuticals played an extremely minor role in the world of medicine. In the last 35 years, medical practice has changed dramatically and prescription drugs have become a vital part of health care. In the last decade or two, we have seen a pharmaceutical revolution. Hundreds of amazing new drugs have been developed to treat and manage all different kinds of diseases and medical conditions. Those of our population who suffer from these diseases have benefited greatly.

More and more these days prescription drug are keeping Americans of all ages out of hospitals, enhancing the overall quality of life and, yes, keeping people alive. Hundreds of drugs that were unknown decades ago play a critical role keeping our seniors healthy, active, and alive. Yet many of our most vulnerable citizens are seniors who have trouble affording prescription drugs because their Government-provided Medicare coverage has failed to keep pace with medical progress.

In addition to being exposed financially to the cost of needed drugs, seniors without prescription drug insurance do not benefit from the lower prices that most third-party buyers—such as insurers, hospitals, and pharmacy benefit managers—are able to negotiate with pharmaceutical manufacturers. As a result, seniors without drug coverage must pay the highest retail price for needed medication.

That is a situation we must change. It is time to modernize our Medicare system and to add a prescription drug benefit to protect the health care security of our seniors. The Medicare Program needs to be updated to reflect the past 35 years of medical progress. The millions of Americans who rely on Medicare for their health care deserve no less.

Fortunately, over the past few years the debate in Washington has shifted from whether or not to provide a prescription drug benefit to how to best craft a program to provide seniors with the best prescription drug coverage possible. Now is the time to act to include prescription drugs as part of an overall health security package for our seniors.

An issue this important deserves debate and serious consideration. How can we consider a serious import issue such as this without the benefit and expertise of the Finance Committee? I have heard the structure and process of this debate described aptly as one of mutually assured destruction, or ''mad.'' This issue is too important to too many seniors for this debate to be treated in this manner. Because of the terms of this debate, any drug proposal that passes ultimately must have strong bipartisan support, because 60 votes will be needed to pass it. Is that truly ''mad''? I hope not. But I sense that, without the benefit of the Finance Committee working on this, we may be in a very difficult situation.

Some watching may ask how did we get into the situation where a prescription drug bill will require 60 votes to pass rather than a simple majority. The answer is simple. The first reason is because the majority leader has decided to bring a bill straight to the floor and bypass the committee process entirely. This is a troubling pattern. The farm bill, the energy bill, the trade bill all bypassed the committee structure—a mad process.

This action is troubling to me because I understand there was one proposal with the votes to pass in the Finance Committee, the so-called tripartisan bill. But the committee was not allowed to act on this important issue. That is a shame.

How in good conscience can we consider the largest addition to Medicare since its inception without the thoughtful input of the committee with jurisdiction over the Medicare Program? That does not make any sense. That is mad.

The second reason 60 votes are necessary is because we have no budget. For the first time since 1974 we have no budget in the Senate. This is one of the consequences of not having passed, or even, for that matter, considered a budget on the floor. Because there is no budget, we are operating under the budget guidelines passed last year that would spend about $300 billion over 10 years to add a prescription drug benefit to Medicare. Therefore, any prescription drug plan brought to the floor must be within the $300 billion or it is subject to a budget point of order.

This is another problem with the scheme under which we are operating. We will be considering shortly the largest expansion of an entitlement program in the history of our Nation. We bypassed a committee, we have not had a hearing on it, we have not had a markup, the Congressional Budget Office has not scored it, and we will be bringing the bill straight to the floor. Mutually assured destruction. This is mad. It is a recipe for disaster and inaction.

What is most troubling to me is the real losers. If the Senate is unable to pass a prescription drug benefit, it will be our seniors. The seniors are the ones who will be forced to endure another year without the safety net that a Medicare prescription drug benefit could and should provide.

Enough about my concerns about the process. As we look forward to this debate, there are a number of fundamental principles that need to be outlined as we consider various prescription drug options. These are fundamental elements to any serious, responsible, bipartisan prescription drug benefit.

First and foremost, a prescription drug benefit must be permanent, it must be affordable, and it must be immediate. Seniors need help now. With the high cost of prescription drugs, they cannot continue without that assistance. They are hurting today. Seniors often make painful choices between buying food and buying prescription drugs. Seniors need action and results on this issue—not an election year issue in November. Seniors want, need, and, quite frankly, deserve the stability of a permanent drug benefit.

One of my most serious concerns with the majority leader's bill is the fact it will sunset after only a few years. A prescription drug benefit that sunsets after 2010, just a few years after it finally begins, is simply not good enough. Medicare is an entitlement program and seniors deserve permanent benefits they can count on today, tomorrow, 10, 12, 15 years from now. A hollow benefit, with temporary relief that sunsets after 5 or 6 years, does not provide adequate health care security for seniors.

Think about the lunacy of the situation we are in. We seem to be unintentionally on a track of telling seniors they had better die in 2010. We passed elimination of the death tax, but we did not make it permanent, so we tell seniors, you had better die in 2010 or the tax rates are going to jump back up and the death tax is going to spring from the grave. Now we are saying, you can be protected on prescription drugs through 2010, but you had better move on because in 2011 this program sunsets.

Somebody is not thinking. Somebody is not realizing what they are doing. Let's get serious. We need to make the death tax repeal permanent, and we need to make prescription drug benefits for seniors permanent.

Seniors should have the right, also, to choose the prescription drug plan that best meets their needs. They should not be told what they need by a politician or a Washington bureaucrat. I fear the majority leader's bill dictates a one-size-fits-all, Government-run benefit for all seniors and puts the Government in the position of determining what drugs would be covered under the plan. We must protect our seniors from a Government-run drug program that delays, restricts, or denies access to the newest and most effective drugs available on the market.

Seniors should have the right to choose a benefit that best meets their needs and does not restrict access to the newest and most effective drugs. I fear that the majority leader's bill leaves no room for innovation and flexibility in terms of plan design, no choice for seniors, and could limit access to breakthrough drugs. A prescription drug benefit must address the high cost of prescription drugs and attempt to restrain the skyrocketing cost of prescription drugs which cannot be sustained long term.

All existing drug benefits make manufacturers compete to reduce prices and pass along the savings from price competition as larger discounts and lower premiums for beneficiaries. That is the only proven way to keep a drug benefit affordable. The majority leader's bill locks in copayments and premiums for beneficiaries and prevents competition that could lower drug prices.

According to the Congressional Budget Office, bills that rely on public-private-sector partnerships and an element of competition, such as the tripartisan bill, will help manage the cost of drugs. Sadly, the CBO found that bills similar to the bill of the majority leader, because of the lack of competition and inflexibility of the benefit, would in fact increase drug costs. Given the current climate, I simply cannot support a plan that increases drug costs or one that sunsets at the end of 2010.

Finally, a prescription drug benefit should be fiscally responsible and sustainable long term. The best guess we have, without the CBO's scoring, is that the proposal by the majority leader and some of his colleagues would cost at least $600 billion over the next 8 years. In a time of deficit spending and a tight economy, such a benefit would ultimately require cuts in other fields, such as education, Social Security, or national defense, and place a heavy burden on the current generation receiving benefits, the generation paying for those benefits, and the next generation.

Seniors have a right to demand a drug benefit now, but I believe most of them will tell you they do not want to mortgage their grandchildren's future in the process. Seniors must be protected from catastrophic drug costs. No senior should face financial ruin because of an illness that triggers catastrophic drug costs. Our Nation's health care system has changed significantly since Medicare was first created. To make it effective, we must change Medicare as well.

We must work to bring affordable prescription drug coverage to every Medicare recipient. The Senate has the opportunity to pass a bipartisan—tripartisan permanent Medicare prescription drug plan this year. The House has already passed a bill. The President has indicated repeatedly that he wants a prescription drug benefit for America's seniors. With this kind of momentum, the time should be now. I hope we will move forward with an honest and open debate that will produce a responsible, bipartisan bill consistent with the principles I have outlined that fulfill Medicare's promise of health care security for all seniors.

I yield the floor.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS ACT OF 2001—Resumed

The PRESIDING OFFICER. The clerk will report the pending business.

The legislative clerk read as follows:

A bill (S. 812) to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals.

Pending:

Reid (for Dorgan) amendment No. 4299, to permit commercial importation of prescription drugs from Canada.

Reid (for Stabenow) amendment No. 4305 (to amendment No. 4299), to clarify that section 1927 of the Social Security Act does not prohibit a State from entering into drug rebate agreements in order to make outpatient prescription drugs accessible and affordable for residents of the State who are not otherwise eligible for medical assistance under the Medicaid program.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, I am going to send a modification to the desk very shortly, but I want to comment briefly on the statements of my friend from Missouri that were just made. He talked about lunacy of what is going on here. I will use his exact term—lunacy. Talk about the death tax, that is, the estate tax, at the same time you are talking about Medicare prescription drugs, the vast majority of people, the vast, vast majority—over 98 percent—of the people on Medicare have no relevance to the estate tax. Why he would bring up the estate tax at the same time we are talking about Medicare prescription drugs is beyond my ability to comprehend.

I would also say he talks about why we bring up some of these bills without going through the committee. We do not do that very often, but we have done it. When we were in the minority, it was done all the time. We have seen a number of these measures being brought up because of what has gone on after September 11.

Take terrorism insurance. We passed that. It was really good legislation. The President told us how much it was needed. It took us a long time to get the bill up because they objected to it. Now they will not let us go to conference on this bill. It is interesting to note, the majority leader said we should have a 3-to-2 ratio and we had a 3-to-2 ratio. They said no, we want 4-to-3 or we will not go to conference. We gave them 4-to-3, and they still won't go to conference. This is terrorism insurance. That is stopping construction

projects in Nevada, in New York, I am sure in Louisiana, all over the country.

There are other examples, of course—the trade bill. The trade bill is something the President said he wanted. He wanted us to get it to the floor as quickly as we could. We did, and it passed. Only the last couple of days were we able to get conferees appointed.

The farm bill, that is pretty important legislation—the President signed that into law. The energy bill, we finally got conferees there. The President said that was an important bill.

I only mentioned a few of them—the trade bill, the farm bill, the energy bill, the terrorism bill. They couldn't be too bad. They passed the Senate by large margins in every case.

I hope people will understand that we are doing the best we can to work our way through a difficult situation in this country. We are making progress. We passed legislation in spite of the obstinacy we have had—not the least of which is the legislation on which the Senate is now working. We spent all day yesterday on importation. I think we should have been able to do more. I agree about the fact that we finally passed our first appropriations bill.

As I see down the hall, we are completing the very difficult conference on the supplemental. I should be there. I am a member of that committee. I hope to go there in a matter of a few minutes. Senators BYRD and STEVENS, chairman and ranking member of that committee, indicated to me that they expect to complete that conference in the next hour and a half. That will be by 12:30.

AMENDMENT NO. 4305, AS MODIFIED

Mr. REID. Madam President, I have a modification at the desk. I call it up.

The PRESIDING OFFICER. Without objection, the amendment is so modified.

The amendment (No. 4305), as modified, is as follows:

At the end, add the following:

SEC. ___. CLARIFICATION OF STATE AUTHORITY RELATING TO MEDICAID DRUG REBATE AGREEMENTS.

Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended by adding at the end the following:

''(1) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State from—

''(1) directly entering into rebate agreements (on the State's own initiative or under a section 1115 waiver approved by the Secretary before, on, or after the date of enactment of this subsection), that are similar to a rebate agreement described in subsection (b) with a manufacturer for purposes of ensuring the affordability of outpatient prescription drugs in order to provide access to such drugs by residents of a State who are not otherwise eligible for medical assistance under this title; or

''(2) making prior authorization: (that satisfies the requirements of subsection (d) and that does not violate any requirements of this title that are designed to ensure access to medically necessary prescribed drugs for individuals enrolled in the State program under this title) a condition of not participating in such a similar rebate agreement.''.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Madam President, I would like to speak to my amendment which is now before us.

I ask unanimous consent that the following Senators be added as cosponsors to the amendment: Senators DORGAN, SCHUMER, FEINGOLD, TORRICELLI, CARNAHAN, LEVIN, JOHNSON, SNOWE, JEFFORDS and DURBIN.

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

Ms. STABENOW. Thank you very much, Madam President.

Madam President, I am very pleased to offer this amendment which is a bipartisan amendment, and hopefully one that we will be able to pass, working together and moving forward on the issue of lowering prices of prescription drugs and also providing Medicare coverage for our seniors and the disabled.

This amendment addresses an issue that our States are facing, the question of allowing States to have the right to have flexibility to lower prices.

This is a simple amendment. It would give States the flexibility to set up programs to pass along negotiated Medicaid rebates and discounts to their citizens who do not have prescription drug coverage and are not covered by Medicaid. So the States will have the ability to negotiate and pass on those similar discounts to their citizens who are without coverage and who are not on Medicaid.

This is critical. States should have the ability to provide similar discounts to all of their uninsured citizens. Since Medicaid only covers low-income people, and lower and middle-income citizens, they do not have the ability to get the same negotiated discount. Some States are setting up programs to do that.

One of the biggest challenges, as you know, and as we all know—we will be debating it this week and next—is the challenge facing not only our citizens, our families, and our seniors but also the business community, which I have talked about frequently. Also, State governments are addressing this issue of the rising cost of prescription drugs and the implications to Medicaid.

In fact, the National Governors Association is meeting right now. Earlier in the week, I shared a newspaper article where all of the Governors of the United States were speaking about their biggest challenge. Their biggest challenge, according to the article, is the rising price of prescription drugs and the rising cost of Medicaid to the State budgets. This is a critical issue for them.

We know that from 2000 to 2001 prescription drug prices rose about 17 percent. This is not unusual. It has been that way every year. This is causing health care expenditures and health insurance premiums to go up for business, for States, for individuals, and most certainly for those who do not have any insurance and don't have the clout to negotiate a discount. Those citizens are paying retail, which, in fact, is the highest price in the world right now.

In an attempt to respond to the skyrocketing prices, 30 of our States have enacted laws with some type of prescription drug coverage for those without insurance. They are looking for ways to be innovative—to use what we often have heard on the floor from our colleagues—the innovations of the States, the laboratories of democracy, and the ideas that come from our States. About 30 of them are looking for ways to enact something that relates to prescription drug coverage—looking for ways to lower prices and expand coverage. That is according to the National Governors Association.

However, unfortunately, the drug companies' trade association—PhRMA—has mounted legal challenges against several of those States, including my own State of Michigan. They have been opposing State efforts to lower prescription drug prices and increase coverage for those without insurance.

Specifically, they filed lawsuits against Maine and Vermont for their programs because the drug lobby does not want them to extend the Medicaid discounts to those without insurance who are hard-working citizens. In fact, we know that a majority of the people without insurance in this country work in small businesses. They are working. Their small business is trying to get health care coverage for themselves and their workers. Those individuals have no access now to any kind of group purchasing power or to any kind of discount. States are trying to use their group purchasing power for Medicaid and extend that same discount—usually 15 to 20 percent—to their employees. Many work in small businesses and don't have any insurance.

While Maine's two programs have been upheld in court, Vermont's program has not. It was actually struck down by the courts. Both States are embroiled in a very lengthy appeals process.

Specifically, the Maine Rx program is now pending before the Supreme Court. The current administration is supporting Maine's right to implement their program.

I commend President Bush and the administration for siding with the State of Maine and their right to make decisions about their citizens and how to operate their businesses for their State.

In fact, the Solicitor General, Ted Olsen, filed a brief on behalf of the Federal Government urging the Supreme Court to allow Maine's Rx program to go forward without further delay.

I argue that this amendment, in fact, is supported by both parties, people on both sides, and that administration certainly has indicated—I have not heard directly regarding the amendment, but they certainly have indicated support for the program on which this amendment is based. I appreciate their leadership on this issue.

These legal challenges are very costly to taxpayers. They just deter other States from establishing other similar demonstration projects, such as the underlying generics bill. Unfortunately, the drug companies are trying to stop these kinds of innovations.

This amendment would, in fact, try to stop the drug companies from using the legal system to keep their prices high. We all know that they will dispatch their high-priced attorneys whenever they can to, unfortunately, keep their profits as high as possible.

Since the price of prescription drugs is soaring, States have the unfettered ability to pass on Medicaid rebates to their residents. They should have that ability to pass those rebates on to their residents.

I hope we will agree to this amendment because even if Congress passes a Medicare prescription drug program this year, it will be several years before it is fully phased in.

I hope and pray that we will come together and pass a Medicare prescription drug benefit. It is long overdue. But we know it will take several years to phase it in.

In the meantime, our States are struggling to help their citizens. I believe they need our support.

The Rx flexibility-for-States amendment would seek to remove the legal hurdles that are preventing States from providing lower priced prescription drugs to their citizens.

Specifically, States would be able to extend their Medicaid rebates and discounts for prescription drugs to non-Medicaid-eligible persons.

State governments are close to the people. I know our Presiding Officer was in the State government, as was I. We understand that States and local governments are on the front line hearing from people, and wanting to respond. We have States that are responding, and are being stopped through the legal system right now by the drug company lobby. The solution to higher prices, higher prescription drug prices, is not just in Washington. It is not just in the Senate, or in the House of Representatives. But it is in capitals all across the country where our Governors and our State legislators are working to respond to what is critically one of the most fundamental issues that families and seniors and businesses face to today, which is the explosion in health care costs, predominantly coming from the rising cost of prescription drugs.

Today we have a chance to send a very important message to our colleagues and to States across the country.

I ask my colleagues to join with us, on a bipartisan basis, as we have in this amendment, to adopt this amendment and to tell the States that we are standing with them as they fight to lower prices for their citizens and make lifesaving medicines available.

If we fail to pass this amendment, many States could be faced with legal challenges from PhRMA as they try to come up with programs to lower prescription drug prices. Right now, we have the ability to stop the dollars going into the lawsuits and redirect those to lowering prices and making prescription drugs available.

I invite and urge my colleagues to join with us. This is an opportunity for us to stand together in support of our State governments. Let the Governors know, this week, as they are meeting, that we understand what they are going through and we want to back them in their efforts to make sure that lifesaving medicines are available to their citizens.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I commend my friend and colleague from Michigan for this absolutely excellent amendment. I am hopeful we can get strong support for this amendment because it is so compelling in its logic and reason, and the result will be so important to our fellow citizens across the country.

Just to catch up to where we are, Madam President, the underlying bill, the Schumer-McCain legislation, tries to halt the gimmicking that the drug companies use to get around the Hatch-Waxman bill that was passed a number of years ago. They have gimmicked the rules, and they do it in ways that completely circumvent the spirit and the understanding of the law, in order to keep prices artificially high. And every family and every user of prescription drugs knows the challenges families are facing with high drug prices.

Under the McCain-Schumer legislation, we have tried to deal with that issue. I think we have dealt with it effectively. That is the matter that is before the Senate.

We had a good debate yesterday on different measures that continue to put downward pressure on the escalation of drug prices. I think we had a very good debate on that, both in support of the underlying legislation and in support of the Dorgan amendment, yesterday. Now we have the Stabenow amendment before us, which will, in a very important way, continue this effort to exert downward pressure on the prices of drugs in this country.

I am amazed at the opposition to this amendment. For a good part of the afternoon yesterday, we listened to talk about the free market system that urged us to get away from price controls and use the free market system. But when the States use the free market system, in order to bargain for the lowering of the prices, what happens? What is the reaction of the drug companies? The drug companies go ahead and sue the States to try to restrain them from using the free market system.

This isn't Government intervention, it is the States themselves, States that have Republican Governors and Democratic Governors. The States themselves are trying to use the States' power in order to get the best price for the neediest citizens in their States: the poorest individuals, the ones without insurance. And here comes PhRMA with their legal actions to make sure the States are not going to be able to do that.

When does that greed stop? When does that greed stop? When do they stop wringing the final few cents out of the poorest individuals in this country? That is what this is all about.

The States are trying to negotiate lower prices for the poorest individuals in these States, and PhRMA says no. They gimmick and circumvent the clear spirit and language of the Hatch-Waxman law in order to perpetrate billions and billions of dollars of additional profits.

Then we hear a great deal of debate in this Chamber and much admonition from many of those who are opposed to the underlying legislation saying: Let's let the free market work.

We had hours and hours of discussion about price controls in Canada. We are not for price controls, as in Canada. We want the free market to work. But what is happening when the free market works in the State of Maine, the State of Florida, the State of Michigan, and other States? In comes PhRMA, and they say: No, we are not going to let it work. We want to stop them from doing it.

This is the same kind of action that is underlying the basic measure.

So I want to review, very briefly, the situation. I understand the problem we are looking at.

Under the terrible burden of skyrocketing drug prices, the State governments are trying to use their authority and bargaining power to help residents—and our constituents—obtain lower prices.

Already, 30 States have passed laws to extend drug coverage or lower prices. But PhRMA has done it again, suing the States to stop our ''laboratories of democracy'' from fighting the drug industry on behalf of American consumers.

The drug industry has sued the State of Maine. They have sued Vermont, Michigan, Illinois, and Florida. The drug industry is waging war against our Governors and our State legislatures in the courts.

The Stabenow amendment puts the question to the Senate: Will you stand with the States or will you stand with the drug industry for higher drug prices?

Many of my colleagues are former Governors themselves. I hope they take particular note that just yesterday the Nation's Governors issued a statement of solidarity with the administration in its legal fight with PhRMA over the Michigan Medicaid waiver that reduces the State's drug costs.

Let me read from the NGA statement of July 15, which quotes Michigan Governor Engler:

The nation's governors are extremely disappointed with the course of action chosen by PhRMA. It is unfortunate that their organization feels compelled to use the court system to manipulate public policy.

That is a Republican Governor.

The Governors, the administration, and consumers all support State efforts to reduce drug prices. Now, with the Stabenow amendment, it is the Senate's turn.

The amendment is based on a simple but powerful idea: Extend the scope of an existing Federal law to help the States supplement the rebates we require under Medicaid.

Medicaid already collects ''best price'' rebates from the drug industry, thanks to a 1990 law we passed under the leadership of Senator David Pryor from Arkansas, a champion of lower drug prices.

I was always impressed by the work and the commitment of Dave Pryor and his strong desire for protecting the consumer. And this tradition follows with Mark Pryor in Arkansas today: they are strong protectors of consumers and lower drug prices.

The Stabenow amendment simply permits States to negotiate similar State rebates to help lower-income residents afford their drugs. All this amendment does is let the States use the same negotiating tools used today by the private sector to lower their drug bills. I do not see why those who otherwise support the free market would oppose this amendment.

We find out that large companies use their negotiating ability. HMOs use their ability. Why not permit the States to use their ability? But PhRMA says: No, we are not going to let them do that, particularly when they are using it for the lowest income citizens.

The amendment empowers the States to use the same tools and negotiations used by the private sector to lower its drug costs. If a drug company refuses to negotiate with a State, its drugs would still be available but would be subject to ''prior authorization.'' This is precisely what the State of Michigan is doing. This is precisely why PhRMA is suing the administration. And this is precisely why the Stabenow amendment is needed.

Here is what the drug industry did when the State of Maine and the State of Vermont enacted State laws to lower drug prices.

Naturally, the industry sued the States. No surprise so far, given their abuses of the Hatch-Waxman Act. But then the drug industry instructed its front group, the so-called Citizens for Better Medicare, to run TV, radio, and print ads in Maine and Vermont attacking the laws. That is what the drug industry does to keep the prices sky high.

They sue our State governments and waste taxpayer dollars defending against their frivolous lawsuits. And they run attack ads.

Lest anyone question whether the so-called ''Citizens for Better Medicare'' is anything but a front group for the drug industry, let me quote the June 18 Wall Street Journal—

[T]im Ryan, PhRMA's past marketing director, founded the grass-roots-sounding ''Citizens for Better Medicare'' at the behest and expense of major drug companies.

There it is. Enough is enough. The American public is sick and tired of the drug industry's abuses. Let's support the Stabenow amendment, and help our States lower drug prices for all Americans.

I see others who want to speak on this issue. I want to mention to our colleagues an excellent report being released today. It is a review of the impact of the three principal proposals that have been advanced on coverage. What this study does is take your State, the key features of each of the programs that have been advanced, the Republican House program, the Graham-Miller program, which I am proud to cosponsor, as well as the tripartite program. Then it takes the numbers of citizens who would be impacted, the number of elderly, senior citizens, and disabled on Medicare, and it runs through how each of these programs would impact the seniors in your State.

It reviews for each of the programs who would be affected, what the impact would be on each of the seniors in the State, who would benefit the most, and who would benefit the least.

We will be releasing this report this afternoon at 2 o'clock. We can say without question that in the review of all 50 States, their powerful, compelling, and overwhelming conclusion is that if you want to make drugs available, accessible, affordable, and dependable, there is one plan that stands out head and shoulders above all the others, and that is the one introduced by our friend from Florida, Senator GRAHAM.

There are others who wish to speak on this. I will come back and address it later.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. Madam President, I ask unanimous consent that following my remarks, the following Members be recognized to speak: Senator HATCH and Senator FRIST, in that order.

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

Mr. SCHUMER. Madam President, I rise in strong support and as a proud cosponsor of the Stabenow bill. It is worthy legislation. What I will do for a few minutes is talk about the underlying bill and the Stabenow bill and what they have in common.

The Senator from Massachusetts outlined it. These are free market approaches to lowering drug prices. The one, the Schumer-McCain bill, allows more competition. What could be more all-American than more competition.

The second, the Stabenow bill, allows people within the market to gather together in the form of their government and negotiate a lower price. We do this every day in America. That is what a corporation is in certain ways. That is what a union is in certain ways. Here we have the State doing the same thing.

As the Senator from Massachusetts said, there were some yesterday who talked about the Canadian bill and price controls. These are not price controls, but we just saw yesterday or 2 days ago Pfizer and Pharmacia merge. What were they trying to do? Well, in a free market way, they were trying to aggregate to increase their bargaining power. Doesn't it make sense to say that the citizens of Maine or Vermont or Massachusetts or Utah or New York can aggregate to equal that—well, they will never equal it, but at least to gain a little leg up on that bargaining power and get some help?

Both of these proposals are free market. There are some people whose view of the free market is to let big companies do whatever they want. I am a little worried that over at the FCC, the whole idea is, let us have one big communications empire. Actually, the free market needs some competition. But the free market has also said, as it has evolved since the Adam Smith days, that combinations to try and increase our bargaining power are legitimate, recognized ways that the free market works.

I see that my colleague from Utah is in the Chamber. I first want to pay him some tribute. I said this in committee a year or 2 years ago. I think Hatch-Waxman has been one of the greatest consumer advances we have done in the last quarter of the last century. When I said it, it was still the previous century. But he has done a great job there.

Our goal, in terms of the Schumer-McCain bill, is to restore the balance of Hatch-Waxman. The bottom line is a simple one: That in 1984, we had a very simple template. We said: God bless companies that come up with innovative drugs. They research them; they make a lot of mistakes. For every drug they bring to market, there are a lot of drugs that don't come to market. They need the help. They need a return. God bless them. Give them a return. They are creating a product that makes us all live better and longer.

But we also said that rate of return, that patent, which is what the patent really is, can't be unlimited. And so we said, after a period of time, 20 years after the patent was filed, others could come and produce the drug. It worked. Innovation, from the date Hatch-Waxman passed to the present, in the field of pharmaceuticals has been unparalleled. Lives have been saved. The people are living longer and better and healthier. We see that in our parents and our grandparents. It is amazing.

In the last 5 years, I believe Hatch-Waxman has steered off course. In fact, the whole pharmaceutical industry has steered off course. For people who make a wonderful product, they are evolving into an industry that is despised and hated.

They could say to themselves: It is only because these drugs cost a lot, and we can't help it because it costs a lot to research them.

I would say it is not that simple. I wish it were. They have evolved because, in a headlong rush to keep their profitability as high as it has been in the past, they are desperately clinging to extend patents longer than Hatch-Waxman ever intended. They end up hiring not just the best researchers anymore but the best lawyers.

A drug company should go to Harvard Medical School, not Harvard Law School, as it continues its work. But they have been spending much of their time and effort in coming up with schemes—that is what they are—to extend the patent beyond the time it should be extended.

What does that mean to the average citizen? It means a drug, instead of costing $25 a month, is going to cost $100 a month—vital drugs. If anything, they have pushed it further and further because so many of these blockbuster drugs, these wonderful drugs, are coming off patent shortly.

I know my colleague from Utah has a lot invested in Hatch-Waxman. I very much appreciate it. The little changes that we make, Senator MCCAIN and I, in our bill, just build on it and readjust it. But I think the view that Hatch-Waxman is just fine as it was in 1984 is off base. The statistics will show it. That is why this bill has such great support. I am certainly open and willing and eager to hear whatever suggestions my colleagues from Utah and Tennessee will make. But I will tell them this: The view that we should just go back to the old way in 1984 doesn't work.

Mr. KENNEDY. Will the Senator yield?

Mr. SCHUMER. I am happy to yield.

Mr. KENNEDY. We have before us the author of the amendment. Since the Senator has the floor, I would like to ask him a question or two.

Isn't it true that HMOs use their bargaining power to lower costs of prescription drugs today? HMOs all over the country have been doing that.

Mr. SCHUMER. Yes, all over.

Mr. KENNEDY. Isn't it true that insurance companies use their leverage and powers to get the lowest cost possible?

Mr. SCHUMER. Yes, and they are proud of it. They brag about it.

Mr. KENNEDY. What could be the possible logic in denying the people of the States, particularly the smaller States—or large States, for that matter—what is the logic of denying them their bargaining power? If we are going to let the HMOs and insurance companies do it, why not the States?

I am sure we will hear that it is because the States are a governmental power and therefore this is price control. As I understand it, if the drug company doesn't want to sell to them, they don't have to, do they?

Mr. SCHUMER. My colleague is exactly right. By the way, our Federal Government does the same thing in Medicare. They bargain with the drug companies for a lower cost for Medicare. Why can't the States do it for their citizens who are not under Medicare and Medicaid? My colleague from Massachusetts is right on the money.

Mr. KENNEDY. It seems we will hear that somehow the States can't bargain because they are a governmental institution. But the concept is very much the same. For the insurance industry, it is fine—it is a free market system; and for an HMO, it is fine—it is the free market system. But somehow for the State, it is government. Even though the pharmaceutical company is free to say: We don't like these negotiations; therefore, we won't sell to you. If all the pharmaceutical companies did that, obviously, the State would have to bargain in good faith. There is no indication that they are not bargaining in good faith.

As the Senator pointed out, there is no indication that these industries have been suffering adversely. They are one of the most profitable industries—and Lord only knows they are paying the highest salaries to their executives as well. But I am not as interested in that as in the concept of what we are talking about here.

Finally, if the Senator would agree, I am perplexed: We are not talking about bargaining for high income people in the State; we are talking about bargaining for the lowest income, the poorest of the poor, many of whom would not be able to have access to the prescription drugs unless this were offered. Why is that PhRMA says: No no, you can't do it; we are going to squeeze the very last dollar out of them?

Mr. SCHUMER. The Senator is literally on the money. The bottom line is that the Senator is exactly right. There is no difference, from an economic point of view, in a State getting together and bargaining for its people and an insurance company or HMO doing it. In fact, you can argue that the State has more legitimacy, being an elected body and representing the will of the whole people of Michigan, Maine, Massachusetts, or New York, No. 1.

No. 2, what about over in Europe or in Canada? They put on a price control. The pharmaceutical company still ends up selling the drug. Do you know what ends up happening? It is the American citizen who ends up paying for all the research, which does good around the whole world, for, say, Celebrex or Vioxx. Who pays the whole thing? Us.

Why shouldn't the American taxpayer and citizen, through his and her State government, be allowed to say we should not bear that whole cost ourselves?

That is the thrust of the amendment of the Senator from Michigan. It is free market. There is no lock-in. Just as Germany said, you can sell Vioxx for 3 pfennigs, and that is not worth it. The company doesn't have to sell it. It is the same exact thing here.

Mr. KENNEDY. Well, the point is that the State is not even doing it for all the citizens; it is not even doing it for all of them. They are doing it for the poorest of the poor. That is whom they are trying to bargain for in these circumstances. The drug industry is contesting that.

Let me, finally, ask my friend, Senator STABENOW, if she has a viewpoint on this matter. As I understand, this is not a partisan issue in any respect. I read Governor Engler's very strong comments about this where he was actually talking about manipulating public policy. He was using the word manipulate, suggesting that we have to manipulate public policy. The drug companies are manipulating public policy in their patent policy and in the collusion with the generics, which is being addressed by the Schumer proposal.

So we have a Republican Governor talking about manipulating public policy. I was interested in the fact that this should not be a partisan issue. The silence in support from the other side of the aisle is deafening with regard to the Stabenow amendment. I am hopeful there will be voices on the other side that will rise in support of this. To their credit, they supported the Schumer proposal in the committee. Five Republicans did. I hope we will hear those voices again.

I just say to the Senator, this isn't really a Democratic or Republican, or liberal or conservative issue. I find there are liberals and conservatives, Republicans and Democrats, as well as Republican and Democratic Governors who share the view of the Senator from Michigan and the Senator from New York. If the Senators would comment on that, I would appreciate it because it is an important issue.

Mr. HATCH. Madam President, I have one simple question.

Mr. SCHUMER. I am happy to yield to the gracious Senator from Utah for that.

Mr. KENNEDY. If they can answer my question, then I will be seated.

Mr. HATCH. If I may ask, how much longer does the Senator need?

Mr. SCHUMER. No more than 5 minutes longer. I thank the Senator. I will yield to the Senator from Michigan to answer these very worthy questions.

Ms. STABENOW. I thank both of my friends and colleagues, who are such champions on this underlying issue—the entire issue of Medicare and prescription drug coverage and lowering prices. In fact, as our leader, the Senator from Massachusetts, indicated, this is a measure that is a bipartisan amendment. We have Governors—frankly, the majority of Governors—Republicans and Democrats, who are struggling with this question of lowering prices and making prescription drugs and lower prices available to their citizens. So as the National Governors Association is meeting right now, they have said their biggest challenge is the price of prescription drugs

and the explosion, in their budget, of Medicaid. They need to address these issues.

This amendment will support the Governors across the country. It is a bipartisan amendment. It is something supported across the country on a bipartisan basis. I am very hopeful that we will have colleagues' overwhelming vote on both sides of the aisle supporting the effort to say yes to this innovation of the States. This is not mandatory, it is purely based on States taking action on their own to decide if they would like to do this. If they do that through their State legislatures and the Governors on behalf of their people, this simply says that this is legal and that, hopefully, it will stop the suits PhRMA has been bringing against our State governments.

Mr. SCHUMER. I thank the Senator. She is on the money. It is voluntary. No State is forced to do this. But if the citizens of the States, through their elected representatives, both Republican and Democratic Governors, want to do this, they should be allowed. We should not be tied up in litigation for years while the prices go up and up and up.

I am fully supportive, again. To underline this, this is a free market policy. It is no different than what the insurance companies do, the HMOs, and God bless them. It is saying that people may aggregate. Are we going to have people opposing mergers of the big drug companies? No, we are not. They say they can do it better in a larger size. Why can't the average citizen do something in a larger size? That is what we are trying to do.

I am going to conclude with one little pitch today. I know my colleague from Utah has been patient, and I very much appreciate that. Whether it be the Schumer-McCain bill, generics, or this bill, these are reasonable and modest proposals. I say to my friends in the drug industry—again, I admire them; I think they have done a good job—please, you have become ''Dr. No.'' Whenever that comes up, you say no. No change. You are willing to change it with your lawyers to extend the patents, with all these new ways you find around what we think the original intent of the Hatch-Waxman law was. Do not be Dr. No. Get with it. Go back and innovate. Go back and form new wonderful drugs and get your patent on those, but when people want to get together to lower those prices in a fair negotiation, when this Congress says we ought to prevent the lawyers from changing the original intent of Hatch-Waxman and drawing it off course, do not stand in the way.

In fact, I challenge PhRMA to come up with one constructive proposal to help people with the cost of drugs, not just to keep doing it the same way when we know there is an outcry. They know best what helps with innovation. Come up with a proposal. Do not go the way of the cigarette companies and spend all your life being sued. Do not go the way of the cigarette companies and become the object of scorn and hatred.

You make a wonderful product. You do something good. Support the bill of the Senator from Michigan. Support our bill or come up with some constructive proposals.

I will make one other point, Madam President, and then yield the floor. I went to PhRMA a year and a half ago. The Senator from Utah knows this because I informed him of the negotiations. I said: Let's sit down and figure out something. Let's get the generic industry and brand industry together to come up with a compromise to deal with some of the problems.

They listened politely, but, frankly, I do not think they thought our legislation had much of a chance for passage, and they said no.

Now we are knocking at the door. We are almost there, and it is not too late. It is not too late to come up with some answers that will solve our problems—the problems that the Senator from Michigan deals with in her legislation, and the problems that Senator MCCAIN and I deal with in our legislation—and get something done. I think I speak for all of us that much rather than make speeches, much rather than win political victories, we want to get something done, and that is what we are here to do today.

In conclusion, I urge support for the Stabenow amendment to restore some bargaining power which is voluntary. Let a State's Governor, if they want, do this. Do not wait 5, 10 years until the litigation is finished—it will probably come out the same way—and give people a break. Let them be able to afford these wonderful medicines that we have and at the same time allow the drug companies to continue on their path of real innovation as opposed to false innovation of patents, pill sizes, colors of bottles, and different applications.

Madam President, I yield the floor and once again thank my colleague from Utah for his courtesy.

The PRESIDING OFFICER (Mrs. CLINTON). The Senator from Utah.

Mr. HATCH. Madam President, I rise to speak on the pending legislation, S. 812, the Greater Access to Pharmaceuticals Act. I did not realize the pioneer companies that have been referred to as PhRMA are as satanic as they have been represented to be on the floor today. One would think they are everything that is bad in this world and that they are the cause of all the high costs of drugs in our society; that they are not being fair to the generic companies that help bring drug prices down; that HMOs are the reason drug prices come down and that the States do not have the same type of market power. I heard all these things. I heard how terrible the research-based companies are. My goodness, I have never known that before. I am so happy to get this information.

I would like to cite a book called ''The System.'' This book was written by Haynes Johnson and David S. Broder, hardly a conservative set of authors, but very intelligent, and highly respected journalists and authors. The book is an excellent account of the infamous and failed Clinton health care plan. History has a way of repeating itself. You can hear a theme on the floor over the last several days that comes right out of the Clinton play book.

On page 90 of that book, it says, in speaking about the political tactics to garner public support, a group of the President's political advisers have the following discussion, which sounds familiar to the way the debate is going on the floor of the Senate and elsewhere:

> In the campaign period, Fried recalled, Clinton's political advisers focused mainly on the message that for ''the plain folks, it's greed—greedy hospitals, greedy doctors, greedy insurance companies. It was an us-versus-them issue, which Clinton was extremely good at exploiting.

That was Fried. Then they go on further, and I quote from the Broder and Johnson book:

> Clinton's political consultants—Carville, Begala, Grunwald, Greenberg—all thought ''there had to be villains.'' Anne Wexler——

Who, of course, is not known for her Republican politics——

> remembered, It was a very alarming prospect for those of us looking long term at how to deal with this issue. But at that point, the insurance companies and the pharmaceutical companies became the enemy.

All this sounds familiar.

That is what has been going on here on the floor. Frankly, I do not think it is right. My experience has been there is no one single group who should be blamed for the high costs of pharmaceuticals. I do not want to blame the FDA because it takes up to 15 years and 5,000 different compound experimentations to get an approval of a drug and at a cost, according to some of the top authorities, of up to $800 million. That is 15 years out of the patent life. Frankly, one wonders why, with the few remaining years they have on patent life, drugs cost so much. I am not going to blame the FDA because their job is to protect Americans, but on the other hand, that is a long time, and I may talk a little bit about that today.

I am not going to blame the generic companies. They provide a tremendous amount of support for American people who need help. I believe in the generic industry. By and large, those companies are doing a great service, as we intended in the Hatch-Waxman bill.

By the way, without the pharmaceutical companies, the pioneer companies, there would not be any drugs for the generic companies to copy and reduce prices. So there has to be a delicate balance between the two, and that is what Hatch-Waxman is all about.

This underlying bill, of course, which for some reason is being debated before the Federal Trade Commission comes out with its comprehensive study and

recommendations on the very issues addressed in the pending bill, which should occur before the end of next month—will change one of the most important consumer bills in history. I am not concerned just because it is my bill and Congressman WAXMAN's bill, but because without waiting for the FTC to give its recommendations, this underlying bill will change the Hatch-Waxman law before we have had a chance to hear from the FTC, FDA, other experts and interested parties. I do not think it is right to change the law until we have all the facts and understand better what this bill will do.

Hatch-Waxman, according to almost all authorities, has saved consumers $8 billion to $10 billion every year since 1984. It created the modern generic drug industry, but it also strengthened the PhRMA companies, the pioneer companies. Back then, they were spending about $3 billion a year on research and development. Today, it is over $30 billion a year. I think almost as satanic as they are portrayed on the floor by our friends on the other side, it seems to me they ought to be given a little bit of credit for some of the major therapeutical pharmaceuticals we have today.

Without them, we would not be where we are. We would not be the leaders in the world with pharmaceuticals, nor would we have the balance of trade surplus we get from the sale of American pharmaceuticals.

Let me comment on three aspects of the underlying legislation: Politics surrounding floor consideration; the process by which the bill moved to the floor; and finally, the substance of this bill.

At the outset of this debate, I congratulate and commend the original cosponsors of this legislation, our colleague from New York, my friend, Senator SCHUMER, and my colleague from Arizona, my friend, Senator MCCAIN. Even though I disagree with them on the way they resolved the key issues addressed in S. 812, and although the bill that emerged from the HELP Committee does not adhere to the original Schumer-McCain language in virtually every key policy area, they deserve recognition for their effort in highlighting issues, issues that are of concern to each of us to in this body: Access to prescription drug coverage and affordable prescription drug coverage.

As most of my colleagues know, I have a special interest in today's pending legislation. Throughout my career in the Senate, I have helped fashion a portfolio of legislation that facilitates our Nation's pharmaceutical research and development capacity. I am proud to have played a leadership role in crafting the law that the bill we are considering seeks to amend, the Drug Price Competition and Patent Term Restoration Act of 1984, known as the Hatch-Waxman bill. A key partner in this effort was my good friend from the House, HENRY WAXMAN. That a liberal member like Mr. WAXMAN and a conservative like ORRIN HATCH got together to write this law is but one sign of the bipartisan consensus that developed with respect to the 1984 law and that should be developed today.

Incidentally, on the House side of the Capitol, this law is often referred to as Waxman-Hatch and in the Senate the names are often reversed. This shorthand is only used because it is so time consuming to keep repeating the Drug Price Competition and Patent Term Restoration Act of 1984.

I have a lot of complaints about the process we followed to bring S. 812 to the floor, and despite my grave dissatisfaction over the process, I do want to recognize the efforts of Senators EDWARDS, COLLINS, KENNEDY, GREGG, and FRIST to make improvements to the substance of the bill. To be fair, there have been improvements in some critical areas of the legislation. As a general matter, in moving away from some key provisions of McCain-Schumer, the HELP Committee substitute is headed in the right direction.

Now, I hasten to add, though, that some new provisions were added to the bill during the markup process to make it impossible for me to support a bill that is so important to me—a bill that amends the law carrying my name, a law that has been shown to benefit millions of Americans every day.

Let me talk about the politics and process. Before I discuss the merits of the committee substitute for S. 812, I want to make a few comments concerning the politics and process whereby we find ourselves discussing these issues at this time.

One of the things about which I am most apprehensive in the current debate is the way the Drug Price Competition and Patent Term Restoration Act of 1984, a painstakingly crafted bill that passed with overwhelming bipartisan support in both the Senate and the House, now finds itself at ground zero in one of the most controversial and potentially divisive issues of this year, that is the debate over the Medicare drug benefit.

The Medicare drug benefit is certainly an issue that deserves the Senate's attention, and I am in one of the original tripartisan groups that I believe has come up with a nonpartisan bill that would solve the drug benefit problems for the American people, especially the poor.

I commend our colleagues in the House for successfully passing a prescription drug bill that promises to make a major expansion of Medicare benefits by providing an outpatient drug benefit. I think it is now time for the Senate to debate this issue, pass a bill, conference with the House, and present a bill for the President to sign into law. I am also, like I say, proud to be the cosponsor of the so-called tripartisan Medicare prescription drug benefit bill. I think Senators BREAUX, JEFFORDS, GRASSLEY, SNOWE, and I have put together a strong bill that our colleagues should, and I think will in the end, support.

I had hoped the tripartisan bill could have been the subject of a Finance Committee markup, as it deserved. I think it would be approved by the Finance Committee, which more than likely explains why we are on the floor today with S. 812. So as we enter this debate, let us be clear that the way the Senate Democratic leadership has chosen to structure the floor vehicle, it is very possible the partisan fervor that often accompanies Medicare legislation will spill over into the heretofore bipartisan consensus surrounding the 1984 Waxman-Hatch law. I hope not.

One of the things we did back in the 98th Congress in 1983 and 1984 was to take the time and effort to build a broad, bipartisan coalition for the Hatch-Waxman law. I hate to see us lose support as this body becomes caught up in the unavoidable election year politics of Medicare. Frankly, it is almost amusing how the Democratic leadership has structured the debate on the Medicare drug benefit. A bill that involves hundreds of billions of dollars and over a trillion dollars in some of the proposals will be debated as an amendment to the more modestly sized S. 812. Talk about the tail wagging the dog.

I hope if, as is well possible, we cannot achieve consensus on the Medicare drug debate, the inevitable ill feelings and political posturing do not create a poisonous atmosphere in which the broken tail of Medicare crushes the dog of Hatch-Waxman. Conventional wisdom has it that a large part of what is at stake in the legislation we will debate over the next number of days has to do with jockeying for political positioning over who is left holding the bag with the voters in the fall if we fail to enact a Medicare drug benefit before the November elections. That is why I hasten to add that I hope my colleagues will look at the tripartisan bill, which is nonpartisan, which basically can solve these problems for especially the poor in our society with regard to drug benefits and the cost of drugs.

I firmly believe the best thing the Senate can do for the American public is to lay aside, as best we can, the political infighting and genuinely try to strike an acceptable compromise on the Medicare drug bill.

Make no mistake about the fact that although S. 812 may be nominally the pending business before the Senate, the real matter we will be debating is the Medicare drug benefit. I would have greatly preferred to debate Hatch-Waxman amendments as a stand-alone bill in a less charged atmosphere. If we had to debate amending Hatch-Waxman with other legislation, probably my last choice would have been to lump it together with the politically volatile Medicare drug bill.

Then we have the ill-advised drug reimportation bill, which has been added as an amendment to S. 812. This would have been my second to last choice to add to Hatch-Waxman. I laid out yesterday my concerns with that proposal.

Suffice it to say, the reimportation language was a bad idea in the year 2000, and it is an even worse idea today, given the threats of our post-September 11 world.

While the regrettable encore appearance of this feel-good but ultimately downright dangerous drug reimportation legislation is deeply troubling to me, it is doubly troubling to me that it will now be linked to the 1984 Hatch-Waxman law because of the way the majority has chosen to proceed.

I recognize part of the reality of being on the minority side of the aisle is that we have to go with the flow as the majority leader calls up legislation that he desires or his side desires, and I understand that. As a coauthor of the legislation that S. 812 seeks to amend, I take exception to calling up a bill that opens up Hatch-Waxman in order to create a legislative vehicle that promises to throw into play every conceivable way to punish one of the great American success stories in innovation and in the pharmaceutical industry.

This, ''everything but the kitchen sink,'' mentality, may be satisfying to some politically. But mark my words, it starts this body down a path that ultimately can only punish the American health care system. In my experience, delicate provisions and nuances of patent law, antitrust law, and FDA regulatory law are generally not best crafted in the elbows-flying, raw meat atmosphere of high-stakes election year politics such as we will have during the course of this debate, in addition to what I consider to be an unfavorable environment that will be created by the likely flood of major amendments not relevant to S. 812 or the underlying Waxman-Hatch law.

I must also raise objection to the manner in which the bill so hastily was reported from the HELP Committee. Frankly, I am deeply disappointed in the way the HELP Committee has acted, although I guess we should not be altogether surprised given the perceived political advantages my friends across the aisle believe they have and that they have gained by calling up S. 812 as the backdrop—or should I say backstop—to debate pharmaceutical issues.

It is true that S. 812 was referred to the HELP Committee. It is true that the committee held a hearing on this bill on May 8. I testified at that hearing. I stated my reservations about the way the McCain-Schumer legislation acts to distort the original premise of the Drug Price Competition and Patent Term Restoration Act of 1984.

While I am heartened by the fact that the HELP Committee version of S. 812 that is pending before the Senate today resembles more closely the perspective of my testimony than the original Schumer-McCain language, I am troubled by the fact that we basically have a bill emanating from the HELP Committee that centers on patent law, civil justice reform, and antitrust policy. I object to this outcome, and I want to take a few moments to comment that the way the Judiciary Committee was effectively cut out of the process is a matter of great concern to me.

Even if three members of the Judiciary Committee serve on the HELP Committee and are highly involved in this effort, I am concerned that the recent actions of the HELP Committee with respect to this bill will come at the expense of the jurisdiction of the Judiciary Committee both today and into the future. This is wrong. The Judiciary Committee has a role to play in overseeing and legislating with respect to pharmaceutical patents and competition in the pharmaceutical marketplace. The process and timing that are being pursued can only undermine the appropriate role of the Judiciary Committee, a balanced committee.

The fact is, last year we held a hearing on competition in the pharmaceutical marketplace and reported Chairman LEAHY's bill, S. 754, the Drug Competition Act, which I support. I cooperated with Senator LEAHY in the development and refinement of his bill, S. 754, the Drug Competition Act. I voted to report the bill out of committee even though I had some reservations about some of the language, and I remain prepared to work on those concerns.

The fact is, the HELP Committee bill contains patent forfeiture provisions, similar in many respects to the concept once under discussion as Chairman LEAHY and I worked to refine S. 754. I ask why the HELP Committee adopts a policy of patent forfeiture not on the outside of its jurisdiction but already rejected by members of the Judiciary Committee. I emphasize that this is not a matter of public health policy but a patent law and civil justice reform, and so is within the province of the Judiciary Committee, not the HELP Committee.

I am mindful of the fact it was referred to the HELP Committee, but this body has a history of committees working in tandem on issues of mutual interest. In 1998, although the tobacco bill was referred to the Commerce Committee, the Judiciary Committee held 10 hearings on aspects of the legislation that touched upon our jurisdiction. We all know the long-awaited FTC study of the pharmaceutical industry that focuses precisely on the provisions of the law that the HELP Committee seeks to change today will be completed in a few short weeks. Why not wait for that? Why not get the best advice of the Federal Trade Commission? They have done an extensive review.

Whether we agree or disagree with the final outcome of that, we at least ought to get it before we try to wholesale change the law that has been called the best consumer piece of legislation in the last 50 years.

It is clear, to me, that consideration of this legislation would be more informed if we had the information that is about to be presented by the FTC to Congress and the public. We should ask the experts at FTC, DOJ, the Patent and Trademark Office, and Health and Human Services if their perspectives on the changes in the law are advisable. It would have been preferable to hear what the experts think of the HELP Committee language before it was brought to the floor. Whatever happened to holding a hearing on the actual language of an important bill?

The reality is, in the course of the markup, the HELP Committee virtually rewrote the major components of S. 812. Unfortunately, this sprint to the floor cannot foster the careful type of review and analysis that the Senate conducted in 1983 and 1984 when we passed the Drug Price Competition and Patent Term Restoration Act.

Despite my disappointment about the committee process on consideration of the Medicare drug benefit in the Finance Committee and the way the Judiciary Committee was bypassed from playing a role in shaping S. 812 before it reached the floor, I want to take some time to make a few remarks about the spending bill, the underlying bill, and how it might affect the law it would amend; that is, the Drug Price Competition and Patent Term Restoration Act of 1984.

It is useful to think about the words in the title of the law because they remind us that we had two distinct goals in writing the law—goals, by the way, which have been met. Attempts to change the law must also reach the critical test of these two goals: First, to provide incentives for the development of innovative pharmaceuticals—if we don't have that, we don't have anything; second, to promote widespread distribution of generic drugs by permitting a shortcut to regulatory approval, which Hatch-Waxman did.

There is evidence to conclude that the 1984 law has met with success in accomplishing both of these ends, much to the benefit of the American public. The 1984 law contains the incentives with respect to the intellectual market that have brought hundreds of therapeutic new drugs to the American public.

To mention a few of the drugs, these include products such as Vioxx to treat arthritis; the cholesterol drug, Lipitor; new medications that help millions of diabetics; and as recorded from Barcelona last week, a family of drugs to treat HIV infection and the complications of AIDS, two areas in which both the distinguished Senator from Massachusetts and I have spent a lot of time working together.

Private sector investment by research-based pharmaceutical firms increased from $3.6 billion in 1984 to over $30 billion this year. This substantial level of private sector applied research funding, coupled with the $27 billion invested by the taxpayers in the National Institutes of Health budget next year, helps explain why the unique public-private partnership that forms the U.S.

Biomedical Research Enterprise has American scientists positioned to usher in a revolutionary new age of discovery in the biological sciences. We all should take pride in the fact that the United States leads the world in developing innovative medicines. Part of the reason for this leadership is the intellectual property protections contained in the 1984 statute.

The debate on the pending legislation centers on the price competition that occurs between generic and name brand drugs. But as we consider legislation that alters protection of the innovator firms' intellectual property, it is important not to lose sight of the importance of the fierce competition between the generic companies and the brand name companies. It is the competition for new drugs that creates advances in medicine and improves public health and ultimately provides blockbuster drugs for generics to copy and to put out at, hopefully, less cost.

As we debate how to see that the American public, particularly senior citizens, gains access to today's pharmaceutical products, during the golden eggs of our biomedical research establishment we must be mindful of the long-term health of the goose that produces these innovative drug products. Not only does the American public enjoy the benefits of the latest breakthrough medicines, but consumers also reap the savings associated with the use of generic drugs.

Since the 1984 Drug Price Competition and Patent Restoration Act, the share of the prescriptions written for generic drugs has more than doubled and has increased from somewhere less than 20 percent to almost 50 percent of all prescriptions written. And as we will hear in the debate that will take place over the next several days, everyone in Congress knows that senior citizens, particularly senior citizens, have a great interest in programs, such as the 1984 law that resulted in cutting the costs of drugs.

One undeniable bottom line measure of success of the Drug Price Competition and Patent Restoration Act of 1984 is the fact that according to the Congressional Budget Office, this law has contributed to annual consumer savings of $8 billion to $10 billion every year since 1984. I wish all our legislation would be as effective and as successful as this one.

It might prove useful to summarize briefly how the Drug Price Competition and Patent Term Restoration Act works. When you hear how the statute operates, you will understand that a central principle of this legislation is balance among the incentives of both the research-based firms, the pioneer firms, and the generic firms.

This balance is not on only a simple matter of fairness to both of these sectors of the pharmaceutical industry. Achieving a balance was critical to help ensure that both of these sectors would succeed because the bottom line of Hatch-Waxman is to help the American public receive both the latest in medical breakthroughs, and the more affordable generic drugs.

As we consider changes to Hatch-Waxman, we must be careful not to upset the balance because if we do, it is the American people who will suffer. Here is how the law works. In order for a drug to be marketed in the United States, a manufacturer must prove to the Food and Drug Administration that the drug is both safe and efficacious, effective. Drug discovery and development is an extremely time-consuming, expensive, and risky process.

As I have mentioned before, experts at the Tufts University Center for the Study of Drug Development have placed the costs of developing a major new drug at $800 million, when the opportunity costs of capital and the cost of failed drugs are factored into the rare, successful product.

During this debate, some will no doubt be tempted to characterize the drug industry as nothing more than a bunch of greedy, money-grubbing companies. In fact, for much of the last decade, it has been the most profitable sector of the U.S. Economy.

Nevertheless, as many analysts have noted, and was discussed by Senator WYDEN at the Commerce Committee hearing this past March, drug discovery is a highly speculative venture and there is currently an industry-wide slow down in the pipeline of products close to final FDA approval.

For every drug that succeeds in gaining FDA approval, more than 5000 compounds are screened and fall by the wayside during testing. Some of these compounds fall out in the lab; only about 250 of the original 5000 compounds will proceed to full-scale animal testing; and, of those 250 that enter animal testing, only 5 will make it to human clinical trials; and, finally, the great majority—4 out of the remaining 5 of drug product candidates—will fall out during the required 3 phases of human clinical testing.

The first phase of clinical testing usually entails about 30 patients. The goal of this phase is to assure that the compound under study is safe for human use. This is a very difficult hurdle as, for example, it can be expected that a compound that can eradicate cancerous cells will also likely be toxic to the surrounding healthy cells. It is no wonder that the pharmaceutical industry invests a higher percentage of its revenues into research than other industrial sectors. Are they given any credit for that on the floor over the last number of days? Give me a break. They certainly have not. In fact, they have been condemned in talk after talk as though they are the sole cause of the high cost of drugs.

In the second phase of clinical trials, efficacy is examined. This may involve several hundred patients and it may take several years to design, conduct, and analyze the trial.

If success is sustained through Phase II—and remember that experience teaches us that most of these costly trials will result in failure—an investigator may proceed to the third and final phase of human clinical testing in which the drug is administered to several hundred and sometimes several thousands of patients.

Phase III trials attempt to further evaluate safety and efficacy, fine tune dosing regimens, and uncover any propensity for adverse reactions among subgroups of the broad patient population taking the medicine.

Because they involve more patients and seek more precise information, Phase III trials are generally even more expensive and time consuming than the earlier phases of drug development. In order to gain FDA approval, the agency prefers to see two successful Phase III studies.

In addition to costing hundreds of millions of dollars to screen and test drug candidates, it also takes a great deal of time. It has been estimated by experts that it takes, on average, about 14 years to bring a drug from the lab through clinical testing and FDA review.

And all during this time the clock is ticking on the patents held on these drug candidates. For example, in the case of the anti-inflammatory drug, Daypro, the patent lapsed during the 21-year FDA review of the product.

While this case was clearly an outlier and FDA review time has improved somewhat over the last decade due to the user fee legislation, it remains true that the U.S. pharmaceutical industry is one of the most highly regulated sectors of the economy.

It is an expensive process, mainly an expensive regulatory process. If we could somehow find a way of cutting that down, then the cost of drugs would come down, too.

We passed a bill—it was another Hatch bill—called the FDA Revitalization Savings Act, in the early 1990s, that said we should create a central campus with state-of-the-art buildings and equipment and scientific facilities instead of the almost 40 different locations, some of them converted chicken coops, where they are conducting research today. The FDA has hardly hired a research scientist in the last 30 years. The reason is there is not the prestige in their eyes to work for the FDA for less money than they would get in the private sector.

NIH doesn't seem to have that problem because it is so prestigious to work there, even at the lesser salaries, that scientists flock to NIH. It is exciting, plus they have state-of-the-art buildings and equipment with which to work.

We need to do that. We need to stop blaming the pharmaceutical companies, the pioneer companies for all the problems here.

In recognition of the exacting and time-consuming nature of FDA review of safety and efficacy testing, the Drug Price Competition and Patent Term Restoration Act provided a number of

incentives designed to help research based pharmaceutical companies.

The statute provides for partial restoration of pharmaceutical patents, but only under limited rules:

First, the law allows one day of patent term restoration for each two days spent in the human clinical trial phase.

This is known as the IND Phase. IND stands for the investigational new drug and refers to the exemption that FDA grants to allow the human clinical trials to proceed.

The law also allows day-for-day patent term restoration when the drug is in the final stage of FDA review. This is called the NDA phase. The NDA, or new drug application, is the formal application that contains the data demonstrating safety and efficacy. I should point out that given that each NDA contains data and records on thousands of patients, the NDA literally contains hundreds of thousands of pages of information. In some cases those millions of pages of information would fill this whole Chamber—that's how complicated it is. Yet, we hear badmouthing of the pioneer companies every day here on the floor. There are fair criticisms, but I don't think all the criticism has been fair.

There are two further limitations on the partial patent term restoration. First, when the one-for-two rule in the IND Phase is applied with the day-for-day rule during the final review of the new drug application, no patent may be restored more than 5 years. You should keep in mind that, as I said earlier, it takes about 14-years to bring a drug through pre-clinical studies through FDA approval.

Finally, even after this 5-year limitation kicks in there is another rule that prevents any patent from being restored such that it will have an effective patent life beyond 14 years.

The 5-year and 14-year limitation rules are sometimes referred to as the Hatch-Waxman caps.

So I just want to point out that you will hear a lot of talk during this debate about patent extensions, but what we are talking about is partial patent term restoration to offset part, and a relatively small part at that, of the time lost during the rigorous FDA review of safety and efficacy. You don't hear many comments about that from the critics the fact of the matter is, this is a long, arduous expensive time consuming, costly process. To blame the pharmaceutical companies for everything that is wrong is just not fair.

It is worth noting that the 14-year cap on effective patent life contained in the Waxman-Hatch Act stands in contrast to how other types of patents are treated with respect to administrative delays at the Patent and Trademark Office.

This is a somewhat complicated story but I think it bears discussion in order to place the Hatch-Waxman policies into context with subsequently enacted changes to the patent code.

Basically the GATT trade treaty required implementing legislation that mandated the United States to change its patent system from 17-years, measured from the date of approval to a new system of 20-years, measured from the of date of application with the Patent and Trademark Office.

There was concern by many intellectual property owners that this change in the law could actually decrease effective patent life due to administrative delays at PTO. As a result, a provision was included in the 1999 American Inventors Protection Act—a bill that passed with broad bipartisan support—that allowed patent term to be restored up to 17 years in cases where there was undue delay at the PTO.

The 17-year patent term floor in the American Inventors Protection Act extends to all types of patents and should be contrasted with the 14-year patent term ceiling contained in the Waxman-Hatch for pharmaceutical patents. Moreover, most patent applications are reviewed by PTO in one and one-half to two years, so that the effective patent life for most products is actually 18 to 18.5 years. When all is said and done, most patents run appreciably longer than patents related to drugs due to the 14-year Waxman-Hatch cap.

In addition to the partial patent term restoration provisions of the 1984 law, the statute provides that each FDA-approved new drug that consists of a new chemical entity receives 5 years of marketing exclusivity—not 18 years, which other manufacturers get, but 5 years of marketing exclusivity. In other words, we want to treat them at least somewhat fairly.

This 5-year marketing exclusivity provision means that FDA may not approve any generic drug for that time 5-year period regardless of whether the drug is protected by any patent.

The last major incentive on the R&D side of the ledger that I will discuss is the provision that entitles a pioneer drug firm that successfully undertakes a clinical trial yielding data that significantly improves, or modifies the use of an existing drug compound, to 3 years of marketing exclusivity.

As you can see, this is complex. But it works, and it has worked amazingly well. Our country has benefited from it. And it was bipartisan. Actually, you would have to say it was nonpartisan. That is what I would like to see in a full Medicare prescription drug bill. This 3-year incentive helps encourage incremental, but often vitally important improvements, to existing drugs and does not bar generic competition from the original approved uses of the drug once any patent or marketing exclusivity has expired.

I hope my colleagues can see that the 1984 law contains a powerful set of intellectual property incentives that help foster the necessary private sector investment in pharmaceutical R&D.

That is one reason our pharmaceutical companies have done so well. That is why we have such a good balance of trade. They have been among the most successful companies in our society up until now, and they are about to be stratified where they won't have the money to go through this $800 million and 5,000 misses to get one single drug, if they are lucky and then have just a few years of patent life. You wonder why drugs cost so much through that market exclusivity.

In parallel with the incentives I have just described for innovator firms, the Drug Price Competition and Patent Term Restoration Act provided the necessary regulatory regime that created the modern generic drug industry. Rather than unnecessarily squander societal resources by requiring the duplication of the expensive and time consuming process by which safety and efficacy is established for pioneer products, the law provided a shortcut through the FDA regulatory process.

That was one of the generic aspects of the law. The 1984 law, in essence, allows generic competitors to rely upon the proprietary safety and efficacy data generated by the pioneer firm and requires that the generic drug merely be shown to contain the same active ingredient and be absorbed by the human body in a bioequivalent fashion. This simple provision of law allowed generic firm to bring on high quality copies of the pioneer drugs for a fraction of the cost and, most importantly, to pass these savings onto consumers.

Their cost is less than 1 percent to put the drugs in the marketplace. I want it that way. We wanted it that way when we did the Hatch-Waxman bill.

Another key feature of the law is a unique change in the patent code designed to allow generic product to enter the market literally the day after the patents on a pioneer drug expire.

Upon first consideration this may not sound like a dramatic development in the law but it is. Here's why.

Let us start with the Constitutional basis for patent protection. Article I, Section 8 of the United States Constitution provides: ''Congress shall have the power . . . to promote the progress of science and useful arts, by securing for limited times to authors and inventors the exclusive right to their respective writings and discoveries.''

It is said that Thomas Jefferson had his hand in the drafting of the first patent statute enacted by Congress back in 1790 and that in his capacity of Secretary of State actually issued and signed some of the first patents issued by the United States federal government.

In areas such as pharmaceuticals, where it is relatively easy to copy pioneer products that require enormous R&D expenditures—I mentioned $800 million to find one drug—it is critical to have strong laws prohibiting the infringement of patents.

I should also like to add that a patent right is a negative right and does not automatically confer monopoly power; a patent only allows the patent

owner the right to exclude others from utilizing the patented invention or process.

Section 271(a) of title 35 of the United States code contains the general rule against patent infringement. It says: '' . . . whoever without authority makes, uses, offers to sell, or sells any patented invention . . . during the term of the patent . . . infringes the patent.''

This is a tough provision and a good provision because it protects the rights of inventors, inventors of all products used, manufactured or sold in each of our states, who have made substantial investment in research and development.

In order to allow generic drug firms to enter the market the day the patent expired, the general rule of section 271(a) had to be modified. This is so because in order to get the drug through the truncated FDA review process and gear up production the generic firm has to make and use the patented drug, and this is important, while the pioneer drug is under patent protection.

I should also add that under the common law there is a research exception to the general rule against patent infringement so that academic researchers could be free to explore new areas of scientific inquiry.

During the course of the negotiations over the Waxman-Hatch law, a question arose in the courts with respect to whether this research exemption might carry over to the type of research activities necessary to develop a generic drug.

And right in the middle of these negotiations we got the answer when the precursor court to the Federal Circuit Court of Appeals issued its opinion in the case of Roche v. Bolar. The court held that the research exception did not extend to commercialization activities such as those necessary to prove bioequivalence.

The result was that the Drug Price Competition and Patent Term Restoration Act contains a legislative override of the court case. This provision, the so-called Bolar Amendment, creates a unique provision in patent law. Section 271(e) of title 35 contains the Bolar Amendment. Section 271(e)(1) says: ''It shall not be an act of infringement to make [or] use . . . a patented invention . . . solely for uses reasonably related to the development and submission of information under a federal law which regulates the manufacture, use, or sale of drugs or veterinary biological products.''

When considering the pending legislation, it is important to understand that in preparing an abbreviated new drug application, or an ANDA as they are called, the generic firm gets a head start over virtually all other types of generic manufacturers in that they are permitted to make and use—and thus violate—pioneer firms drug patents while these patents are still in effect.

That is a major change in patent law that we put into Hatch-Waxman to get the generic industry really going. And it helped to create the modern generic drug industry.

(Mr. EDWARDS assumed the Chair.)

Mr. HATCH. In the interest of accuracy, I must add a footnote. In the 1990 Supreme Court decision of Lilly v. Medtronic, the Court held in an opinion written by Justice Scalia that the Bolar amendment also applies to some other FDA-regulated industries such as medical devices. While you need to read the opinion for yourself to see how this not-so-obvious result was accomplished, as coauthor of the bill, I did take note of Justice Scalia's observation that:

> No interpretation we have been able to imagine can transform section 271(e)(1) into an elegant piece of statutory craftsmanship.

Mr. President, ouch!

But the Medtronic decision has only limited significance and it is still fair to say that the generic drug industry enjoys a head start that virtually no other type of generic manufacturers could even imagine—the ability to make and use on-patent products for commercial purposes. The head start granted to generic drug firms by the Bolar amendment was an integral part of the balance of the 1984 law and must be kept in mind when I next discuss the closely related patent challenge provisions of the bill.

But before I discuss these provisions, I want to first emphasize that the central feature of the Hatch-Waxman law thankfully remains unscathed by the pending legislation.

This is the policy tradeoff whereby part of the patent term lost by innovator drug firms during the extensive FDA review is restored while, at the same time, generic drug firms were permitted to rely upon the proprietary safety and efficacy data of innovator drug firms and enter the marketplace upon a showing that the generic copy of the drug is delivered to the patient in a bioequivalent manner.

And from the summary I have just provided, I think you get the idea that the Drug Price Competition and Patent Term Restoration Act of 1984 law is a complex piece of legislation. It took us 2 solid weeks, 18 hours a day, in my office. I was there every minute of those negotiations to get this negotiated between the PhRMA companies and the generic companies. I will also concede, as Justice Scalia has noted, that the statute does not read like a novel.

The 1984 law has been instrumental in delivering both new drugs and more affordable drugs, but this is not to say that such a complex piece of legislation cannot be improved to address unanticipated or unintended consequences as well as changes in the marketplace and science.

Before I discuss my views on the pending legislation, the HELP Committee substitute to S. 812, I would like to complete my summary of the Drug Price Competition and Patent Term Restoration Act by describing the patent challenge features of the statute. Perhaps no feature of Waxman-Hatch has generated as much controversy as the provisions relating to patent challenges. These are the least understood and, indeed, least appreciated provisions of the law. The guts of the HELP Committee substitute focus on these provisions.

I hope that everyone agrees that patents are critical to the drug development process because absent patent protection it would be relatively easy to copy virtually any drug. The challenge of drug development is not in the chemistry of manufacturing, but in conducting the extensive and expensive preclinical and clinical research that demonstrates safety and efficacy.

While patents are integral to drug development, consumers can benefit greatly from earlier price competition if it were determined that, for whatever reason, the underlying patents on a drug were invalid or not infringed.

At any rate, during the negotiations over the bill in 1984, a policy question arose regarding how best to guarantee that drug patents would be challenged and what to do in cases in which a challenge was successful.

We ultimately decided that a generic firm which successfully attacked the patents on a new drug would receive a period of 180-days of marketing exclusivity during which no other generic competitor could be approved by FDA.

The 1984 law contains an elaborate set of rules surrounding patent challenges. Here is how the system works.

From my earlier discussion, you will recall that all new chemical entities—even and especially drugs without any patent protection—receive a 5-year period of marketing exclusivity during which the generic drug firm may not rely upon the safety and efficacy data generated by pioneer drug firms.

And keep in mind that there may be no other industry in which generic competitors can rely upon pioneer manufacturers' proprietary information submitted for Federal approval purposes.

In any event, the law allows the generic drug firm to submit an abbreviated new drug application after 4 of the 5 year marketing exclusivity period has lapsed. When the generic drug application is submitted, the generic firm has to make one of four certifications with respect to each patent related to the drug listed in the official FDA records called the Orange Book.

This chart sets out these choices.

First, that such patent information has not been filed.

Second, that such patent has expired.

Third, the date on which such patent will expire.

And fourth, and finally, that such patent is invalid or will not be infringed by the manufacturer's use or sale of the new drug for which the application is submitted.

It is the last certification, the so-called paragraph IV certification, that is the chief cause of the major problems the bill pending on the floor seeks to address.

As I have said many times over a number of years, by the way, and will say again here today, I acknowledge there are some problems with paragraph IV patent challenges.

These need to be corrected. I would like to shape legislation to correct them.

But it is also no secret that my preference was to address these problems in the course of a comprehensive review of the Drug Price Competition and Patent Term Restoration Act.

In fact, in the good old days when I was still chairman of the Senate Judiciary Committee and my friend from Vermont, Senator JEFFORDS, was the chairman of the HELP Committee, we were working together to conduct such a review.

But times have changed. What should not change is that this body should resist the pile-on mentality which villianizes an industry which is doing more to help millions and millions of Americans daily than any other industry we could imagine.

Before I close my remarks today, I will outline the types of issues that ought to be considered a more thorough review of the 1984 law than the pending bill contemplates.

In any event, to return to the paragraph IV litigation procedures, the filing of a generic drug application triggers a 45-day period during which the pioneer drug company or firm could initiate a lawsuit to determine whether its patents were valid or infringed. In order to give a court adequate time to familiarize itself with, and hopefully dispose of on the merits, the almost always complex issues attendant to patent litigation, the Waxman-Hatch law provides a statutory 30-month stay.

During this 30-month period FDA may not approve the generic drug application in dispute unless a court resolves the matter.

It is also true that this is a unique provision not available to other types of patent holders. However, this unique 30-month stay provision that benefits patent holders must be understood in context of the overall system of balances contained in the 1984 law, and, in particular, in connection with the operation of the Bolar amendment.

The Bolar provision, you will recall, has the laudable public purpose of trying to get the generic drug product onto the market the very day the patent expires.

As I explained earlier, in order to achieve this pro-consumer end, the patent code was amended to allow the generic firms to infringe patents.

But we must recognize that the reality of the Bolar amendment is that it takes away the customary rights of a patent holder to bring a patent infringement action the moment a generic drug manufacturer makes or uses a patented product. In this case, the commercial purpose consists of seeking FDA approval and gearing up production. It cannot be disputed that section 271(e) of the patent code—the Bolar amendment—places pharmaceutical patent holders in a disadvantageous position from which to defend themselves against challenges to its patents by generic drug challengers.

This is so because a second prong of the Bolar amendment, codified at section 271(e)(2) of the patent code, treats the somewhat artificial act of filing a generic drug application as an act of patent infringement, and it is at that point, and not before that point, that the patent holders can assert their normal patent rights through the courts.

It seems only fair to recognize the unique head start that the Bolar amendment allows to generic firms on the front end of the generic drug development by making available to pioneer firm patent holders the 30-month stay that allows the courts adequate time to delve into the merits of the challenged patents. Absent the Bolar amendment—and don't forget that this provision reversed the Federal Circuit Court of Appeals decision that decided against generic drug firms on the matter of patent infringement—the case for the 30-month stay would not be as strong.

In any event, during the course of the 30-month stay, it is hoped that an adjudication on the merits of the patent challenge will be completed. If at the end of the litigation the pioneer firm prevails, the generic drug applicant must wait until the patents expire before the FDA can approve its application and the generic product can be marketed. On the other hand, if the courts determine that the patents are invalid or the generic drug firm has successfully invented a way around the patents, the 1984 law grants an award of 180-days of marketing exclusivity. As I said earlier, this is to encourage vigorous patent challenges so that consumers can benefit from earlier access to cost-saving generic drugs.

I thought then, and think now, that it is sound public policy to contain an incentive to assure legal attacks on pioneer drug patents, and we all must recognize that such litigation is risky, complex, time-consuming, and costly.

Now that I have laid a foundation by discussing the basic provisions and policies of the Drug Price Competition and Patent Term Restoration Act, I want to add to the debate that was initiated yesterday by briefly describing the key problems that have been observed in recent years with respect to the 1984 law.

I first remind the Senate that in the next few weeks the Federal Trade Commission is expected to issue a comprehensive report that centers on what many believe are the two most important abuses of the current system: First, the manipulation of the patent system for the purpose of triggering multiple overlapping or late-in-the-process 30-month stays; and, second, collusive arrangements between pioneer and generic firms to game the Paragraph IV litigation in order to preclude the triggering of the 180-day marketing exclusivity clock so that no generic can reach the market in a timely fashion.

I am frustrated by the fact that the tactical choices of my colleagues across the aisle preclude us from debating this important legislation without the benefit of the FTC report.

I await with great interest the final version of the forthcoming comprehensive FTC report on the drug industry so we may get a more accurate picture of the number of instances in which drug firms have tried to game the system by listing a late-issued patents into the FDA Orange Book.

While my staff and the staffs of a few other Members have been briefed on the general findings of the FTC study, it was under the condition of confidentiality and with the understanding that the commissioners had not evaluated the data and given us their interpretations, conclusions, and recommendations.

Along the same lines, I would like to add that the FDA Chief Counsel, Dan Troy, convened a meeting in February of representatives of both the generic and pioneer drug firms.

Mr. Troy elicited information and debate on several maters, including a full and frank discussion of both the 30-month stay and the 180-day marketing exclusivity provisions of the 1984 law.

One of the many down sides of rushing this bill to the floor in this fashion was that it precluded members of several committees, including the Judiciary Committee, Commerce Committee, as well as HELP Committee, from first reviewing the comprehensive FTC study on the very issues that the pending legislation seeks to address.

We may have also missed out on a meaningful opportunity to have the usual give and take of a public hearing with the FTC and the FDA on these issues. We could have—and should have—taken the more routine and orderly path to legislation by holding a hearing to solicit the administration's detailed advice in crafting language, including soliciting their views on the language that arose just last Tuesday in the HELP Committee.

Yesterday, Senator GREGG read from the first, but no doubt not the last, missive from the administration commenting on this new language.

In any event, let me turn to the 30-month stay provision. It is my understanding that the FTC report will reveal that there have been several—perhaps about 10—cases of either multiple, consecutive 30-month stays or later-issued patents that resulted in surprise 30-month stays.

The facts matter.

We need to learn about these cases. We also have to keep matters in perspective. Although some in this debate suggest that there has been, and will continue to be, an epidemic of unjustified triggering of the 30-month stay, I am not sure that the evidence will support this charge.

We must take care not to overcorrect any problems based on anecdotal information.

But I will say this: the now famous case of the drug Buspar convinces me and many others that Congress should take action to address the problems associated with late-issued patents triggering new 30-month stays.

This was the case in which a patent on the metabolite of a drug was listed in the Orange Book just as the original patents on the drug were set to expire and generic were literally on the loading dock ready to be shipped.

I do, however, want to note for the record that in the case of Buspar the courts stepped in and the stay lasted only 4 months, not 30-months.

The HELP Committee bill would freeze those patents eligible for the 30-month stay to those patents filed with FDA within 30-days of approval of the New Drug Application. All other subsequently issued patents would be eligible for injunctive relief but would not be entitled to the longstanding protection afforded by the 30-month stay.

First, I commend Senators EDWARDS and COLLINS for overturning the McCain-Schumer language that completely—and unjustifiably—eliminated the 30-month stay. The Edwards-Collins amendment also is a great improvement over the language that Chairman KENNEDY circulated in the days before the markup.

The Kennedy language would have arbitrarily limited the types of patents eligible for the 30-month stay to drug substance patents and method of use patents.

By treating some patents as inferior to others, the Kennedy draft would have reversed a longstanding principle of Hatch-Waxman not to discriminate among types of patents.

The very purpose of the 30-month stay is to give the courts an adequate period of time to make an informed analysis of the complete patent portfolio surrounding a drug product.

The 30-month stay allows the time necessary to make fact-based determinations of the validity of the challenged patents as well as to determine if the generic challenger has successfully navigated the field of valid patents and produced a non-infringing version of the drug.

I know that Senator GREGG was working on a language that would have retained the 30-month stay for each patent recorded in the Orange Book prior to a generic drug challenger filed a marketing application with the FDA. I think that there is great merit in this approach.

The Hatch-Waxman law does not even allow generic drug applicants to file a generic drug application until four full years have elapsed after the NDA has been approved for a new chemical entity.

That is because, as I stated earlier, under the 1984 law, drugs consisting of new chemical entities—and these are likely to be the breakthrough products—automatically receive five years of marketing exclusivity before FDA can approve a generic copy of the drug. It seems reasonable to conclude that, at a minimum, all patents filed before a generic can first challenge a pioneer drug, that is, after four years have elapsed, should be accorded the protection of the 30-month rule.

For example, consider the hypothetical but not unrealistic case of an approved intravenous drug covered by pre-NDA issued patents on the compound and the method of use. In addition, assume the drug sponsor has applied for, but does not receive, a patent on the intravenous formulation until two years after the NDA is approved. While the Edwards-Collins language is barely one week old and I am still studying its implications, upon first consideration, I find it difficult to justify treating the post-NDA-issued formulation patent differently than the earlier two patents. After all, a generic challenger—although free to infringe the patent under the Bolar amendment for the purpose of providing bioequivalence data and to prepare for full-scale production—cannot even contest any of the three patents for 2 years after the third patent issues.

That is because the filing of the generic drug application creates the artificial act of patent infringement required by the Bolar amendment that allows the Paragraph IV litigation to commence.

I emphasize the fact that the lawsuit may not begin at least until the four year statutory bar on submitting a generic drug application expires.

And if it makes sense to include all patents issued within the first four years during which no ANDA application and Paragraph IV challenge can be made, one can argue, as Senator GREGG has, and I suggested in my testimony before the HELP Committee in May, that it makes sense to freeze the patents listed in the Orange Book for the purpose of the 30-month stay on the day that any particular ANDA is submitted, whether or not it is filed on the first day of ANDA filing eligibility, or years later.

The McCain-Schumer proposal to do away with the 30-month stay altogether is dead.

The Kennedy proposal to allow only some types of patents to qualify for the 30-month stay is dead. Perhaps the governing principle should be one bite, and one bite only, of the 30-month apple and all we are debating is when, not whether, to cut off the availability of the stay. As I said last night, in some respects the Edwards-Collins language is a step in the right direction and this is one of those improvements.

We know that it currently takes, on average, about 18 months for FDA to complete its review of generic drug applications. I understand that it takes, on average, about two years to reach a district court decision in Paragraph IV patent challenge case. We also know that the generic have argued—and the Edwards-Collins amendment embraces—that it would be unfair to start the 180-marketing exclusivity clock—a matter that I will discuss latter in my remarks—until a final decision has been reached by an appellate court. This appellate review takes about another year, so the total litigation period of Paragraph IV cases is about 36 months.

I can understand why generic Paragraph IV challengers want to wait—the prospects of treble damages seems to me like a good reason for them to exercise caution—until an appellate court decides the merits of the patent challenge. Given the risk adverse behavior engendered by the threat of treble damages, I don't see why it is so absolutely critical in the first place to bifurcate the application of the 30-month rule at the time a new drug application is approved.

Perhaps the FTC study will unveil a pattern of cases in which courts have ultimately determined that frivolous, or at least invalid, patents were filed between the approval of the NDA and the first ANDA submissions. Perhaps not, only time will tell.

But frankly, this is an area where the actual data that presumably will be forthcoming in the FTC study will be extremely helpful. I will be greatly interested to know how the patent challenge cases would have broken down if the Edwards-Collins NDA-plus 30 day rule were applied retroactively. Stated another way, are there any significant differences in the outcome Paragraph IV challenge litigation between Orange Book patents listed before, and those patents listed after, 30-days after the NDA has been issued? It will be beneficial to get a sense on whether there is a pattern with respect to when invalid patents and patents that have been circumnavigated tend to be listed.

And as I said earlier, I think we would have all been better served if the Committees of jurisdiction had been afforded the opportunity to conduct hearings with the purpose of analyzing the actual language of the Edwards-Collins Substitute and with the hindsight provided by the FTC report, together with the expert advice and analysis of the FTC, other federal agencies, and other experts and interested parties.

We should all recognize that patent litigation is often, as in the case of pharmaceutical patents, inherently technical and complex.

For example, The Legal Times recently reported that the Federal Circuit has a reversal rate of 40 percent in certain patent cases. I am concerned that to the extent we adopt a policy that relies too heavily on simply throwing the matter of injunctive relief to federal district courts absent a period to allow the court to sufficiently familiarize itself with the issues at hand not only disrupts a justified internal check and balance of Waxman-Hatch, but also may have the effect of creating uncertainty as the district courts wrestle with arcane matters of patent law.

While I can see how some enterprising generic firms and their attorneys might be able to turn this new and potentially unpredictable environment into leverage for settling patent challenges, I am not sure that this instability is either fair to pioneer drug firms or in the long run interests of the American public.

For now, I will listen carefully to the debate on this matter but, from what I now know, I am inclined to conclude that the Gregg proposal is preferable to the NDA-plus 30-day standard contained in the HELP-reported version of S. 812.

Moreover, as I stated earlier, I think a case can be made for making the 30-month stay available to all patents listed within four years after the NDA has been approved since no patent litigation can commence under the 1984 law until that time.

In short, while I am open to further debate and discussion on the matter, at this point I question whether the Edwards-Collins language unnecessarily cuts off the 30-month stay too early in the process?

I welcome the understandable and justified attempt to address the problem of late or even multiple 30-month stays that can occur when later-issued patents are entered into the Orange Book. As I said in my testimony in May, if there is a compelling case to keep the current policy of universal availability of the 30-month stay for all patent whenever listed, let's hear the arguments.

Once again, let me commend Senators EDWARDS and COLLINS for moving the Committee away from the these negative aspects of the McCain-Schumer and Kennedy proposals.

I am pleased that there appears to be something of a consensus on the importance of retaining the 30-month stay even though, for the reasons I have just described, I think we need further discussion of when the stay should be available and when it should not be operative.

Having addressed the general issue of the wisdom of retaining the 30-month stay, I would be remiss if I did not comment upon some aspects of the Edwards-Collins substitute that would also drastically affect patent litigation under the 1984 Waxman-Hatch law.

Mr. President, I speak now of the what I will call the file-it-or-lose-it and sue-on-it-or-lose-it provisions of the HELP Committee Substitute.

Mr. President this is a case of the HELP Committee trying to rewrite patent law and doing an absolutely horrible job at it to boot.

There are three very similar and very disturbing provisions that essentially say a pharmaceutical patent holder can effectively forfeit their rights by not filing patent information or a patent infringement action at a certain time.

The first of these provisions is found in Section 3 (a)(1) ''(2)(F)'' of the bill. This provision requires manufacturers of innovative new drugs to file certain patent-related information in the FDA Orange Book upon penalty of—and here's the rub—forfeiture of their patent enforcement rights.

A second provision of the bill, contained in Section 3(a)(2)(B) of the bill makes this filing requirement applicable to drugs approved prior to enactment of S. 812.

This provision says, in effect, that upon enactment of S. 812, every holder of a pre-enactment approved new drug application has 30 days to file all specified patent-related information in the FDA Orange Book or lose forever their rights to sue for patent infringement.

Talk about Draconian remedies for failing to file information with the government. This takes the cake! I should also point out that section (a)(1) ''(2)(C)'' of the bill significantly expands the type of patent information that must be filed, including requiring very precise claim by claim certifications of what each particular patent covers. I am concerned about the policy and potential effects of this language.

Given that forfeiture of patent rights is the penalty for the two file-it-or-lose-it provisions I just described, you should not be surprised to learn that the patent right forfeiture trifecta is completed in section 4(a)(2)(C) which contains a sue-on-it-or lose-it provision that appears to say that failure to defend against any Paragraph IV challenge waives your patent rights against all challengers for all time.

I was relieved to hear Senator KENNEDY state on the floor yesterday that this last provision was not intended to require forfeiture of patent rights as against all potential infringers. I take him at his word that this language will be clarified. But, once again, I must ask why we find ourselves on the floor with a poorly drafted patent provision that has not been vetted by the Judiciary Committee, the PTO, the White House or the patent bar or any number of other experts?

Nevertheless, I find these three provisions so troubling I hardly know where to start my criticism. Under the current law, failure to defend against a Paragraph IV challenge does not result in automatic forfeiture of patent rights.

Mr. President, my colleagues should know that under current law the penalty for not promptly defending against a Paragraph IV litigation challenge is waiver of the 30-month stay, not forfeiture of any patent rights.

It seems to me that the current law waiver of the 30-month stay against the particular litigant bringing a particular paragraph IV challenge is a proportionate response to the failure to defend against a particular lawsuit.

I think that both of the two file-it-or-lose-it provisions and the sue-on-it-or-lose provision simply go too far. I am not aware of any analogous provision in title 35, or in case law, but I am the first to admit that because this language is only a week old my study is not complete. I must question embracing the principle that if a patent holder, for whatever reason, fails to file information with the FDA that those rights should be automatically surrendered against any would-be patent infringers.

It seems to me that these provisions should be subjected to careful scrutiny under the takings clause before they are adopted. As well, the disadvantageous treatment accorded pharmaceutical patents under these three positions should be examined from the perspective of the TRIPS provisions of the GATT Treaty. That involves the Finance Committee as well.

We must not lose sight of the fact that patents are presumptively valid. We must not lose sight of the fact that the reason we have laws to protect intellectual property is because society benefits from advances in the arts and sciences, as the Constitution asserts.

If we expect to have breakthrough medicines, we better protect patents.

Why would we ever support a system in which the failure of a mail room clerk, even if underpaid and overworked, or the U.S. Postal Service could result in the forfeiture of rights stemming from literally hundreds of millions of dollars and precious human capital invested in cutting edge biomedical research?

Just this week, because of the anthrax problem, I received some Christmas presents. One can imagine what can happen on some of these patent cases.

Why shouldn't pharmaceutical product patent owners retain the same time-honored rights exercised by all other patent owners to decide how and when to respond to patent challenge litigation?

Mr. President, I must tell my friends on the HELP Committee that this member of the Judiciary Committee—the committee charged with overseeing the patent law, antitrust law, and the administration of civil justice—that I do not support the manner in which they have resolved significant matters of patent law, civil justice and antitrust policy.

In fact, when Judiciary Committee Chairman LEAHY and I were negotiating over the provisions of his bill, S. 754, the Drug Competition Act, at one point a Leahy staff draft contained a provision in some ways similar to the pending bill's file-it-or-lose-it and sue-on-it-or-lose-it provisions. Ultimately, that approach was rejected. And for good reason.

As many of my colleagues know, S. 754 requires the prompt reporting of any potentially anticompetitive agreements between brand name and generic drug firms to DOJ and FTC.

Basically, the Leahy staff proposal—I cannot say whether Chairman LEAHY was aware of all of the details of this particular provision—was that a drug company would surrender its patent rights if it did not promptly report to

FTC and DOJ any potentially anticompetitive agreement with a generic drug firm.

Let me read the Leahy staff draft that was circulated to my staff last July.

It was contained in the enforcement section of the bill, and it said:

> Contract and Patent Enforceability—if any person, or any officer, director, partner, agent, or employee thereof, fails to comply with the notification requirement under section 5 of this Act, such failure shall render permanently unenforceable any agree which was not filed with the Commission—[referring to the FTC] and the Attorney General, and [here comes the relevant language] shall also render permanently unenforceable any patent of the generic drug manufacturer or the brand name drug manufacturer that is the subject of the agreement.

I must give Senator LEAHY's staff a great deal of credit. One of them is Ed Barron, the deputy chief counsel of the Judiciary Committee Democratic staff. Ed is a level-headed, gifted lawyer and has been an asset to the Senate and the Judiciary Committee for many years.

As well, Susan Davies, a former Supreme Court clerk, is an extremely talented lawyer.

When they consulted with experts in the field and further studied the matter, they properly concluded that patent forfeiture was an improper response for a mere reporting failure—even if that unreported agreement was ultimately found to be violative of the Federal antitrust laws.

How does a patent law provision with civil justice reform implications aimed at an antitrust problem find its way in three places in a HELP Committee-reported bill, one year after the chairman and ranking Republican member of the Judiciary Committee considered and rejected the same basic policy in a bill that covers the same concerns as the pending legislation?

Mr. President, I am afraid that yet another casualty of the truncated process observed by the HELP Committee in its consideration of S. 812 can be seen in the last minute inclusion of the ''file-it-or-lose-it'' and ''sue-on-it-or-lose-it'' provisions of the pending bill. But this is exactly the kind of negative outcome that can occur when there is a markup on a Wednesday and untested language appears the day before.

The truth of the matter is that is exactly what took place last week in the HELP Committee.

While I have commended Senators EDWARDS and COLLINS for rejecting the key provisions of the McCain-Schumer bill, in the case of the ''file-it-or-lose-it'' and the ''sue-on-it-or lose-it'' provisions, I must commend Senator MCCAIN and Senator SCHUMER for not including such troublesome language in the first place.

I urge all of my colleagues to think carefully about the precedent this body would be setting for patent and copyright owners if we follow the lead of the HELP Committee and retain this language.

At a minimum, I hope the Judiciary Committee will have a chance to hold a hearing on this novel language.

If the press of election year politics precludes the Senate Judiciary Committee from holding such a hearing, I would hope that the House Judiciary Committee will step up to the plate and fully vet this issue.

We need to hear from PTO and the patent bar on this issue.

We need to hear from the American Intellectual Property Law Association and the intellectual property groups on this issue.

This matter is far too important to be brushed aside in the rush of the HELP Committee to report a virtually complete substitute to S. 812—a substitute that suddenly springs forward last Tuesday, a day before the markup—a substitute that is then hastily plucked off the Senate calendar before, I believe, a committee report is even filed, and then rockets its way onto the floor as a straw man for the Medicare prescription drug debate.

I am dubious of the language in the bill that creates, I am told, perhaps for the first time in the Federal Food, Drug, and Cosmetic Act, a private right of action.

I am speaking of the provision in the Section 3(a) ''(2)(E)'' of the bill that creates what appears to be a new cause of action to attack patent listings.

Aside from setting an unwelcome foothold for trial lawyers to reach into the FDC Act, one must wonder how a provision that seems to create a parallel course of litigation to the well-established Paragraph IV patent contests simplifies or adds any measure of certainty to the patent challenge system? As the debate unfolds, I may have more to say on this matter and urge my colleagues to act to strike this language.

The last major area on which I wish to comment with respect to the pending legislation relates to the collusive agreements that have occurred in connection with the 180-day marketing exclusivity incentive of the 1984 law.

Mr. President, in closing, I have just discussed why I believe the pending bill's treatment of the 30-month stay is an improvement over the McCain-Schumer bill. For the reasons I have just discussed, I think the NDA plus 30-day rule goes too far. I come here today to give you my views on the 30-month stay issue and to see how the sponsors of the pending legislation respond to my arguments. If they say this is a nonnegotiable matter, that is one thing. If they are willing to modify the language, I will be willing to work with them on this. I would like to hear from them on this issue.

I have a number of other issues I will raise, but I want first to see whether there is a willingness to work with me in correcting what I consider to be inflexible language and to work with me in providing the flexibility to work on the 30-month stay, the file-it-or-lose-it or the sue-on-it-or-lose-it provisions, and the private right of action.

I have worked on many occasions with the Senator from Massachusetts. I have worked against him. I have worked with him. I know sometimes he adopts the no amendment strategy. The minute we yield the floor, I am raising the question of whether the sponsors are totally locked in on the language, and then I would like to hear what they have to say about the arguments I have made. This is too important an issue to play politics. We are talking about the health of the American public. I am willing to work to improve the bill. The language has improved as it has moved further away from the original Schumer-McCain language, but for the reasons I have described I think the language still needs some work.

I have a lot more to say, but I will end by rereading first an administration policy from the Executive Office of the President and then rereading a paragraph from this book.

In the Statement of Administration Policy, it says:

> However, the administration opposes S. 812 in its current form because it will not provide lower drug prices. S. 812 would unnecessarily encourage litigation around the initial approval of new drugs and would complicate the process of filing and protecting patents on new drugs. The resulting higher costs and delays in making new drugs available will reduce access to new breakthrough drugs. Moreover, this new cause of action is not necessary to address patent process abuses. Clearly, the bill would benefit from consideration by the Senate's experts on Hatch-Waxman law on the Judiciary Committee, the proper committee of jurisdiction for this bill.

Let me finally conclude where I began, and that was the book written by Haynes Johnson and David Broder, highly respected journalists, certainly not conservative journalists but journalists I respect, and they said this on page 90:

> In the campaign period, Fried recalled, Clinton's political advisers focused mainly on the message that for ''the plain folks, it's greed—greedy hospitals, greedy doctors, greedy insurance companies. It was an us-versus-them issue, which Clinton was extremely good at exploiting.'' Clinton's political consultants—Carville, Begala, Grunwald, Greenberg—all thought ''there had to be villains.'' Anne Wexler remembered—

Who is one of the leading Democrats in this town, one of the leading lobbyists in this town. I respect her greatly. She said—

> It was a very alarming prospect for those of us looking long term at how to deal with this issue. But at that point, the insurance companies and the pharmaceutical companies became the enemy.

All I ask in this debate is that we get rid of some of this rhetoric that the large pharmaceutical companies are a bunch of criminals and bad people who have run up the costs of drugs and who really do not play much of an important role in our society, and who literally are the reason we cannot get low-cost, affordable drugs to the American people.

During those 18 days or so, whatever it was, that we debated in my office and came up with the Hatch-Waxman

Act, we had almost fist fights between the PhRMA companies, the pioneering companies, and the generic companies, but in the end we were able to bring them together. Neither side was totally happy, but I believe both sides have been totally happy with the Hatch-Waxman results over the last 18 years. To be honest, before we change something that has been so doggone effective and efficacious, I might add, to use an FDA term, it seems to me we ought to at least make sure we are doing it the right way.

I have a lot more to say, but I have spoken for a long time. I understand that. I apologize to my colleagues, but I will be back to discuss other issues such as the 180-day rule which is at the center of what are considered to be collusive deals between the generics and the pharmaceutical firms.

To me, these issues are important. I want to apologize to my colleagues for going on so long, but this is a very complex bill. There is no way it can be explained in a matter of a few minutes. I have only covered a small part of it, but I have covered some very important parts, and I think, and I hope, my colleagues will realize I have made a case that they really ought to give consideration to.

I do not have any political axes to grind. I like both sides of this business. I like the pharmaceutical companies that have done so much to come up with lifesaving drugs, and I love the generic firms that have done so much to duplicate those drugs at an almost nonexistent cost, compared to the $800 million to create those products, but that have gotten them out there in bioequivalent ways for the benefit of the American people.

They both deserve a great deal of credit. Neither one of them deserves to be torn down in the Senate. I think we can fix Hatch-Waxman in ways that will continue to give both of them the incentives to continue to provide a pipeline of very wonderful drugs, lifesaving drugs, for us, and at affordable prices ultimately. I hope my colleagues will listen to what I have to say. I do not have any desire to malign anybody, but I really believe what I have had to say today is important and that Hatch-Waxman is an important bill. I do not want to see it fouled up because we are unwilling to pay the price to do it right.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Tennessee is recognized.

Mr. FRIST. Mr. President, I rise to extend in many ways the comments made by the Senator from Utah. At the outset, I not only express my respect and admiration for his eloquent remarks, but also for the tremendous commitment he has shown on this particular issue over the last 20 years, especially with the Hatch-Waxman law which for the last 18 years has achieved so much for the benefit of the American people. The Senator from Utah has shown a commitment and has shown real foresight, in sponsoring and authoring—along with other colleagues in this body—the original Hatch-Waxman bill in his eloquent analysis of the legislation before us, as has been modified and improved markedly in the Health, Education, Labor, and Pensions Committee. He has also provided an excellent analysis of the underlying McCain-Schumer bill and some of the deficiencies he sees within this legislation.

After listening to his remarks, I think the underlying message was the real beauty in this legislation and in the original Hatch-Waxman legislation in achieving a sense of balance between the brand pharmaceutical companies and what they achieve through research and development, creativity and innovation, that balance with the growth and the appropriate incentives given to the generic community, where we know that cost-effectiveness has been demonstrated and needs to continue to be demonstrated as we move forward. We need to keep this in mind especially in this world with skyrocketing drug costs, which are putting the cost of pharmaceuticals out of the reach of seniors, of everyday Americans, and of individuals with disabilities.

Much of the discussion over the last 3 days has been on how best to provide seniors and individuals with disabilities in Medicare access to prescription drugs, and that debate will continue into next week.

Throughout this entire discussion is the whole issue of cost—what we need to do responsibly that can be sustained long term in terms of cost to make sure the cost of drugs are appropriate, reasonable, and not beyond the reach of Americans. The Hatch-Waxman law has had 18 years of balance, and now is the time to go back and readjust and make sure that balance is well situated for the next 5, 10, 15, or 20 years.

I heard the distinguished Senator from Utah say the legislation, as currently written—and recall he commended the various amendment processes in the HELP Committee to improve the bill—goes too far in correcting what is out of kilter today. That balance needs to be readjusted. The underlying legislation has many deficiencies that he believes, and I agree, should be addressed. I will walk through several of those from the perspective of having served on the Health, Education, Labor, and Pensions Committee.

The issue of cost is one that disturbs everyone. It is at the heart of the discussion on health care and on extending prescription drugs in an affordable way, in a bipartisan way, to seniors and individuals with disabilities. The cost is not just in the public sector but the private sector as well. The skyrocketing cost is driving people to the ranks of the uninsured.

As we look at the overall skyrocketing cost of health care, the cost of prescription drugs is increasing in a way that cannot be sustained over time. In the name of cost savings and in the name of reaching out and rallying support for particular pieces of legislation or amendments focusing on cost savings, never should we threaten public health, which we talked about yesterday. Furthermore, never should we threaten the research and innovation that has made us the envy of the world in terms of health care—the great breakthrough drugs, the investment in research and delivery, which eventually will deliver a cure for things which are not curable today, such as HIV/AIDS. That virus will kill somewhere around 60 million people over the next 20 years. We do not currently have a cure, however, I am confident a cure will be found by research and development from our pharmaceutical companies.

The Hatch-Waxman Act has served us very well. As the distinguished Senator from Utah said, generic drugs represented only about 20 percent of the market in 1984. Yet today, half of all drugs in this country are generic which, again, is a huge advance. At the same time, we have been able to see this rise in the generic industry, which I advocate because of the cost-effectiveness that is demonstrated there because of the balance we have. The brand name pharmaceutical companies have continued to invest in research and development. Over that same period of time since 1984, that research and development by the brand name pharmaceutical companies have increased not twofold, threefold or fivefold but have increased ninefold since 1984.

We have seen dramatic breakthroughs in pharmaceutical treatments for such areas as mental health, cancer, and heart disease. Costs have put drugs out of reach for too many Americans today, and we must address that. Over time, both the generic industry and the brand name pharmaceutical companies have, unfortunately, circumvented the intentions of Hatch-Waxman. That circumvention is clearly an abuse because it ultimately drives up the cost of health care, and it must be addressed. Adjustments are in order. What concerns me and what clearly concerns the original author of the Hatch-Waxman legislation, the Senator from Utah, is that this underlying legislation goes too far.

I will comment on several of the areas. First, I restate the legislation in the Senate today is currently much improved over the original Schumer-McCain legislation introduced last May. The original version of S. 812 took a heavy-handed approach to this very real problem. It would have dealt a serious blow to pharmaceutical research and innovation, which we all depend on as we look for potential cures and potential therapies in the future.

My colleagues, Senators EDWARDS, COLLINS, GREGG, HUTCHINSON and others should be commended for working

with the chairman of the Health, Education, Labor, and Pensions Committee. Senators MCCAIN and SCHUMER also worked to approve the legislation. Nevertheless, the bill before us has significant flaws. Let me briefly outline several of my concerns.

First, we are focused most importantly on cost savings, the driving force. Everyone knows the costs are too high. It is important for our colleagues to understand there has been no demonstration that the underlying legislation will actually save money, lower the overall burden of prescription drugs and generic drugs in the aggregate to either consumers or in the aggregate in terms of the overall health care dollar.

The intent of the authors has been clear—the goal of the legislation is to improve competition. If improving competition is achieved, and I have real questions about whether competition will be improved as written, I believe costs will decrease. It will speed cheaper generic drugs to the market, which is the intent of the authors of this legislation.

Part of the legislation discussed today is clearly being promoted because of the intent, or what the proponents say it would do, and that is to lower costs. The real question is, Does it? Is there any evidence that it will do so?

The Congressional Budget Office, to the best of my knowledge, has not scored this piece of legislation. By score, I mean it has not estimated the cost of this legislation. Neither this legislation nor the original bill introduced by Senators SCHUMER and MCCAIN has been analyzed by the CBO.

As you listened to Senator HATCH's eloquent comments earlier and you listened to the complexities of this bill, I ask, Does this increased complexity and new cause of action actually contribute to increasing costs?

Lastly, I am not aware of any other estimates of potential savings by independent, nonpartisan experts that members of the Senate will have a chance to review before we go forward.

My second point refers to how best to curb abuses. The whole idea of curbing abuses is a common goal that we share in the underlying legislation, in the amendment process, and in the H.E.L.P. Committee. As Senator HATCH again spelled out in his comments, the Federal Trade Commission is currently conducting an extensive study of potential abuses in this area. As we discussed in the hearing several days ago and as Senator HATCH requested, the FTC is preparing a report regarding this area. It would be nice to have an objective body like the Federal Trade Commission present its data before we potentially complicate legislation over the next several days and weeks.

Unfortunately, we are not going to have that opportunity. It is too bad because as I understand it, the real problem is being made in terms of the Federal Trade Commission's ongoing study.

Current law, as we look at the 180-day exclusivity provision, provides an incentive for the first generic that challenges an innovator's original patent. It awards that generic company 180 days, or about 6 months, during which other generics may not be approved. The bill before the Senate, which is quite different than the original legislation, provides that if one generic loses that 180 days of exclusive rights, it can pass on to the next generic.

I am told the 180-day exclusivity rule has been the most frequently litigated area of the Hatch-Waxman legislation over the last several years.

I am concerned and again this understates the concern of Senator HATCH. The provisions in the proposed bill are overly complex and they might actually encourage even more litigation and promote even greater confusion in this area.

As Senator HATCH mentioned, during the Health, Education, Labor, and Pensions Committee's evaluation, we reached out to understand the language in this particular bill. I have to admit that the new bill's language was confusing to me, but at the end of our discussion, my interpretation as we listened to the proponents of the bill is that the 180-day exclusivity period would allow, theoretically, a rollover indefinitely.

If that is a correct interpretation, it could actually take longer for cheaper generic drugs to get to the market. While a generic drug would be cheaper during this 180-day period than a brand name drug, it certainly would be more inexpensive during the 60-day or 180-day exclusivity period, where it had absolutely no generic competition.

Last May, Senator HATCH and others were highly critical of a concept of rolling exclusivity when they testified before the Health, Education, Labor, and Pensions Committee. In fact, Senator HATCH testified and quoted former Acting Director of FDA's Office of Generic Drugs, Gary Buehler, as follows:

> We believe that rolling exclusivity would actually be an impediment to generic competition.

Senator HATCH further stated:

> If our goal is to maximize consumer savings . . . it is difficult to see how rolling exclusivity achieves this goal.

In fact, many experts believe and have expressed that the 180-day exclusivity period is no longer necessary today, and that if it were abolished, even more significant cost-savings could be achieved. Moreover, eliminating the 180-day provision altogether, in my opinion, could be the best way to curb abuses currently being investigated by the FTC—where brand companies and generic companies have allegedly entered into collusive and potentially anti-competitive agreements to prevent cheaper generic drugs from coming to market and benefitting consumers.

My main point is if we are going to act in the absence of the FTC report, which examines this very issue and their findings, we clearly should not add confusion to this area. We should not add provisions which would increase litigation or increase costs, and we should not add provisions that could exacerbate incentives for anti-competitive behavior by both generic and brand name drug companies. This is the area we need to fix.

If we are not ready to eliminate this 180-day rule or wait for the FTC report to help guide us on how we can make that ultimate decision and act responsibly, I believe what is called a ''use it or lose it'' policy would better discourage anti-competitive behavior. This so-called ''use it or lose it'' policy would take away incentives for generic companies to make their own potentially anti-competitive arrangements.

Senator GREGG initially proposed this ''use it or lose it'' policy during the Health, Education, Labor, and Pensions Committee consideration of this legislation. I believe this policy would clearly benefit consumers more than any form of ''rolling'' exclusivity. If we are going to act in the absence of the full report of the FTC, we ought to at least to do so in a straightforward way that promotes competition and that clearly helps consumers.

The third issue I would like to raise is the issue of bioequivalence. This is a particular issue that I introduced in the Health, Education, Labor, and Pensions Committee and spoke a little about on the floor two days ago. Again, it is an issue I want to put out to my colleagues for their consideration. The unintended consequence, in the way this legislation is written, is potentially harmful in a way that I will delineate.

The Hatch-Waxman law allows generic companies to market off-patent drugs if they are able to demonstrate this so-called bioequivalence. Bioequivalence simply means the active ingredient in a generic pharmaceutical or a generic drug is absorbed at the same rate and to the same extent as the brand drug.

The bill before us—and this is the key point—could significantly weaken this important patient protection by giving the Food and Drug Administration broad authority to significantly relax, to loosen, the statutory Hatch-Waxman bioequivalency standard. My concern is this potential loosening of the standards.

We all have agreed—at least in the Health, Education, Labor and Pension Committee discussions, including the proponents of the legislation—that the FDA has broad authority with regard to bioequivalence and that there has not been a successful challenge to the FDA bioequivalence standards as they exist today.

Based on existing statutory language the FDA has developed through the process of notice and comment—rulemaking specific bioequivalence test methods to address a range of products have been established over time. They

have not been successfully challenged. As we discussed this in committee, the FDA has been uniformly successful in defending its bioequivalence methodology and its findings. In fact, we agreed in committee that the FDA's authority in this area has been repeatedly upheld. There has not been a reported case challenging the FDA's bioequivalence standards since the case was decided in FDA's favor back in 1997, five years ago.

Therefore, as we look at bioequivalence, I think it is unnecessary, imprudent, and unwise to include any bioequivalence language in this legislation. Nonetheless, the bill before us would deem FDA's regulations to be authorized under relevant provisions of the Food, Drug, and Cosmetic Act.

Again, my concern is that it could insulate the FDA from any potential challenge in this area.

The reason I keep bringing it to the floor and talking to my colleagues about this issue is because I hear a lot about it from the medical community, the scientific community, and the biological research and development community. Given the importance of the bioequivalence requirement in assuring the safety of generic drugs, I believe any loosening of standards is in the disinterest of the American people. Why? Because, once again, it goes back to safety and public health. Instead of moving forward, it is moving backwards.

There are many examples, but a typical example would be taking a blood thinner such as Coumadin. Coumadin is used all over the country. It is a tremendous drug and a very powerful drug. It is well known that one generic of Coumadin versus another versus yet another behaves in a different way, even if you prescribe the same dose in milligrams. The bioequivalence can be variable and might be tiny, 3 percent, 5 percent, 8 percent. But when the goal is thinning of the blood so you do not have another stroke or heart attack, when you go from one drug to another drug for whatever reason—it might be the pharmacy telling you to do it, it might be your health plan, it might be you who has chosen to do it—your blood might be thin one day and not thin the other, and you think you are taking the same drug.

That is what bioequivalency is—where there might be loosening of the current standard. The reason I say there might be loosening is because people who are a lot smarter than I who study the language tell me the language as written looks to be loosening.

Mr. GREGG. Mr. President, will the Senator yield for a question?

Mr. FRIST. I am happy to yield for the question.

Mr. GREGG. The Senator from Tennessee understands the issue better than anybody else, and certainly the points he makes are excellently made.

It was my understanding on this specific point of bioequivalency that the Senator had a commitment from a primary Democratic sponsor of the bill, Senator EDWARDS, that this would be worked out or straightened out before the bill came to the floor. Am I correct?

Mr. FRIST. Mr. President, in response to my distinguished colleague, this issue of having a general agreement that we would work out technical language, and then after 48 hours or 72 hours have the bill come to the floor without the opportunity, in a bipartisan way, to be able to access experts in the field, is what concerns me most. You can take an initial bill and improve it a little bit, and then you can leave something out and not reach bioequivalency. In response to the question is a particular instance where during the discussion, the mark-up, we said let's get together and make absolutely sure that we address it in a way so that standards are not being loosened; yet, the bill that comes to the floor does not have that guarantee in it.

Mr. DURBIN. Will the Senator yield for a question?

Mr. FRIST. Mr. President, let me continue. Let me answer one question, and then return to my comments. I would be happy to yield for a question.

Mr. DURBIN. The Senator from Tennessee is the expert. He is a cardiac heart surgeon who is recognized for what he has done before he came to the Senate. I will certainly bow to his educational and professional experience.

Talking about bioequivalency, is it not true that when it comes to the efficacy of a drug that we should also take that into consideration when we are dealing with women, children, or pregnant women? It is my understanding that all of these are relevant to the efficacy of drugs—bioequivalency.

Is it not correct that were it not for the congressional pressure and mandating the same pharmaceutical companies the Senator is speaking of they would not be engaged in clinical trials sufficient to make certain that the efficacy of drugs would be the same for women and men, and dosages for children?

The point I am making is the industry, itself, had to be pushed into a position to find exactly what was better for people in usual circumstances of life. Is that not a fact?

Mr. FRIST. Mr. President, I agree with my distinguished colleague that we need to do a much better job in pushing the pharmaceutical industry to make sure that when it comes to testing of drugs or investigating drugs that they are adequate, especially as you look at bioequivalency in a varied population.

In fact, in the HELP Committee, as my colleague knows, we have passed legislation and we will continue to work on legislation that says we need to do more in terms of testing to see what the bioequivalent standard is. What is called in my profession of medicine a ''dose response'' relationship is in populations—whether it varies by race, age, or gender—we need to do a lot more. We need to keep pushing there.

My concern with bioequivalence—we will agree, whichever population it is or whether clinical trials are being conducted—the way this language is written today allows a significant loophole for a lessening of the bioequivalent standards that we as the American people deserve. That is my concern.

As the Senator from New Hampshire addressed in his question to me, we are reaching out. Clearly, we are in the minority. We are not going to have the votes. But I am going to continue to reach out. And I think you will see that our side will continue to reach out in the interest of cost savings. We do not want to push so hard that we lower the standards for the safety of the American people who take these drugs. I do not care if the cost savings is $100, $50, or $5. If that drug is not bioequivalent—if the dose is too strong, then your blood will not clot properly and you can get a stroke from bleeding in the brain, or, if the dose is too weak, then your blood clots too easily and you can get a stroke from having a blood clot go to your brain—you have done a disservice to the American people.

As the Senator from New Hampshire just mentioned, I will continue to reach out on this particular issue of bioequivalence.

You heard Senator HATCH from Utah stress that we need to slow down a bit to make sure that your intent in having cost savings does not hurt the American people. That is really the issue.

I am not the expert. Of course, I have dealt with a lot of these drugs, and I know what it is like being told by a managed-care organization that you have to switch drugs. The fear I have is that the drug has not been tested in a certain population effectively. Again, it could be by race or gender or age. That concerns me. Therefore, I do not want any lowering of those standards by our Government.

The Biotechnology Industry Organization sent a letter to Senator KENNEDY dated July 15.

I ask unanimous consent that it be printed in the RECORD.

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

BIOTECHNOLOGY INDUSTRY ORGANIZATION,
July 15, 2002.

Hon. EDWARD KENNEDY,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR KENNEDY: This letter protests proposed legislation (the Edwards-Collins substitute) to alter the Hatch-Waxman Act of facilitate generic drug approvals. The substitute's proposed changes raise serious concerns for members of the Biotechnology Industry Organization (BIO). We urge you to reconsider these amendments and to work on a more considered basis on any effort to revise the carefully-balanced Hatch-Waxman system.

As you know, the Drug Price Competition and Patent Term Restoration Act of 1984 (the ''Hatch-Waxman'' Act) strikes a balance between promoting access to generic drugs and fairly protecting the legitimate rights of the patent holder. It proves an expedited path to market for generic drugs, while ensuring that innovators receive an adequate term of patent life to stimulate new drug development.

The initial purposes of proposed amendments to Hatch-Waxman were to prevent abuses and facilitate efficient market entry of generic products. The reported bill goes far beyond these purposes. Among other things, the reported bill would completely abolish patent rights if litigation is not initiated within 45 days of notice by a generic that it intends to challenge a patent, or if a new drug applicant failed to list its patent with the FDA within 30 days. It creates a private right or action for generic manufacturers to attempt to ''correct'' patent information filed on a listed drug. At least prior to committee consideration, the bill provided the FDA with broad authority to define and apply standards governing bioequivalence—the critical determination of safety and efficacy of a generic drug—without challenge (or even comment) from affected members of the public. If enacted, these proposals would significantly erode the measures included in Hatch-Waxman to ensure an effective patent incentive for new drug development, and would create undesirable precedents for sound science-based regulations of drug products in the United States.

Our specific concerns follow:

When it enacted the Hatch-Waxman Act, Congress recognized that patent disputes over drugs regulated by the abbreviated new drug procedure were inevitable. The abbreviated new drug system thus provides procedures to permit generic and pioneer manufacturers to resolve these disputes before the FDA grants marketing approval to a generic producer. Under its procedures, the FDA will not immediately approve an abbreviated new drug application if the ANDA applicant challenges a patent that has been identified as covering the drug (a so-called paragraph IV patent certification). Instead, the patent challenge triggers, by statute, an opportunity for the patent owner to initiate a legal proceeding to resolve the patent dispute. The initiation of a patent suit in response to the paragraph IV certification will trigger a 30-month stay of action by the FDA on the abbreviated new drug application. The patent challenge procedures and the stay of approval ensures that products that would clearly infringe the patent rights of the innovator will not enter the market.

The amendments approved by the HELP Committee convert these procedures—which were designed to enhance the ability of a patent owner to enforce its rights—into an all or nothing system that can eliminate the patent rights of our companies. Under the legislation, a patent owner who for any reason fails to initiate litigation against a generic drug applicant within 45 days of receiving notice under the ANDA procedure will be barred from enforcing patent rights in any forum against either the ANDA applicant or any party that manufactures, uses, sells or offers for sale the approved drug product. In addition, a new drug applicant—who may not even be the patent owner—who fails to list a patent with the FDA within 30 days of approval of a new drug application, or within 30 days of the grant of a patent if that occurs after the NDA is approved, is similarly barred from enforcement of patent rights on the drug against a generic manufacturer. Either of these events will completely abolish patent rights in new drugs or related technology.

The legislation also creates new opportunities for generic drug makers to harass our companies through unnecessary and pointless litigation. As proposed, our companies and their drug marketing partners would be required to list patents that pertain to an approved new drug. Failure to list patents would render our patent rights void. Notwithstanding this mandatory listing process, the legislation would create a private right of action to permit a generic manufacturer to challenge these mandatory patent listings. The legislation also would allow generic drug applicants to initiate this litigation regardless of whether our companies or their partners intend to assert their patent rights in the ANDA process. Plainly, the motivation to prevent improper listings of patents has been turned onto its head by these procedures.

Members of BIO thus unquestionably will be harmed by the Edward-Collins substitute. Many of our companies focus on improving currently marketed drugs regulated under the new drug and abbreviated new drug approval system. These innovations of our companies create new and better medicines for patients that are more effective, easier to administer and open up new opportunities for treating unmet medical needs. These technologies frequently—often by commercial necessity—are licensed to multiple drug manufacturers who have the resources to bring new drug products that use these technologies to market. Perversely, under the legislation approved by the HELP committee, if our companies elect to not aggressively enforce their patent rights by immediately suing every generic drug applicant, or if one of the marketing partners makes administrative errors in listing patents with the FDA, the patent rights of our companies will be forfeited. This forfeiture will occur without compensation, without a right of appeal and without any recourse. This provision is probably unconstitutional, and in any event is totally unconscionable.

Finally, as you know, as originally drafted, Section 8 of the bill would selectively codify certain regulations governing ''bioequivalence'' requirements and would legislatively shield the FDA from challenges to its actions in setting approval standards. We understand the purposes of Section 8 to be limited: to confirm the authority of the Food and Drug Administration to use testing methods other than those specifically set forth in current law to establish the bioavailability and bioequivalence of a generic drug, when the methods specified cannot be applied. Types of generic drugs to which alternative testing methods would be applied would include drugs intended to deliver the active moiety locally, such as topical preparations for the skin or oral dosage forms not intended to be absorbed.

As pointed out by Senator Frist during markup, section 8 as currently drafted goes far beyond the intended purposes of the provision. The draft proposal presented during markup would codify fifteen pages of FDA regulations governing ''bioequivalence'' requirements on both new drugs and generics and would legislatively shield the FDA from challenges to its actions in setting approval standards. In essence, the proposed changes would make it impossible for drug manufacturers, whether pioneer or generic, or members of the public, to challenge improper standards enacted by the agency on key approval criteria, or to challenge improper decisions made under valid authority. Moreover, the current regulations include several provisions in which FDA provides to itself unfettered discretion to create or define at will any standard ''deemed adequate by FDA.'' This makes an otherwise legitimate challenge to an agency decision virtually impossible to sustain. Shielding the agency from actions to challenge its proper authority simply makes no sense, particularly when the consequences involve potential risks to patients and to public health.

We were assured by your staff that this provision would be narrowed to its intended scope, in consultation with BIO, prior to floor consideration, and we provided alternate language to your staff that would accomplish the intended purpose of section 8. We have been presented with another draft that would continue to codify all of FDA's bioequivalence regulations (including the ability to define at will any standard it deems adequate) but only preserves ''existing'' legislative authority to regulate biologics under the Federal Food, Drug and Cosmetic Act. This is simply unacceptable to BIO. At this stage we can only ask that the entire section 8 be deleted. We point out that FDA's authority to establish different standards for non-systemic drugs has been confirmed by the courts. See *Schering Corp.* v. *Food and Drug Administration*, 51 F. 3d 390 (3rd Cir., 1995).

Provisions in the draft that served as the basis for committee discussion were made available to the biotechnology industry less than two days prior to markup. These provisions would have an enormously negative impact on the property rights of the emerging biotechnology industry and completely upset the delicate balance between the interests of pioneer and generic companies crafted by the Hatch-Waxman law. They go far beyond the provisions of McCain-Schumer, which served as the basis for the Edwards-Kennedy redraft; the late release of the redraft made meaningful legal review and comment impossible.

We urge you not to rush this bill to the Senate floor. The implications of the changes being proposed by the Edwards-Collins substitute are far reaching and will significantly and adversely impact biotechnology companies. They would severely diminish the incentives of the patent system for our industry to develop newer, safer, easier to administer and more effective drugs that could help patients lead better lives. The changes being proposed, simply stated, will not yield better results for patients or the biotechnology industry.

Sincerely,

CARL B. FELDBAUM,
President.

Mr. FRIST. Mr. President, I also ask unanimous consent to have a similar letter from the Massachusetts Biotechnology Council be printed in the RECORD.

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

MASSACHUSETTS BIOTECHNOLOGY COUNCIL,
Cambridge, MA, July 16, 2002.

Hon. EDWARD M. KENNEDY,
Russell Senate Building,
Washington, DC.

DEAR SENATOR KENNEDY, I request that you oppose S. 812, legislation to alter the Hatch-Waxman Act. The bill raises serious concerns for our Massachusetts Biotechnology Council membership. I urge you to work on a more considered basis on any effort to revise the carefully-balanced Hatch-Waxman system.

I understand that under the reported bill, a patent owner who for any reason fails to initiate litigation against a generic drug applicant within 45 days of receiving notice under the ANDA procedure will be barred from enforcing patent rights in any forum against either the ANDA applicant or any party that

manufactures, uses, sells or offers for sale the approved drug product. In addition, a new drug applicant—who may not even be the patent owner—who fails to list a patent with the FDA within 30 days of approval of a new drug application, or within 30 days of the grant of a patent if that occurs after the NDA is approved, is similarly barred from enforcement of patent rights on the drug against a generic manufacturer. Either of these events will completely abolish patent rights in new drugs or related technology.

The legislation also creates new opportunities for generic drug makers to harass biotech companies through unnecessary and pointless litigation. The reported bill would create a private right of action to permit a generic manufacturer to challenge these mandatory patent listings. The legislation also would allow generic drug applicants to initiate this litigation regardless of whether our companies or their partners intend to assert their patent rights in the ANDA process.

The proposal would codify fifteen pages of FDA regulations governing ''bioequivalence'' requirements on both new drugs and generics and would legislatively shield the FDA from challenges to its actions in setting approval standards. In essence, the proposed changes would make it impossible for drug manufacturers, whether pioneer or generic, or members of the public to challenge improper standards enacted by the agency on key approval criteria, or to challenge improper decisions made under valid authority. Moreover, the current regulations include several provisions in which FDA provides to itself unfettered discretion to create or define at will any standard ''deemed adequate by FDA.'' This makes an otherwise legitimate challenge to an agency decision virtually impossible to sustain. Shielding the agency from actions to challenge its proper authority simply makes no sense, particularly when the consequences involve potential risks to patients and to public health.

I urge you to oppose S. 812. The implications of the changes being proposed are far reaching and will significantly and adversely impact biotechnology companies. They would severely diminish the incentives of the patent system for our industry to develop newer, safer, easier to administer and more effective drugs that could help patients lead better lives. The changes, simply stated, will not yield better results for patients or the biotechnology industry.

Sincerely,

STEPHEN MULLONEY,
Director of Government Relations and Communications, Massachusetts Biotechnology Council.

Mr. FRIST. Mr. President, the Biotechnology Organization represents over 1,000 biotechnology companies and their members all over the country and in every State. California, Massachusetts, and Maryland have the highest concentration of biocompanies in the United States.

I think what people understand and what my colleagues understand is that the biofield is a fairly new field. When I was in medical school, these biotech companies were not out there. The drugs they are looking at today were nonexistent. For the most part, they are in their infancy today. Fifty years from now and looking back, we will see on the curve an increase that right now we are at the beginning of.

Of the 130 biotech drugs approved by the FDA, all were produced by fewer than 100 companies. As I just said, there are over 1,000 biotechnology companies that exist today. What that means is, if you have ten companies working at the early research stage to figure out what drug is going to cure HIV/AIDS, or reverse a certain case of emphysema or reverse that blood clot just about ready to cause a stroke in your brain, one company will ultimately produce an effective product. Many of these companies are small, emerging companies.

Look at Senator KENNEDY's language on bioequivalence. That is the language that will ultimately go into the bill.

These letters make clear the concerns raised by myself in committee and others during the Health, Education and Labor Committee markup. The bioequivalent language in the underlying bill has not been addressed.

You heard Senator HATCH's plea. Even if this bill sails through, please listen to us and allow us to participate in changing that language.

Let me just say that I also share the concerns of others about the codification in this bill.

Let me quote from their letter only three sentences. This is from the biocommunity.

. . . section 8 as currently drafted goes well beyond the intended purpose of the provision. In essence, the proposed changes would make it impossible for drug manufacturers, whether pioneer or generic, or members of the public, to challenge improper standards enacted by the agency on key approval criteria, or to challenge improper decisions made under valid authority. Moreover, the current regulations include several provisions in which FDA provides to itself unfettered discretion to create or define at will any standard ''deemed adequate by FDA.'' This makes an otherwise legitimate challenge to an agency decision virtually impossible to sustain. Shielding the agency from actions to challenge its proper authority simply makes no sense, particularly when the consequences involve potential risks to patients and to public health.

Bioequivalence—again, that is probably the last time I will be able to address this issue on the floor. It is a plea that we work together and come to an agreement so we do not accomplish a loosening of these standards.

The Senator from Utah also mentioned the 30-month stay provisions.

Let me just say that this 30-month stay provision has served a very important purpose. If you look back at the legislation, which is consistent with remarks from the Senator from Utah, you will see that the 30-month stay is part of the balancing act between the brand name pharmaceutical companies, which are heavily invested in R&D, and the cost-effective generic companies to achieve that balance, which we have seen is so important.

As I have said, it has been the magic over the last 16 to 18 years. We need to be very careful when we start tinkering with that and whether or not that goes too far in upsetting that balance.

I know and my colleagues know that there have been huge abuses by some brand name companies versus the generic companies in our discussions. They have filed what are late patents. They file late patents that may not represent significant medical advances. Their purpose is because they saw the law written this way as simply to extend that 30-month stay protection period. And they are protected. When you have that sort of protection, obviously, it affects prices throughout.

The legislation before us would treat patents, listed after a new drug application is approved, differently than patents listed when a new drug application is approved. Providing lower protections to patents at any point in time will have real implications in terms of innovation, in terms of incentives to innovate as you develop new formulations and new aspects of drugs.

There are a whole slew of examples where these patents that are issued, not early on but later, could involve an important innovation. I will not go through the examples here today, but we have talked about them in our Health, Education, Labor, Pension Committee.

So if you have a new drug here, a patent here, and you can improve on that drug later in the life cycle, that improvement needs to be protected in some way. Furthermore, you need to give a pharmaceutical company an incentive, which is what this patent protection is. That is what patents are all about: an incentive to look at a new formulation of that drug that could be important.

There was a question, a few minutes ago, about certain populations. For example, this applies very specifically to the pediatric population. If you have a drug that can either be injected or be applied intravenously inside a vein, and you have a patent on that drug, it would be nice to give somebody an incentive to make sure you can use that same drug in a liquid formulation, to give them some incentive to develop that liquid formulation. And it may come later in the cycle of that drug.

In fact, two weeks ago Dr. Tony Fauci of NIH was quoted in the New York Times about the importance of developing an oral formulation of a drug that was discovered as an injectable drug to treat HIV/AIDS. Forty million people in the world today with HIV/AIDS are struggling in countries, such as in Africa, where two out of three of these cases are today. Many of my colleagues, on both sides of aisle, are trying to figure out how we can link prevention, care, and treatment. The problem is, treatment today is just so expensive. So we want to incentivize people to take an injectable drug, which is very difficult to administer throughout Africa, and develop an oral formulation of that particular drug.

Dr. Tony Fauci talked about the importance of developing and patenting an oral formulation of this drug. Unfortunately, that is the kind of new patent, on a previously discovered drug,

that would be afforded less protection under this bill. When you afford something with less protection, it is true that fewer companies, fewer people, are going to be interested in investing and figuring out that new formulation.

Again, because the distinguished Senator from Illinois mentioned the pediatric population, it brings to mind the fact that we worked very hard on what is called a pediatric exclusivity bill. We unanimously passed it in the Senate. It provides a market incentive for brand-name drug companies to test certain drugs in the pediatric population. Many of us were cosponsors of that bill, and it unanimously passed in this body. It provides a market incentive for brand-name drug companies to test certain drugs for pediatric use for which the FDA issues a written request.

We gave certain protections. Now, all of a sudden, we are saying: Well, maybe or maybe not in the pediatric population. Let's lower the protections that we are giving instead of increasing the protections—which was the intent of this body—and give less legal protection just because of the timing in which a patent was filed.

The issue is complex, as Senator HATCH has said. People say, you are being critical of it. You illustrate the problems. Are there better approaches? The answer is, yes, there are better approaches, to my mind, that I hope we will have the opportunity to debate.

One approach would be to not allow brand companies to automatically extend the 30-month stay for patents issued after the filing of what is called an abbreviated new drug application—what is called an ANDA—by a generic company.

Another alternative would be to allow an additional 30-month stay only for patents that were filed but not approved by the Patent and Trademark Office at the time of the NDA.

The impact of this would be to reduce incentives for brand companies to ''game'' the system, something that all of us want to avoid—companies coming in and trying to take advantage of whatever structure we set up.

The fifth point that I want to bring up, in the hopes that we will be able to come back in some form to be able to address these issues, is the broad bar on patent lawsuits. Senator HATCH also raised this point, for the record.

I am troubled by provisions in the bill that cause patent holders to lose their rights to sue for infringement of a patent if the patent holder does not meet certain requirements, including these timing requirements.

For example, a patent holder would lose its right to sue for infringement if it does not submit appropriate patent information to FDA within the specified deadline, or if it does not bring an infringement lawsuit within 45 days of receiving notice from the generic applicant that its patents are being challenged.

I believe this fundamental change, of which the Senator from Utah spoke, to the Hatch-Waxman law will force companies to bring more litigation, not less litigation. In our hearing, we kept saying that we want to see less litigation. It will force more companies to bring more litigation to avoid the risk that otherwise they will waive their rights for all time.

If they do not sue, they are going to waive those rights for the future. That is a concern to me, especially as we are looking to decrease the number of lawsuits and decrease overall cost.

In fact, as I understand it, this provision alters basic rights that go with a patent, rights that give brand-name drug companies the incentives, as I mentioned earlier, to improve upon existing products.

I have to ask: What happens if a patent owner does not have a good-faith basis to sue at some point in time, but later learns something that would give him reason to sue for infringement? The answer is that that patent holder is simply out of luck.

America's research institutions and academic medical centers would clearly suffer under the ''list-it-or-lose it'' or ''sue-or-suffer'' provisions of this bill. Under these provisions, NDA holders are required to file patents that meet listing criteria whether or not they own or have a license under those patents. Under the bill, patent owners will be lose their rights to enforce their patents if the NDA holder fails to list, and the patent owners can do nothing about that (only NDA holders, not patent owners, have the ability to list patents).

For example, suppose Harvard University owns a patent on a drug substance discovered by one of its academic researchers. Normally Harvard would license that patent to a brand name pharmaceutical company that would develop the drug and submit an application for approval to the FDA. Under the bill before us, if that brand name company failed to list the patent within the arbitrary 30 day period, Harvard, the patent owner, would irreparably forfeit its ability to enforce its valuable patent rights against any generic drug applicant forever.

This is true even if a company completely unrelated to Harvard develops a drug that might potentially be claimed in a Harvard patent. Under this approach, Harvard, which has not control over the timing of the listing, would suffer a complete loss of its patents rights against generics without any recourse or ability to remedy the situation. That is both arbitrary and punitive.

While we are acting, in large part, over these next several days out of concerns over health care costs, as I mentioned before, the Senate has no formal cost estimate from the Congressional Budget Office, the Office of Management and Budget, or really any other credible source.

I mention that only because the overall assumption—and what we would all like—is that whatever we pass here will ultimately bring costs down. But we do not have any outside independent evaluation of that.

While we are acting aggressively to curb past abuses, we do not have the benefit, as you have heard from Senator HATCH and myself today, of the ongoing information that is being compiled by the Federal Trade Commission. The FTC has been specifically charged with the investigation of potential abuses by brands and generics. I believe and I am confident this report will provide crucial additional information. As Senator HATCH has said: We just simply don't have the facts.

I look forward to working with my colleagues on these issues. Again, Senator HATCH and I have spent a long time outlining our concerns, in large part, because I do not think we are going to be in the climate—I know we are going to other very important amendments about extending prescription drug coverage to seniors—that each of these very technical issues are going to be able to be adequately debated, but also to write in language that would fulfill the intentions on the floor, and that we are going to reach out and hopefully have that opportunity to work together on these.

I will likely end up, for the reasons I have outlined, voting against this underlying base legislation, despite the good work and the incremental advantages that have been added to this bill by Senators COLLINS—and I mentioned most of them—EDWARDS, GREGG, HUTCHINSON, and many of my colleagues.

The bottom line is, the balance is critical. Balance has been achieved to a very successful degree, much better than I would think anybody would have anticipated in 1984 from the Hatch-Waxman legislation. It is the magic as to why it has worked. It is why we have seen this proliferation of generic drugs and, at the same time, preserving the innovation and research.

What I am afraid is that in the legislation as written, we have gone too far. Going too far could indeed have a detrimental impact on research and innovation and the public good, without providing the cost savings promised by its supporters.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I ask unanimous consent that before I am recognized to speak, the Senator from Missouri be recognized for 5 minutes.

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

The Senator from Missouri.

Mrs. CARNAHAN. I thank the Senator from Illinois.

Mr. President, over the next 2 weeks, the Senate will address an issue that Americans have come to understand far too well—the high price of prescription drugs. We need to do all we can to lower the price of prescription drugs for consumers.

Senator STABENOW's amendment is one example of a concrete action the Senate can take. Her amendment would give the State the flexibility to negotiate Medicaid drug discounts for non-Medicaid-eligible individuals. This amendment would help lower prices for all consumers. I am a cosponsor of the amendment and encourage my colleagues to support it.

We need to do much more. We need to pass the underlying Schumer-McCain legislation. Today, pharmaceutical companies are making historic profits while average Americans are paying historic prices. Let's look at those profits.

Earlier this year, Fortune magazine did a comparison of U.S. industries to see how profitable they were in the past year. The pharmaceutical industry ranked No. 1 in all three of Fortune's profitability measures. Almost 20 percent of its revenues were profits.

But now let's look at the prices. In 2001, the prices of the 50 prescription drugs used most often by seniors increased on the average by nearly three times the rate of inflation. For example, Lipitor, which is used to treat high cholesterol, rose 13.5 percent, more than five times the rate of inflation. Paxil, which is used to treat depression, rose 11.6 percent. And Celebrex, used to treat arthritis, rose 10.4 percent. For seniors who are living on a fixed income, the high price of prescription drugs means making tough choices every day between lifesaving medication and food and rent and heat.

The No. 1 issue which I hear about in Missouri from our seniors is prescription drugs. Whether people live in urban or rural or suburban areas, they are all feeling the pain of high prices.

Recently, I visited the Terrace Retirement Community in Columbia, MO. While I was there, I led a roundtable on the topic of prescription drugs. If you could have heard some of those stories. They were definitely heart wrenching.

One of the women I met that day in Columbia was Annie Gardner. She is an impressive 63-year-old mother of five children, but she suffers from diabetes and high blood pressure. Her hardship began after taking a buyout from her employer. In this transaction she lost her health insurance and was not able to afford insurance on the private market. This left her unable to afford her prescriptions. Often she had to ration them by taking half the prescribed amount so it would last longer.

Ms. Gardner knows how dangerous this can be because she is a licensed practical nurse and has been for 40 years. Later, she had to quit purchasing the drugs entirely because of other expenses, such as fixing her car and paying increased taxes on her home. Ms. Gardner and thousands like her make these tough life-threatening decisions every day. But no one should have to make those kinds of decisions.

Seniors are not the only ones who have been hit hard. For far too many families, the cost of prescription drugs is a budget buster. Working families without health insurance are paying the highest price of all because they do not get the benefits of the negotiated discounts. This issue also hits employers. They absorb the cost of high prescription drug prices in the health benefit packages they provide to their employees.

For example, last year General Motors spent $1.3 billion for prescription drugs for its employees and retirees. This problem has reached such a crisis that companies, including General Motors, have joined the Governors to form the Business for Affordable Medicine Coalition. Their key issue is the one we are debating today—closing the loopholes in the current law so that generic drugs can compete fairly with brand name drugs.

I am pleased that the Senate is considering ways to close these loopholes with the Greater Access to Affordable Pharmaceuticals Act. I applaud Senators SCHUMER and MCCAIN for authorizing this legislation. I, too, am proud to be a cosponsor of that bill.

It is imperative that we close these loopholes in current law that prevents generics from coming on the market. Generics cost on the average one-third the price of brand name drugs. Generics bring competition into the market and lowers the price for drugs for all Americans.

When a brand name drug is under patent, its manufacturer enjoys a monopoly. One company sells the drug; one company sets the prices. Now I support patents for drugs. Patents are there for a legitimate reason—to allow companies to recoup the cost of research and development that they invest in creating the drugs. But drug companies are abusing loopholes under the current law and extending their monopoly on prices sometimes for years at a time.

A 1-year delay in a generic coming to market can translate into hundreds of millions of dollars in profit for the brand name company. In 1984, Congress passed the Hatch-Waxman act. This act was intended to strike a balance, a balance between brand name drug companies being compensated for their investments and generic companies eventually having access to the market. But the original purpose of the law has been distorted.

The law is now being used to extend patent protections far beyond what Congress intended. Balance needs to be restored. American taxpayers deserve better than what they are getting.

Over the next 5 years, a remarkable 26.7 percent of the entire 2001 pharmaceutical market is scheduled to face exposure to generic competition. If generics are allowed to come on the market, it would mean more choices and lower prices.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DURBIN. Mr. President, I yield 5 additional minutes to the Senator from Missouri with the consent of the Senate.

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

Mrs. CARNAHAN. Generics can save consumers over 60 percent per prescription. Here are some examples of brand name drugs whose patents are supposed to expire in the next few years. Listen to the numbers on what consumers should be expected to save.

The patent on Claritin, an allergy medication, is scheduled to expire in December. Annual savings after the generic becomes available are expected to be over $500 million. The patent on Zocor, a cholesterol-lowering drug, is scheduled to expire in December 2005. The annual savings after the generic becomes available is expected to be about $735 million. The patent on Zoloft, a drug for depression, is scheduled to expire in December 2005. The annual savings after the generic becomes available is expected to be $577 million.

However, given the amount of money that is at stake, pharmaceutical companies have a lot of incentive to delay generics from coming on the market. Unfortunately, current law allows them to do this.

If we in this Congress have the courage to act, American consumers will save billions of dollars. If we don't, the money will go directly from the pocketbooks of American families and on to the profit statements of the drug companies.

Congress must move on yet another front. We will soon be considering a historic addition to the Medicare Program, a prescription drug benefit. The legislation I am supporting would create an affordable and accessible benefit administered through the Medicare Program.

This Senate plan is simple. Assistance begins with the first prescriptions. There are no gaps or limits on coverage, and seniors will pay $10 for generic drugs and $40 for brand name drugs. There is certainty and there is stability.

The House bill is the complete opposite. It is complicated. There is a $250 deductible before seniors get relief. There are months where seniors have to pay a premium, but they would not get assistance with their drug costs. Under the House plan, seniors will pay approximately a $35-a-month premium but still pay the full price at the drugstore.

The House Republican plan would require seniors to use drug HMOs to get their benefit. However, there are no guarantees that private plans would provide a benefit in all geographic areas, or that a plan would even stay in business.

Look at what has happened with Medicare+Choice, Medicare's HMO. Since 1998, nationwide, 2.2 million Medicare enrollees have lost Medicare+Choice as an option because of plans withdrawn from the market. In Missouri, from 1998 to 2001, eight health plans stopped providing Medicare+Choice options in the State.

Furthermore, some options are available in only urban centers and not in rural areas.

Why would we rely on this same type of system to give prescription drug coverage to rural areas?

To me, what the House passed is unacceptable. It is an incomplete benefit with absolutely no effort to lower drug prices. It is unacceptable for Missouri's seniors and unacceptable for American seniors. We must do better in the Senate.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Madam President, I thank my colleague from Missouri. The Senator spelled out in amazing detail what this debate is about. We come to this floor understanding that a miracle has taken place in terms of health care in America within the lifetime of most of us. When this Senate considered the Medicare bill back in the 1960s, there was a very limited formula, a limited number of prescription drugs that were available, and they did not include in Medicare the coverage of prescription drugs.

Look at what has happened since then. There has been a massive investment by the Government, the taxpayers, and by private industry, and we have seen emerging from that brandnew pharmaceuticals that give us the hope of conquering diseases that have plagued mankind forever. This new formulary, ever-expanding, has created a new demand. Of course, it is a demand brought on by people who want to save their own lives as well as those of their family members. It is a demand that is monitored by doctors; a doctor will decide whether this particular drug is right for this patient at this moment.

But at the same time that this miraculous evolution was taking place, the cost of these pharmaceuticals was also rising geometrically, to the point that today many average Americans cannot afford the very prescription that their doctor believes will keep them healthy and out of the hospital. So many of them put off filling a prescription and maybe take half of what they are supposed to take or they have to make a sacrifice—whether it is food, shelter, or paying a utility bill—in order to pay for their drugs.

There has been a demand growing in America for the Congress to respond and to expand the Medicare Program again so we would include prescription drugs. That is something that is worthy and is supported by Democrats and Republicans and Independents.

When you come down to the specific challenge of making it work, one of the biggest problems you face is price. If the cost of prescription drugs continues to grow, as it has in the past, there is no way any of us in the Senate or in the House can devise a Government program to pay for it and to keep up with that cost. Last year, the cost of prescription drugs across America went up some 18 percent. You cannot create a Government program and fund it properly that will keep up with that kind of geometric growth in price.

So there are various ways we can address it. To the north of us, Canada has addressed it with a national health system. We can argue back and forth about whether doctors or hospitals should be Government employees, but when it comes to prescription drugs, what Canada said to the drug companies in America is: If you want to sell your product in Canada, we will bargain with you as to how much you will be paid. The American drug companies said: Fine, let's start the bargaining process. As a result of that bargaining process, there are dramatic differences in the price of drugs between the United States and Canada.

If you look at this chart and go through the drug names, you will recognize some of them. These are the drugs that you find advertised on television, on radio, in newspapers, and in magazines almost on a daily basis. Celebrex, for arthritis, goes for $135 for 90 doses in the United States. In Canada, the same drug, same dosage, and the same company, it is $83. Lipitor, for cholesterol, is $266 in the United States and $179 in Canada. Nexium, for ulcers—the little purple pill, I think it is—is $344 in the United States and $219 in Canada. Paxil, which we have seen ads for, is for depression and anxiety; it is $236 in the United States and $152 in Canada. The list goes on. There is Premarin, Prevacid, Vioxx, Zocor, Zoloft—all the names we are familiar with because of advertising.

The lesson to be learned is that when the Canadian Government said they were going to bargain for the good of people living in Canada, they started saving money for their people and their health system. What is missing in this picture? There is nobody in the U.S. who is bargaining for the American consumer.

Yesterday, on the floor of the Senate, my colleague from Pennsylvania, Senator SANTORUM, argued that is just a price Americans have to pay. It is our responsibility, as he argues, to subsidize the profitability and growth of American drug companies. The fact that these same drugs are costing a fraction—the exact same drugs—in countries around Europe, Canada, and Mexico, he believes is just part of their socialized Government-controlled system.

I can tell you from the U.S. consumer's point of view, it is cold comfort to be told that for a drug you have to pay 40, 50 percent more than someone living a few miles over the border in Canada because it is your burden to subsidize American pharmaceutical companies. But that is the argument being made by those who are opposing many of the issues before us today.

Now, Canada isn't the only entity bargaining with American drug countries. Mexico and a lot of European countries bargain and say: If you want to come into our health system and sell your drug in our country, we are going to reach an agreement as to what you can charge; otherwise, you are not welcome. Well, the companies, by and large, have all agreed to do exactly that—enter into this agreement and reduce drug costs in every country but the United States.

In the United States, there are certain elements within our society that have bargaining power with the drug companies. A couple of examples come to mind immediately. The Veterans Administration, on behalf of America's veterans and hospitals, bargain with drug companies to bring down the cost of drugs. I am glad. The veterans benefit from it. Indian Health Service, the same story; Public Health Service, the same story. Many States, through Medicaid, bargain in terms of bringing down the cost of drugs. When you look at it, private insurance companies reach these same bargains. They say to a drug company: If you want to have an eligible drug for the people we insure, we are going to bargain on a price that we think is acceptable. That bargaining takes place to the benefit of another group of Americans.

If you look at the population of this country, who is being left out in the cold? I will tell you. The first group you will notice is Medicare recipients, people over the age of 65. No one is bargaining for them. These people, retired and on fixed incomes, are paying the highest prices, not only in America but in the world, for drugs that are being made in the United States. High prices, of course, apply to many other families as well.

There are several ways we can approach this. We can decide that, as a society and as a government, we are going to negotiate on behalf of American consumers, the same way it is done in other countries around the world. Well, we have not quite reached that decision. Instead, we are trying to inch toward more competition and price justice. I salute the Schumer-McCain bill—the underlying bill—because this bill says we are going to try to make certain that generic drugs continue to play a major role in terms of providing the kinds of protections that Americans need.

Generic drugs have come a long way in America. We have seen, in a very short period of time, that they have become a substantial part of serving America's health needs. Almost 40 percent of the drugs today are generic drugs.

What is the difference between a brand named drug and a generic drug? Well, by classic definition, a brand name drug is under patent protection exclusivity. Only one company can make that drug. But when the patent runs out, expires, other companies can move in and use the exact same formula, make the same drug, and the price drops dramatically.

I will give you an illustration of how it works. I doubt there is a person in

America who hasn't heard of Claritin, made by the Scherling-Plough drug company. The ad shows people skipping through a field of wildflowers saying, I am not sneezing, so go to the doctor and tell him you need Claritin. Scherling-Plough spent more money advertising that drug than Pepsi-Cola spent advertising Pepsi in a given year or Anheuser-Busch spent advertising Budweiser. They wanted the Americans to develop an appetite for this drug Claritin. Then they got panicky because the patent was running out because then someone else could make a Claritin generic drug at a fraction of the cost. So they would come to Congress and try to find, at the midnight hour, a way to slip in an amendment to extend their patent another few months or years. We fought them back time and again.

And Scherling-Plough wasn't the only group trying to do that. What we have seen happen now is Claritin is coming off patent and the generic drugs are going to compete. Scherling-Plough is thinking: What are we going to do?

What did they do? They tweaked a molecule in Claritin and created a new allergy drug called Clarinex. Have you seen it on TV? It will soon be coming to a television near and dear to you. Now they want to create this appetite for Clarinex because it is back at the price they used to charge for Claritin. The odd thing is, if you had asked, many doctors from the start would have told you that over-the-counter drugs are as effective as Claritin or Clarinex will be ever be for most Americans.

The point I am making is, when you are talking about generic drugs, you are talking about affordable drugs for Americans. You are talking about giving them the same type of drugs, bioequivalent, as those under brand name and patents, and making certain they save money in the process. Senator SCHUMER and Senator MCCAIN are trying to eliminate some of the abuses as drugs come off patent and move toward generic so consumers can enjoy that benefit.

Yesterday, on the floor of the Senate, by a vote of 69 to 30, we adopted an amendment by Senator DORGAN. Senator DORGAN of North Dakota said he finds it strange that in Canada, the exact same drug made by the same American company subject to the same inspection sells for a fraction of the cost, and why shouldn't we be allowed to reimport these drugs from Canada for the benefit of American consumers?

They came here on behalf of the pharmaceutical industry and said it is an invitation to terrorism; you are going to bring in counterfeit drugs. One of my colleagues said he had a formula he was holding up that was made out of highway paint. I could not follow the debate very closely, but the suggestion is that drug that moved across the border is, all of a sudden, suspect when it comes back.

I wanted to ask the critics of the Dorgan amendment why, if we have busload after busload of Americans going into Canada buying these drugs, if there is such a danger, why have we not heard some scandalous report about people dropping dead on the buses or as soon as they got home? It has not happened. It will not happen.

In the Senate, by a vote of 69 to 30, we decided to create another opportunity, beyond generic drugs, for reimportation of drugs from Canada, with the approval of the Secretary of Health and Human Services in terms of their safety and the fact they save us money. That was a step forward.

Today, I am happy to be a cosponsor of an amendment presently before the Senate which, frankly, has not been discussed for about 3 hours. I have listened to the debate on the floor, and no one has discussed this amendment by Senator STABENOW.

The last two speakers on the Republican side, Senator HATCH and Senator FRIST, spoke to the generic drug part of the bill, but they are not addressing this bill which I think is a good one by Senator STABENOW.

What this bill says is that States across the Nation, such as Maine, Vermont, even the State of Illinois, can decide they want to try to bargain with the drug companies to bring down prices for everyone living in the State. What is wrong with that? If we are letting it be done in Canada and Mexico, the Veterans' Administration, private insurance companies, the Indian Health Service, why shouldn't a State try to find drug prices more affordable for the people living there? That is what the amendment says. It is as simple and straightforward as that. It is another opportunity for us to put some competition in drug pricing and to give consumers a break when it comes to paying for the pharmaceuticals they need to survive.

I think this amendment moves us in the right direction. It is sad that, once again, we are looking for another alternative to national action. That is what we need in this situation. We can think of a dozen different ways to reduce prices—by where you live, what State, whether you happen to be a veteran, whether you happen to have access to Canada. But shouldn't we as a nation address this in a straightforward fashion, understanding that the drug companies are in business to make a profit?

I will concede that point, but for the last 10 years, when one takes a look at the profitability of drug companies, one finds that it is about 19 percent a year on average. The median income and profitability of Fortune 500 companies during the same period of time is 3.3 percent. Drug companies are extremely profitable, and they are selling more and more drugs at higher prices and driving up that profitability.

We also believe that you should have enough money at a drug company to put money back into research—capital investment in research for new drugs. It is obvious. It is not only a question of making a profit, it is a question of finding that next generation of drugs to improve the lives of Americans. I think that is a very valid thing to do.

Senator STABENOW will not be offering the amendment I cosponsored with her that said those companies that are spending more money on advertising than they are on research ought to be held to only deducting the amount of money equivalent to what they spent on research for their advertising. I think that is reasonable, too. It calls the bluff of a lot of companies that say: We need to be more profitable for research. They need to be more profitable for more advertising, advertising creating many times a false appetite.

I stand today in support of this legislation on generic drugs. I believe it is a step in the right direction. The average price paid for a prescription for a brand name drug is about three times the amount of that paid for generics. The average consumer pays 238 percent more for brand name drugs, an average of $45.96.

Last year, 47 percent of all prescriptions were filled with generic drugs. Remember, the doctor makes the ultimate decision. If the doctor happens to believe a brand name drug is better for you or your family because of some situation, some peculiarity, that is the doctor's call, but having generic drugs available gives that doctor a choice and gives you a chance to find an affordable alternative for safe and efficacious treatment.

The underlying bill on generics is sound. I supported the reimportation amendment and stand in strong support of flexibility for States to act, which Senator STABENOW has submitted and which I am happy to cosponsor. Let us give to the States the opportunity to reduce prices so people can benefit from this competition and bargaining and still remain healthy.

Mr. SCHUMER. Will the Senator yield?

Mr. GRASSLEY addressed the Chair.

The PRESIDING OFFICER. The Senator from Illinois may yield for a question.

Mr. DURBIN. I believe I have the floor, and I have agreed to yield to the Senator from New York.

The PRESIDING OFFICER. The Senator may yield for a question.

Mr. SCHUMER. Mr. President, I know the Senator from Iowa is in a hurry. Maybe I can ask unanimous consent I be recognized immediately after he finishes instead of yielding.

Mr. DURBIN. If the Senator from New York does not have a question, I will be happy to yield the floor.

The PRESIDING OFFICER (Mr. MILLER). Is there objection to the unanimous consent request?

Mr. REID. Mr. President, what was the unanimous consent request?

The PRESIDING OFFICER. The Senator from New York wishes to speak for 5 minutes immediately following the remarks of the Senator from Iowa.

Is there objection? Without objection, it is so ordered. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I am so glad we are in a position where we are able to discuss these very important prescription drug issues, including a prescription drug program for senior citizens as part of Medicare.

I am also glad that we are in a position on the floor of the Senate where we are divided in a traditional way, and in that traditional way, I do not mean just Republican and Democrat because too often that is overplayed.

We are divided between a group of Senators. First of all, I think we may not have 100 Senators who favor a prescription drug program for senior citizens, but I surely believe that we have 85 Senators who believe that we should have a prescription drug program for senior citizens as part of the modernization of Medicare.

Within that 85, I suggest we have some traditional division—division between those who have only confidence in the Government running the program and those, including myself, who have some confidence in the Government but not enough to believe that drug prices are going to be kept minimal through Government control so that we have confidence in the competition of the marketplace to reduce the price of drugs.

We are going to find over the next several days, as we continue to debate this legislation and hopefully bring it to culmination and pass a bill so we answer the concerns of our senior citizens who sometimes have to choose between food or medicine—and they should not have to make that choice—that we will have a prescription drug program as part of Medicare.

During that debate, I hope the American public listening will consider, do they have confidence in the Government running a program or in the private sector and the competition of the private sector keeping down prices?

Quite frankly, I believe when the Government is involved, we are going to run up the price of drugs. I think I can give evidence from the Congressional Budget Office, the nonpartisan scoring arm of the Congress, to that effect. I can also give evidence that if we have a program for senior citizens that has competition in it—in other words different organizations competing for membership of seniors and, in turn, competing for the lowest possible price with the pharmaceuticals—we are going to bring down the price of pharmaceutical medicines.

Since 1965, the Medicare Program has provided lifesaving health care services to our Nation's seniors and disabled populations. Hundreds of millions of Americans have had their quality of life improved and their health protected because of this Medicare Program. So we must ensure that Medicare continues the exemplary service it has provided beneficiaries since its inception in 1965, and through these program changes, including prescription drugs, improve it vastly.

Unfortunately, we have a situation that this is necessary because Medicare has not kept up with the advances in medical treatment. Medical advances in delivering health care have moved us light-years beyond 1965, but the Medicare Program has not changed to reflect those health care advances. So in order to ensure that Medicare is meeting the needs of today's and tomorrow's seniors, the program needs to be brought into the 21st century.

Very few people drive 1965 automobiles today, but every senior citizen is using a 1965 model of Medicare. So that is why, after a year of work, I introduced, with Senators SNOWE, BREAUX, JEFFORDS, and HATCH, a bipartisan bill—or if you look at the political backgrounds of all five, a tripartisan bill. Our 21st Century Medicare Act, as we have named it, is designed to bring Medicare up to date by adding a comprehensive prescription drug program and by making other improvements in the program as well. The Congressional Budget Office has estimated our bill will cost $370 billion over 10 years.

Now there are other proposals. Senator DASCHLE, from the other side of the aisle, has a bill. As I understand it, it has not yet been scored by the Congressional Budget Office. How much does it cost? I have heard figures from introducers of that legislation, maybe $450 billion, maybe $600 billion. We need to know what these programs are going to cost before we vote for them.

I want to take a moment and walk my colleagues through the elements of the 21st Century Medicare Act. First, the prescription drug benefit adds a comprehensive, voluntary, and permanent drug benefit to Medicare. Our monthly premium is $24. It is the lowest premium of any comprehensive proposal before the Congress, as the authors of those proposals have expressed what their premium is. Our drug benefit is focused on providing money where it is needed most—to the low-income senior citizen who has to choose in some instances between food and medicine. They will no longer have to make that choice.

It also targets those who have very high out-of-pocket expenses. Some people might refer to that as catastrophic coverage. We have other names for it, but I think we know that we are trying to protect people where the sky is falling in on them because of the need for prescription drugs.

I will describe for seniors with low incomes what this would do, starting with those below 135 percent of poverty. That would be about a $12,000 yearly income individually, about $16,000 a year income for a couple. Medicare will first pay the entire amount of their monthly drug premiums, no out-of-pocket expenses for them buying into the program.

Secondly, Medicare will assist them in paying for drugs at every level of spending. They will pay only $1 to $2 for their prescriptions. On average, this group of low-income, older people will see a 98 percent reduction in their total drug costs, another example of one not having to choose between food or medicine because they are low-income.

Next we would look at seniors with incomes above 135 percent of poverty but below 150 percent of poverty. This includes individuals with income a little bit over $13,000 and couples with income of almost $18,000. These enrollees will receive Medicare assistance on a sliding scale based upon their income to help pay their monthly premium to get into the program, and also Medicare will assist them in paying for drugs at every level of expenditure. There is no gap for these beneficiaries below 150 percent poverty.

Let us look at those with incomes above 150 percent of poverty, which is above $18,000 for a couple. They will pay an average monthly premium of $24 for their immediate care drug benefit—again, the lowest of any premiums that have been announced by other authors that we know about. They will pay a $250 deductible, and after they have reached the deductible, Medicare will cover 50 percent of their drug costs up to the benefit level of $3,450 in total drug spending. Furthermore, Medicare will cover 90 percent of all drug costs after beneficiaries have paid $3,700 out of their pocket for drugs.

Let me say a bit more about our drug benefit for Medicare beneficiaries above 150 percent of poverty. That is the group I just described. First, I wish we did not have a gap in coverage between $3,450 and $3,700, but the problem is that we are working within a limited amount of money—$370 billion—which is about halfway between the President's program for seniors and, let us say, the other prominent plan before the Senate, the Democrat plan. We are about in the middle. We have adopted a policy of using funds to benefit the largest possible number of Medicare beneficiaries, particularly those with low incomes, as I have demonstrated.

So helping low-income people as opposed to doing more with incomes a little bit higher, it requires some sort of a trade-off, and we have opted to help lower income and to help less the further up the line one goes. It is important to point out and to stress that even with these trade-offs, fully 80 percent of all Medicare beneficiaries will spend less than the initial benefit limit or will have access to low-income protections and therefore will have no gap in the coverage. The percentage, again, is 80 percent.

In the jargon of Washington, DC—and I know our constituents get tired of hearing Washington talk; we need to talk Iowa talk, but for my colleagues, that means 80 percent of the seniors in America under our plan will not be touched by what we call the doughnut hole. For the 20 percent of enrollees exposed to this gap in coverage, our bill

requires that Medicare drug plans pass negotiated drug discounts along to Medicare enrollees all the time. All of those enrollees will be able to purchase drugs at a reduced price.

Everyone is going to benefit from this legislation. Our bill may include this small doughnut hole, but proposals from the other side of the aisle seem to me to include a black hole since this drug benefit ends in 2010, leaving Medicare enrollees without any drug benefit whatever.

Again, when we talk about legislation, if it comes to an end, we say that is a sunset. It is my understanding that the proposal from the other side has a sunset; in other words, a time when the benefit will end unless Congress reenacts it. Seniors are not going to sunset. Seniors are going to continue to need prescription drugs after this other proposal sunsets.

One of the disputes is lack of understanding of our benefit delivery system. I heard my colleagues describe how we arrived at the approach to delivering drugs, as the tripartisan bill does. That reminds me, I want to say another thing because I think we forget how things get done. No Republican plan can get through the Senate. No Democratic plan can get through the Senate. A Republican plan can get through the House of Representatives because that is the way that system runs and the majority party rules with an iron hand. There is a Republican plan that got through the House. There is a Democrat plan in the House that obviously did not pass the House. We got the President's program that is obviously a Republican program because we have a Republican President. We have a Senate Democrat plan. We do not have a Senate Republican plan, but we have a Senate bipartisan plan. That is the only way we will get anything through the Senate, and that is a bipartisan approach.

Getting back to how did we settle upon our delivery system for the prescription drug program for Medicare, we have been working for several months, to my chagrin, too many months, with the CBO to work through policy and what a certain policy would cost and changing policy—not basic policy but fine-tuning our policy from time to time to fit the realities of what CBO says.

The CBO is important in this process. It is an independent, nonpartisan congressional staff office that analyzes legislative proposals for costs on the one hand and workability on the other hand. The CBO does not have any ax to grind. And they had better not. And we in Congress rely on that. They are the bible for a lot of decisions made, particularly budget decisions.

According to CBO, spending on drugs for seniors over the next decade will grow at an astronomical rate. Over the next 10 years, there will be a steep rise in the price of pharmaceuticals. The CBO said the only way to contain the cost of a drug benefit is to ensure that drugs are delivered efficiently. In turn, the CBO says the only way to have drugs delivered efficiently is to have true competition, two or more organizations competing with the drug prices to get the prices down, as opposed to the other program I am talking about that relies on a government-run program. I quote the CBO that a government-run program will not bring down the price of drugs but one where there is true competition. We have a delivery system based on true competition.

According to CBO, this requires that we must use private plans that assume a reasonable degree of risk; in other words, some risk on the organization to make sure it is efficiently run, to see there is competition, as opposed to a government-run program where risk in pricing of drugs is assumed by the government. What I mean by risk is, if they are efficient, they will make money and, if not, they will lose money. If they drive hard bargains with drug manufacturers, they will make money. If not, they will lose money.

A limited degree of risk is all the tripartisan bill requires. People will ask, What sort of risk do you have if there is going to be a 75-percent subsidy for the Medicare prescription drug plans in our program? Because the Federal Government is protecting that 75 percent. We are told by CBO that at 25-percent risk we will be assured this level of risk is high enough to promote sufficient drug coverage and low enough to assure that plans participate in a stable, reliable drug system. It is the optimal level of risk.

Insurers who are so unhappy with the House bill in 2000 have indicated they can live with the level of risk in our bill. They would be crazy not to participate.

Our opponents are saying if the Federal Government lays $340 billion on the table, by far the largest entitlement expansion ever, plans will not participate. Where do our opponents get that? Flatout, according to the CBO, they are wrong. CBO says the insurers themselves say they are wrong. Most importantly, common sense says they are wrong. Unfortunately for our opponents, no one has invented a prescription drug that gives you common sense.

We need to make the dollars we have go as far as we can. Whatever our individual thoughts, the CBO in this case is an arbiter, and they tell us our bill, the 21st Century Act, does that; in other words, it keeps the cost of medicine down, guarantees the participation of those agencies to deliver the drugs.

Now, I know the Presiding Officer is from a rural State. I will address the question of whether the system the bill will establish will work in rural areas. Even if you are from Atlanta, there are a lot of rural areas in Georgia, so you ought to be asking, will we take care of rural areas? If you are in Montana or North Dakota, it is probably even more of a concern. I represent a rural State—maybe not the most rural State—and I would not support a Medicare drug bill that would put the rural parts of our Nation in jeopardy of not receiving equal access to prescription drugs under the same conditions as people in New York City.

Our bill guarantees that every Medicare enrollee will have a choice of at least two Medicare drug plans, a minimum of two. The Government will establish service areas for plans to offer Medicare drug benefits. These service areas must be the size of a State at a minimum. They can be multistate but at least the size of a State.

I stress that because you hear from the other side that plans will cherry-pick. You are not going to cherry-pick in the State of Iowa. You have to serve Des Moines just as you have to serve Armstrong, IA.

Another point I want to make concerns pharmacists. Pharmacists play a very important role in prescription drug programs for seniors. Not only that, but as we have increasing use of drugs, and seniors taking multiple prescriptions, and the interaction of those, pharmacists are going to play an even more important role. They are going to be needed to protect—I don't know whether the word ''protect'' is right—but oversee, to some extent, when prescription drugs are given, how they interact. Maybe a doctor won't be on top of that. You might have a person who gets a prescription from two different doctors. Are they going to interact? The focal point for that determination might be the pharmacist—ought to be the pharmacist, and will be. So there is going to be an increasing need for pharmacists.

Another thing I want to point out about the legislation is our assurance that Medicare beneficiaries will have convenient access to a brick-and-mortar pharmacy. The standards outlining what is convenient will be determined by our Department of HHS. Furthermore, in developing convenient access standards, our Department is explicitly required to take into account Medicare beneficiaries in rural areas.

We ought to consider consumer protection, so I will address that as our bill does. Our drug benefit proposal puts into place important consumer protections for our Medicare enrollees.

By the way, one of the things I didn't say that the CBO said about ours, we will have 99 percent of the seniors taking advantage of this program. That is how high the enrollment is going to be.

First, in regard to consumer protections, all Medicare drug plans will be put through a comprehensive approval process to ensure they will deliver quality drug benefits to seniors. The new Medicare competitive agency in the Federal Department of Health and Human Services will have to review and approve the application of the plan before that plan can participate in the program.

Standardized information on each drug plan will be sent by Health and

Human Services to all Medicare enrollees. If a Medicare drug plan wants to advertise for enrollees, all marketing material will have to be approved by HHS. All seniors will have access to necessary prescription drugs. Health and Human Services will determine therapeutic classes of drugs. Medicare drug plans will be required to offer drugs in all therapeutic classes.

If Medicare drug plans use formularies, they must establish a pharmacy and therapeutic committee to develop and review the formulary. Physicians and pharmacists must be represented on that committee. The P and T Committee shall base formulary decisions on scientific evidence and on standards of practice.

What I have outlined is a few ways in which our bill differs from Senator DASCHLE's bill. I would like to add a few more ways in which our bill differs as well.

First, Senator DASCHLE's plan is overly bureaucratic and I think extravagant, therefore it does nothing to curtail or even slow skyrocketing prescription drug costs. Why pass a bill if we are not going to do something to put the damper on the rapidly rising increases in the cost of drugs?

That is why it is essential that any new prescription drug benefit contain proper cost management controls that moderate growth in price while ensuring Medicare enrollees' access to prescription drugs.

While guaranteeing prescription drug coverage for all seniors, our proposal imposes reasonable cost-sharing obligations on beneficiaries and does promote competition among prescription drug plans which, as I have said so many times, will lead to a better overall effect on drug prices. That is a benefit to Medicare beneficiaries and to all Americans who are not even yet eligible for the Medicare Program because of age.

We have flexibility in Medicare drug benefits that we do not want to overlook because under Senator DASCHLE's plan, seniors face fixed copayments that, in many instances, mean they will actually pay more for drugs than they would under a system such as the one we propose, that gives prescription drug plans more flexibility to offer lower cost copayments.

I suggest that before the plan is finally put before the Senate by the other side—I will bet they will have that fixed because they have looked at our plan and they know we are more fair, particularly to low-income seniors, with our flexible drug benefit than what their fixed costs are.

Senator DASCHLE also writes into law the monthly premium seniors will pay for a drug benefit. But what happens if a plan has been efficient and wants to attract more Medicare enrollees by lowering their premium below that of other plans? Under Senator DASCHLE's approach, Congress would have to pass legislation for the plan to lower the premium. If you look at most of the problems we have with Medicare developing over the last 35 years, probably those coming directly from reimbursement of various health care providers, you will find that micromanagement of the Medicare Program by the Congress has led to most of the problems we have. So to the extent that we can have the marketplace be the disciplinarian in premium prices, copayments, in deductibles where catastrophic kicks in, et cetera, et cetera, we ought to allow that to happen.

We ought to look at what has benefited us as Senators and 10 million Federal employees or retirees or their families. You will see that competition among several of the Federal employee health benefits plans—they have, I don't know how many dozens of plans, but at least a couple of dozen plans, with competition among those plans, flexibility in those plans, the tailoring in those plans for particular interest groups of people in Federal employment, including Senators, they have been able to keep down the price of our Federal programs. That is directly related to the flexibility in the plans and the competition.

Why would you want to write into your plan a certain monthly premium?

Our plan then gives the freedom to offer premiums, copayments, and deductibles that are flexible, saving seniors money, or gives them more money.

We also have an enhanced Medicare fee-for-service option that is an improved and strengthened Medicare option—not one that seniors would have to take. If they are satisfied with the 1965 model, they can keep it with or without prescription drugs. If they would like to have a new and improved 21st century Medicare Program with or without prescription drugs—because prescription drugs are optional on all of these plans—we would give them the opportunity to do that. I will explain that.

None of the other proposals on the table do any of this. It creates the enhanced option. It is within the Medicare Program. It is a fee-for-service program. Let me be clear about the fact that it is delivered by the Federal Government just like Medicare. There has been some confusion on that point. It ought to be easily understood.

We think it is an option that many beneficiaries might find attractive. But the beauty of it is that we are not going to make that choice for them. It is voluntary. It is their choice.

Here is the bottom line. Beneficiaries, such as Medicare, have a right to keep it—keep it until you die. It is their choice. In fact, even future beneficiaries will always have this same choice under our plan—20–50. If you are 65 years old and you want the 1965 model of Medicare, choose it. But if it is 20–50, you are 65 years old and you want a 21st century model of Medicare, then you can choose the enhanced option.

I want to make it very clear that there is no sunset of the existing Medicare benefit package in our bill—like Senator DASCHLE's sunset in his drug benefit. We know on our side that senior citizens aren't going to sunset. They are going to be around forever.

In addition, Medicare enrollees can enroll in the Medicare drug benefit, whether they are in traditional Medicare fee-for-service, enhanced Medicare fee-for-service, or the Medicare+Choice.

Here is the choice that our bill offers seniors, if they want to take it.

Existing Medicare Part A and Part B focus on the coverage of routine, predictable medical expenses. But the enhanced option, which we are going to call Part E, focuses on preventive care and protection against devastating costs of serious illness. If beneficiaries prefer what they have now, for the third time, I say they can keep it. But if they like the idea of a better prevention and better insurance when they need it, then, for the third time, I say they can have the new, enhanced version.

On the subject of prevention, I would like to explain that we put a lot of emphasis on prevention. Medicare's current policy makes beneficiaries reluctant to seek out preventive services that may identify health problems and prevent more expensive care later. Part of that is because they have to pay a deductible.

Unlike many private health plans, Medicare today subjects people in this Part B to usually a 20-percent deductible.

For those who would elect the new, enhanced option, preventive benefits would not be subject to any deductible, or to any coinsurance.

That is an example of moving Medicare from 1965 to the 21st century.

I would like to highlight another improvement of enhanced option.

Medicare today has no limit on a beneficiary's expenses in a year, creating the potential for crippling costs in the event of a serious illness and maybe impoverishing some families. The bill would limit beneficiaries' exposure then to out-of-pocket costs for Medicare coverage services other than drugs to $6,000 per year. Beyond that amount, Medicare would pay 100 percent of any costs incurred by the beneficiaries.

In a given year, it is estimated that 2 to 3 percent of beneficiaries may have costs that reach above that level. Of course, if one looks at beneficiaries over multiple years, the likelihood of such expenses increases accordingly. If beneficiaries want the peace of mind that comes from such protection against serious illnesses, then for a fourth time, I say they have that choice.

Another issue our enhanced option addresses is the Medicare deductible structure. Under current law, the Part A deductible will be extremely high in the year 2005—$920 every time you go to the hospital—while the Part B deductible is going to stay at $100 per

year. The enhanced option includes a unified deductible of $300 per year for all services.

Medicare's irrational two-deductible system is unheard of in the private insurance industry today. Beneficiaries are used to single deductibles from their prior employer-based plan. If they like what they had while they were working, then they have the option, as I say for the fifth time, of taking the enhanced option within Medicare.

Here is another benefit from the enhanced option. Because Medicare benefits have so many holes in contrast to private insurance, most beneficiaries are forced to carry supplemental coverage to fill in the gap. We call that Medigap. Reducing those gaps will make such supplemental coverage less necessary, but, more importantly, if they want to have it more affordable for the beneficiaries, our bill establishes such new more affordable Medigap plans.

By the way, those employers who offer supplemental coverage will also find it less costly to do so under the enhanced option since it will have fewer holes to fill.

Is the enhanced option a better deal? From an actuarial standpoint, the answer is definitely yes.

The Congressional Budget Office tells us it is a more valuable benefit, largely because of the serious illness protections that it offers our seniors. But not all seniors are actuaries. So we are leaving it up to the seniors to decide which of the two plans is a better deal.

We make a few changes also in Medicare+Choice improvement. Starting in 2005, our bill takes modest steps to improve the Medicare+Choice Program. Medicare+Choice has been a big disappointment in my home State of Iowa. Only 1 county out of 99 has it. But seniors elsewhere—particularly in the larger cities and in the Sun Belt—rely on it.

Our proposal keeps that option alive without throwing money at the program as we have so much in the past. Instead, we create a competitive bidding system under which Medicare+Choice plans will compete with each other but not with the Medicare fee-for-service programs for beneficiaries.

I want to emphasize that no one in the fee-for-service Medicare will be affected by this change. We have made this change because today's bureaucratic pricing system sets arbitrary and inaccurate rates, and that discourages Medicare+Choice plans from participating. Our approach to Medicare+Choice is based on a bipartisan model embraced by the Clinton administration, and will result in fairer and more accurate payments to Medicare+Choice.

Before I give up the floor, I would like to comment for a short period of time on some statements that were made yesterday regarding our tripartisan 21st Century Medicare Act by people on the other side of the aisle. I think in some ways the facts were not given straight. I would like to correct the RECORD for the benefit of my colleagues.

Yesterday, there was reference made to an assets test as if there is something wrong with it. There is nothing wrong with it. Public policy for low-income Medicare populations has included assets tests since 1987. Our policy here in the Congress for low-income Medicare populations has included an assets test since 1987.

I said it twice so people know that it is not something new being thrown out there.

Specifically, assets test policies were first included in Federal policy in the Omnibus Budget Reconciliation Act of 1986, which passed the Senate by a vote of 88 to 7 with help from people who, yesterday, were denigrating our plan, and voted for the 1986 plan.

Our bill includes an assets test similar to the 1999 President Clinton—remember he was a Democrat—Medicare bill.

Under current law, States have the flexibility to waive this assets test. Nine States and the District of Columbia have chosen to waive the test.

Our proposal allows assets test flexibility, found in current law, to be retained in the Medicare drug benefit program. The assets test ensures that seniors who need assistance the most are provided the most protection.

Also, let me clarify that current law specifically excludes from the assets test a person's home and the land the home is on, household goods, personal effects, including automobiles, the value of any burial space, and other essential property.

The people attacking our plan also attacked our plan yesterday because of the flexibility we have in it. So I want to respond to that.

Medicare enrollees deserve a quality drug benefit that meets their individual needs. The Daschle-Graham proposal does not allow any variation in cost sharing or premiums and is a one-size-fits-all plan which will fail to adapt to the needs of seniors, as we are now so far behind with the 1965 plan that was adopted in 1965.

It is also important that Medicare enrollees get quality drug benefits at the lowest possible price. The tripartisan plan strikes the right balance to ensure Medicare enrollees have access to prescription drugs they need at the best possible price.

Anyone wanting to offer a Medicare drug benefit will be required to receive the approval of Health and Human Services. This is not a checkoff approval process. There will be intensive interaction between any plan and the Government to ensure that Medicare enrollees are getting what they are paying for.

There are five separate places in our bill where the administrator is required to certify that a plan meets strict standards of actuarial equivalence. The plans will not be determining what is the equivalent standard benefit. The U.S. Government is going to make that determination. If a plan is not equivalent to the standard benefit, it is obvious the bid will be rejected, and should be.

In fact, the Congressional Budget Office has told us our standards of equivalence are strict enough that Medicare drug plans will have little room varying in premiums or cost sharing. In their words, that little room to vary is critical to the success of a Medicare prescription drug benefit and indicates how the tripartisan bill has found the right policy in Government assumption of risk—just enough—to make sure there is competition out there, to make sure plans are run efficiently, to make sure there is competition to drive down drug prices.

While the Democrat plan claims to include competition, I do not understand how Medicare plans will compete if they are required to offer identical premiums and identical cost sharing. If drug plans wanted to lower their cost sharing or lower their premiums in order to attract Medicare enrollees, the only way it could be done is for Congress to pass more legislation.

The tripartisan bill ensures the innovations of the private sector are not stifled by micromanagement, one-size-fits-all, Government-run drug benefits.

There is guaranteed access to the plan. We have had Members of the other side apparently unaware that the tripartisan bill guarantees access provisions. The tripartisan bill guarantees two Medicare prescription drug plans to every Medicare enrollee.

If the enrollee lives in an area where there is Medicare+Choice, the Medicare+Choice plans will not count towards the two-plan minimum.

The Medicare plans are not determining their own service areas. The Government will determine service areas, and the service areas must be at a minimum the size of a State.

The Government will be covering 75 percent of the value of the Medicare drug benefits, equalling $340 billion over the next 10 years. So anyone who says the plans will not participate is simply not operating with any common sense—$340 billion of encouragement to participate. This is a clear attempt, and a failing attempt, I believe, to paint the tripartisan bill not as what it is—something that five Senators have worked on for a year—but to paint it, instead, as the House Republican bill, which it is not.

Lastly, we have been attacked from the other side about the tripartisan's policy toward employers. The tripartisan bill gives employers a 100-percent subsidy to offer drug benefits to their retirees, as long as the retiree plan is, at a minimum, as generous as the standard Medicare benefit.

In contrast to the tripartisan plan, the Democrat plan only gives employers a two-thirds subsidy to retain their retiree prescription drug plan.

Listen, from the other side you heard that our plan does not take into consideration protecting retirees who already have a corporate retirement plan with health benefits in it, when we pay 100 percent of that. And what does the other side pay? Sixty-seven percent. The other side's plan forces a standard benefit on all Medicare beneficiaries. Will employers be forced to change their entire drug benefit structure in order to obtain the two-thirds subsidy? This could result in employers being forced to charge higher drug expenses for their retirees in order to receive the subsidy.

Mr. KENNEDY. Is the Senator willing to yield for a question?

Mr. GRASSLEY. I will try to answer your question.

Mr. KENNEDY. I was just wondering about the time that the Senator will use. We have several Senators indicating——

Mr. GRASSLEY. I will be done in 2 minutes.

Mr. KENNEDY. I thank the Senator.

Mr. GRASSLEY. Currently, employers receive no assistance whatsoever in paying the drug costs for their retirees. Our 100-percent subsidy plan will allow employers who are offering a drug benefit at least as generous as the standard benefit to receive the full value of the standard benefit.

Again, our policy targets dollars where they might do the most good. And an employer subsidy recognizes the value of employer-sponsored retiree drug benefits.

In closing, I will simply say something I said when I started. In the next 3 or 4 days, there will be a lot of debate on this subject. It is very important to have a lot of debate on this subject.

You are going to find strong advocates for plans where the advocates have great faith in Government-run price programs versus whether or not you ought to have competition from the private sector. Remember, CBO says that a Government-run program is going to raise the price of prescription drugs. The alternative is to have competition. The Congressional Budget Office says that is going to reduce the price of prescription drugs.

We should be in the business of having public policy that is going to give seniors the best medical care, including prescription drugs, based on the least cost to the Government, as well as the least cost to the senior citizen.

I yield the floor and I thank my colleagues.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized

Mr. KENNEDY. Mr. President, I know we have not had an agreement with regard to time, but we have had the opportunity to hear from that side of the aisle for about 2 hours 40 minutes of the last 3 hours. So I was going to see if we could recognize the Senator from New York. And although our leaders here don't frown on allocating the time and indicating individuals, the Senator from New Hampshire has been willing to agree to this proposal: The Senator from New York would go for 10 minutes, the Senator from Georgia 10 minutes, the Senator from New Jersey 10 minutes, and I need 20 minutes.

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

The Senator from New York.

Mr. SCHUMER. Mr. President, I have been waiting here patiently to speak for a particular reason. Earlier this afternoon, the administration came out with its Statement of Administration Policy on S. 812, the Greater Access to Affordable Pharmaceuticals Act sponsored by myself, Senator MCCAIN, and 10 others.

I have rarely seen a piece of paper so far from reality and so far from the truth. Let me quote from it:

> . . . the Administration opposes S. 812 in its current form because it will not provide lower drug prices.

What planet are they on? What are they smoking? Generic drugs will not lower the cost of drugs? If you want to oppose the bill for one reason or another, fine. Here are some costs: Claritin, brand name $86; generic $33; Cipro, brand name $89; generic, $35; Zocor, high cholesterol, $116; generic, $45; Zoloft, $69; generic, $27; brand of Singulair, $84; generic, $32.

That doesn't lower costs? It has been estimated it will save the American people $70 billion. It has been estimated it will save our State governments hundreds of millions of dollars. And they say it doesn't lower cost. What kind of argument is that? We all know it will lower cost. If they want to come clean and say they don't want to alienate the pharmaceutical industry, fine. If they want to say there is a better plan and better scheme, fine. If they want to say, keep things status quo, fine. But it won't lower costs?

I think they have a lot of disagreement even from people normally on their side. Here are some of the groups that think it will lower costs: General Motors, Ford, Chrysler, UAW, AFL–CIO, Verizon, Wal-Mart, Kodak, Motorola, Caterpillar, Kmart, Georgia Pacific, Albertson's, UPS, Kellogg, Sysco. The list goes on and on. These companies are not usually supporters of the kind of legislation we are talking about. They are all for this. They are for it for one reason: lower cost. Their own health care plan costs are going through the roof. I am utterly amazed. I ask the administration to retract this statement or prove why they believe that moving to generic drugs is not going to lower cost.

They say a few other things, too, which shows you that they really don't know what the bill is. They say in their statement that this bill would encourage litigation around the initial approval of new drugs. The legislation does not allow litigation for the approval of new drugs. They don't know what the bill does.

Will it prevent unnecessary litigation when someone files a patent in the Orange Book that is frivolous? Yes. That is not about a new drug. In fact, when it comes to a new drug, that is one of the few places where, of course, the patent can be contested by our legislation. What our bill does is simply force them to play by the rules.

The administration says the bill would complicate the process of filing patents. Of course, our initial legislation was clean. There was an amendment to change it, mainly to get support from members of their party. But if what the administration means is that it will complicate the process, if that means it makes brand companies comply with the FDA's current rules, you bet it will complicate the process.

The FDA requires that brand companies only list patents in the Orange Book that cover the drug or cover that approved use of the drug. Now the FDA does not enforce this, so the brand companies don't play by the rules. Our bill requires them to do it.

I had hoped that when Senator MCCAIN and I introduced this legislation—and my hopes were heightened when the legislation passed 16 to 5 and got half the members of the HELP committee from the Republican side—that we could have a debate and come to an agreement. The Senator from Utah, understandably, has pride of authorship. He may want to make some changes. But to just so baldly oppose a bill on specious grounds makes one wonder where the administration is coming from. Are they so afraid to offend PhRMA that they have to put out a statement that is just patently wrong?

We saw in the area of corporate litigation that the administration, which likes the American people to think it is moderate, is to the right of the Business Roundtable. We are finding the same thing here. We are finding that the administration, on the issue of drugs and the high price of prescription drugs, is to the right of much of corporate America.

Please, Mr. OMB Chairman, Mr. Vice President, work with us. We are not going to agree on everything, but work with us. This is a serious problem. If this memo is an indication that all we are going to get on the issue of reducing the cost of drugs and increasing the access of drugs is stonewalling, then it is a sad day for the American people.

We are going to fight hard for this legislation. The American people need this legislation. It needs to go beyond the original bill. That is why I have supported other amendments, and I hope the prescription drug plan offered by the Senators from Florida, Georgia, and Massachusetts prevails. But if even in this modest bipartisan step we get such stonewalling and such failure to grapple with the truth, then all those Americans who are paying such high prices for drugs are in trouble.

Mr. GREGG. Will the Senator yield for a question?

Mr. SCHUMER. I am happy to yield for a question.

Mr. GREGG. The Senator is probably not aware of this because this information has just been forwarded to me. I will actually have a paper on it. But there have been a lot of different representations as to how much the underlying bill would save. I have seen numbers that ran from $20 billion to $60 billion, and I believe the Senator mentioned it is actually a higher number.

We have just been advised by CBO that the underlying bill, the Edwards-Collins bill, will have $8 billion savings assigned to it by CBO. So as we debate this issue—I know some people are planning to use that savings to assist the major movement on the overall drug benefit—this is going to change the dynamics around here a little bit. But just so we are all playing off the same song sheet on savings, this bill is now scored by CBO as an $8 billion savings.

Mr. SCHUMER. If I could answer the question, which I know was meant to be a question, of the Senator from New Hampshire—the junior Senator from New Hampshire to correct the error of my ways—first, the $8 billion is the CBO estimate—I guess; I haven't heard it yet—but that is just for Medicare. The administration is saying it will not provide lower drug prices. The estimates are pretty widespread and pretty accepted that when you take not just the Medicare savings but the savings to every consumer who goes and buys the drug, the savings to all these companies that have their own health care plans, the savings to the States, it is going to be much more than that.

I am not debating how much right now. I don't know if that estimate is correct. It seems low to me. But let's assume it is. It is in direct contradiction to the Statement of Administration Policy that came out this morning which says: ''will not provide lower drug prices,'' period—not ''will not lower them enough,'' not ''will not lower them for everybody.'' It says, unequivocally, no lower drug prices.

So I would like to thank my colleague from New Hampshire because even though he is making a different point, he makes mine. The administration seems so hardheaded against anything to change the status quo, even though the vast majority of Americans are unhappy with the status quo, that it leads them to make statements that are patently absurd on their face.

The PRESIDING OFFICER (Mr. KENNEDY). The Senator's time has expired.

The Chair recognizes the Senator from Georgia.

Mr. MILLER. Mr. President, I rise to urge the Senate to let us try to come together on a prescription drug bill in these next 2 weeks for the sake of America's seniors.

Our seniors are up against a rich and powerful drug industry—an industry that, obviously, will fight tooth and nail against anyone who seeks to meddle with its obscene profit margin or its astonishing salaries for its CEOs or its TV media blitz.

Our seniors cannot fight this battle alone. Goliath is too big. Congress must step in immediately and help America's elderly in their day-to-day life and death struggle with prescription drugs.

This Senate has already taken a very big step toward helping seniors get their medicine at lower prices by passing the reimportation amendment. Now it is time to give some more help. It is time to add a prescription drug benefit to Medicare.

I was very glad to hear this week that the Nation's largest advocacy group for seniors, AARP, has declared the Graham-Miller-Kennedy bill as the one that, in their opinion, offers the very best value for seniors.

Let me take just a few minutes to tell you why they think and why I think this bill is better than the rest.

First, we use a system that is now in place—a system that is now in place for most working Americans, a system that the Federal Government and most employers use right now for their own workers. This new benefit is too important to risk using an untried, experimental delivery system; but the competing bills do just that.

Under our bill, every beneficiary will know how much their premium will cost each month and how much they will have to pay for each drug they buy. We guarantee seniors an affordable premium, while the Republican bill allows private insurers to set the premium cost. That means insurers would be free to charge seniors whatever premium they want, whenever they want.

It is simply a fact that seniors who live in rural America are often older, often sicker. Under the Republican bill, insurers would be able to charge them even higher premiums than those who live in urban areas. That would hurt the very people I call my friends and neighbors back home, and that is unacceptable.

The private insurers that are the centerpiece of the Republican bill will make profits based on managing drug care for beneficiaries, just as HMOs make their profits on managing care. That would result—it could not help but result—in fewer drugs being available to our seniors. That is not the kind of benefit our seniors need. That is not the kind of benefit they deserve.

Our bill uses a system that is already up and running in every ZIP Code in the United States. We guarantee that services will be available to seniors 24 hours a day, 7 days a week, for any emergency that arises. The competing bills offer no such protection.

The Graham-Miller-Kennedy bill is also the best plan out there because it has no gaps in coverage. That is very important to me, and to AARP, and to every senior in this country. We help seniors pay for the very first drug they buy each year. That coverage continues with no interruption through the last day of each year. No other bill makes the same guarantee.

There are two gaps in the competing bills. First, under the House Republican plan, all seniors would have to pay a $250 deductible. That means they would pay premiums but would get no coverage for the first $250 of their drug bills. Then, once drug costs reached $2,000, coverage would be cut off altogether. Seniors would get no help from the program until their out-of-pocket spending hit the $4,800 mark.

During this huge gap in coverage, seniors would still be required to pay their monthly premium even though they were not receiving a single penny of benefits from the program. And every beneficiary would experience that first gap in coverage because every senior would have to spend $250 before they saw the first dollar of benefit.

Then, almost half of all the beneficiaries would fall into the second coverage gap. Sixty percent of them would never climb back out of that gap to receive coverage again. Let me say that again. Nearly two-thirds of seniors who ran up drug bills of $2,000 would never see another penny in benefits for the rest of the year.

Because of these gaps, the typical beneficiary—let's say an elderly woman whose prescriptions run $2,400 each year—would still have to cover 71 percent of her drug bill each year.

Beneficiaries with higher drug bills are even worse off. Take an elderly man whose drug expenses run $400 a month, or $4,800 each year. He would have to pay 85 percent of his drug costs each year under the Republican bill. That is not much of a lifesaver to be throwing a drowning man.

Once again, there are no gaps of any kind in the Graham-Miller-Kennedy bill. Coverage continues every day, every week, every month, all year long, regardless of how high a senior's drug bill is.

Once drug costs have reached $4,000, the Graham-Miller-Kennedy bill says that we will pick up the entire bill for the rest of the year. It is what our seniors need. It is the least they deserve.

Mr. President, the time has come. It is just like back in 49 B.C. when Caesar had to ask himself a question: ''Do we cross this Rubicon?'' Do we make the commitment? Do we take this risk? You know, we throw around the term ''It's a matter of life or death'' pretty lightly. Seldom is that really the case. But this time it really is.

Many seniors—our mothers, fathers, grandparents, and other loved ones—will live or they will die because of this vote. Are we going to pass a meaningful prescription drug benefit as we have been promising and talking about for years? Are we going to go home and face the seniors of this Nation without doing diddly squat?

We have had a lot of sound and fury in this Chamber. Will it signify nothing, just a big fat zero? It isn't enough to have just good intentions, Mr. President. The road to hell is paved with good intentions. It isn't enough to promise good deeds. We must do them.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. TORRICELLI. Mr. President, the Senate is engaged in probably the most important health care debate in a generation. If we succeed in establishing a pharmaceutical benefit for the American people, it will be the greatest contribution to health care since Medicare.

We are engaged in this debate in the middle of an economic and corporate crisis. It would not be honest or even productive to pretend that one event is taking place without the backdrop of the other.

It is an extraordinary time to be redesigning the delivery system of an industry while corporate America is going through a series of tumultuous events.

I have an amendment prepared that I will offer to this legislation that is the nexus between the two problems because the pharmaceutical industry requires a transparency and a proper accounting of itself in the delivery and pricing of its products, just as certainly a variety of other American industries have suffered from their failure to do the same.

I address specifically two persistent problems. First, when an American family goes to a pharmacy to buy a prescription product, they operate under the assumption that they are getting sound medical advice, that the prescription that is being offered to them is suited for their problem, their malady, it is priced properly, and a medical judgment is being made on the merits. That is the assumption of every American family. It may not always be sound.

Through the years, marketing techniques from sporting events and theater productions to expensive vacations and gifts have become part of the routine of marketing pharmaceutical products. American families and senior citizens are left not knowing whether a product is being prescribed because it is the best for their health or because the doctor is indebted to a marketer or a corporation.

The same could be true of a pharmacy. Of all the corporate governance issues in America that deserve transparency, nothing could be more fundamental than the relationship between an individual American family and the delivery of their health care. People want to know, people have a right to know, is a gift an incentive, part of the prescribing of a prescription drug, or is it the quality of the product? Has a doctor been convinced this is the right drug for your child, for your family, for your health, or is this simply part of a relationship with an undisclosed incentive?

Under the amendment that I will offer, any corporation providing a gift to a doctor or health care provider as part of marketing a pharmaceutical product will need to disclose it. The incentive can be provided, the gift can be provided, you can offer the vacation, but at least people have a right to know whether the sales of products are related to price, science, the merits, or the financial incentive to consume them.

Some will argue that such techniques are common in industry. It may be true, but it is one thing if a retailer is getting an incentive to sell you a shirt or an automobile manufacturer is getting a secret or private incentive to an automobile dealer. That might be business. It may or may not interfere with the right judgment of the proper pricing, but that is marketing.

It is something else when it interferes with the judgment of a doctor and the confidence in health care delivery upon which people have come to rely, a judgment that involves not simply price but the intangible of trust in a health care provider.

Second, the amendment expands to deal with pharmaceutical benefit managers, otherwise known as PBMs. PBMs are essentially health maintenance organizations designed to deal with the delivery of pharmaceutical products. They are the middlemen who have placed themselves between drug manufacturers, health plans, and pharmacies. If they operate properly, they negotiate better prices, provide service and delivery at a superior cost to a beneficiary. For most of the last 25 years, that is exactly how they have operated.

A problem has developed, much like the gift, the vacation offered for selling a pharmaceutical product, except it happens on a much larger scale.

Pharmaceutical benefit managers have an obligation to their clients, the people who have contracted with them to buy the best product at the best price. The best product is to be based on a medical judgment. The best price is what can be negotiated. But the law has allowed a practice that is as morally wrong as it is reprehensible.

Pharmaceutical benefit managers who allegedly represent their clients go to pharmaceutical companies and ask for rebates. That is a polite word for a kickback. The client, the senior citizen, the working person is left believing they are buying a pharmaceutical product represented to them because it will deal with their illness and has the best science and is at the best price.

What they do not know is the pharmaceutical benefit manager may be offering that product because they are getting hundreds of thousands of dollars or millions of dollars in a rebate. Indeed, nothing else would explain what has emerged.

Pharmaceutical benefit managers are far less inclined to ever recommend generic drugs. Indeed, at the moment, brand name drugs are offered only 46 percent of the time compared with 54 percent of the time by a local pharmacist. The cost of a brand name drug offered by a pharmaceutical benefit manager can be $47 compared with $37 at a local pharmacy. So people who believe they are in a benefit plan to negotiate a better price are paying more, and they are not only paying more, they may be directed to products that are offered not based on a medical judgment or on a cost basis but because of a secret rebate.

The chart on my left illustrates exactly the problem, in what is now a four-tiered system from manufacturer to senior citizen. The manufacturer may offer a rebate with the belief that it could lower price and make their product more available through pharmacies to senior citizens, and many of these rebates may be offered by pharmaceutical manufacturers with the belief that like the rebate from an automobile manufacturer to an auto dealer, it is making the product more available, but here is the problem. The law allows the pharmaceutical benefit manager to keep the money. It does not go to the pharmacy. It never reaches the senior citizen. It stays here. The pharmaceutical benefit managers are in a contractual relationship supposedly representing the senior citizen. They are supposed to be their advocate, getting their price. Instead, they are keeping the money.

The PRESIDING OFFICER (Mr. CORZINE). The Senator's time has expired.

Mr. TORRICELLI. Mr. President, I ask unanimous consent for 1 additional minute to conclude.

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

Mr. TORRICELLI. Under the amendment I am going to offer to this legislation in the coming days, as certainly as pharmaceutical companies will have to disclose any gifts they are giving, any incentives they are giving to doctors to influence their medical judgments, so, too, pharmaceutical manufacturers will have to disclose any rebates given to PBMs so the clients of the PBMs know what they are getting and can demand that those rebates be handed down to senior citizens at a lower price.

It is simply transparency. It is what every American is asking of every American corporation. We have a free enterprise system for people to price their products, but we do demand truth and honesty. This is a minimum of transparency that we can bring to the pharmaceutical industry in America.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, I appreciate very much the Senator from Massachusetts withholding. The Republican leader is present, and I have a unanimous consent request that I would like to propound.

I ask unanimous consent that following the statement of the Senator from Massachusetts—he has 20 minutes. The Senator from Oklahoma, Mr. NICKLES, will speak for probably 20 minutes. Following that, Senator GREGG will speak for probably 5 or 10

minutes. Following those statements, we would vote on——

Mr. GREGG. Senator STABENOW would then have the right to close.

Mr. REID. I am going to do that before the vote. Following that, we would have a vote on or in relation to Senator STABENOW's amendment; that prior to the vote on Senator STABENOW's amendment, we would have 2 minutes for her to speak on behalf of her amendment, and Senator GREGG or his designee would speak 2 minutes in opposition to that amendment.

Mr. GREGG. Senator STABENOW would close?

Mr. REID. Yes. That upon disposition of Senator STABENOW's amendment No. 4305, Senator DORGAN's amendment No. 4299 be temporarily laid aside, and Senator GRAHAM be recognized to offer his prescription drug amendment; that immediately upon the reporting of his amendment, it be laid aside and Senator GRASSLEY, or his designee, be recognized to offer his prescription drug amendment; that the two amendments be debated concurrently; that no other amendments or motions be in order during the pendency of these amendments, except motions to waive as listed below; that on Tuesday, July 23, at 2:15 there be 30 minutes equally divided between Senators GRAHAM and GRASSLEY; that at 2:45 on that Tuesday, July 23, the Senate vote on waiving the Budget Act with respect to Senator GRAHAM's amendment; that immediately following that vote, the Senate vote on waiving the Budget Act for Senator GRASSLEY's amendment; that if either amendment successfully waives the Budget Act, it be further debatable and amendable; that if either fails to waive the Budget Act, it then be withdrawn; and that the preceding all occur without any intervening action or debate.

I further ask unanimous consent that when the Senate resumes consideration of Senator DORGAN's amendment that Senator GREGG or his designee be authorized to offer a second-degree amendment thereto and that upon disposition of Senator GREGG's amendment, Senator ROCKEFELLER be recognized to offer a second-degree amendment to Senator DORGAN's amendment.

The PRESIDING OFFICER. Is there objection?

The Senator from Massachusetts.

Mr. KENNEDY. Reserving the right to object, and I will not, will the Senator include that the allocation of time be equally divided on Monday and then Tuesday morning?

Mr. REID. That certainly is fair. We will equally divide the time.

Mr. NICKLES. Will the Senator yield?

Mr. REID. I would be happy to yield.

Mr. NICKLES. Is it correct there would be a budget point of order that would lie against both the Graham and Grassley amendments?

Mr. REID. The Senator is correct.

I ask that the request be amended so the time be designated, Senator KENNEDY, Senator GREGG, even though the amendments are those of other Senators. They are the managers of the bill and that is the way it should be.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from Mississippi.

Mr. LOTT. Mr. President, while I object to the process under which this is being considered—I think we should have had this prescription drug issue go through the Finance Committee. We should have a normal debate, markup, and report out what would normally have been a bipartisan bill and probably a tripartisan bill. That is the way we should do business, and I predict right now that eventually the only way we are ever really going to get a real prescription drug result is we are going to have to go back and do that.

Having said that, the bill before us everybody understood was going to be a vehicle to which Senator DASCHLE and others would be able to add prescription drug amendments or bills. That is what has happened.

I think we will have sufficient time for debate later on tonight, on Friday, on Monday, on Tuesday morning, I presume, with the votes to occur one after the other on Tuesday afternoon. I think that is a fair way to proceed.

Right up until the last few moments, we are getting people inquiring about what happens then. Well, of course, if one of them does get 60 votes, as is in the agreement, we could go back and have additional debate and amendments, or if they do not, then other options are available, other amendments to the pending issue that is being set aside or other proposals with regard to a different approach to the prescription drug issue.

I know Senators HAGEL, ENSIGN, SMITH, ALLARD and GRAHAM are interested in the Hagel amendment, and perhaps other amendments on this side.

We also retain the right to move to commit this whole issue to the Finance Committee with instructions, and at some point it might wind up being the most reasonable and popular thing to do. But this is not cutting off other amendments, not cutting off this issue, just setting it aside. It is not blocking other options from being considered. The truth is, both sides have been working for the last couple of days to try to get to this point. So I think it is the fair way to proceed. Everybody will be heard. We will have a vote and then see where we are.

Mr. REID. I want to express the appreciation of the Democratic Senators to the two leaders. It was not easy to get where we are right now, and the reason I appreciate that—I think everyone does on this side; I am sure on their side—we have two big issues that will be debated for several days. This issue, prescription drugs, is why we are here—one of the main reasons we are here, I should say. This will give everyone a chance to listen to what others have to say.

There will be some who do not want either one of these; they want something else. But they have a right to vote accordingly.

I think we have made great progress. If I can get Senator GREGG's attention, Senator STABENOW asked if there would be a problem with her having 5 minutes, and the Senator from New Hampshire having 5 minutes immediately prior to the vote.

Mr. GREGG. That is no problem at all.

Mr. REID. I say to the Senators who are watching, this vote will probably occur around 5:30, give or take a few minutes.

The PRESIDING OFFICER. Under the previous order, the Senator from Massachusetts is recognized for 20 minutes.

Mr. KENNEDY. Mr. President, I yield myself 15 minutes.

I thank our leaders, Senator REID, Senator DASCHLE, and our Republican leaders, for this agreement we have entered into. This is a historic time. It will be the first time in over 5 years since there have been prescription drug amendments before the Senate.

I am a cosponsor of the Graham-Miller bill and later in this debate, either tomorrow, Monday or Tuesday, I will have an opportunity to go over why I think that measure is so compelling and deserves strong support.

We were reminded, once again, earlier in the afternoon, of the publication of a study that reviewed the different options that are before the Congress most actively; that is, the Republican proposal that passed the House of Representatives, the tripartite, and the Graham-Miller proposal. The study examined the impact of each of these proposals on individual States and what impact each would have on seniors and others that would benefit from the program. In every single instance, every single State, without a single exception, the one that was embraced by the seniors, the one that provided the greatest coverage for the seniors, was the Graham-Miller proposal.

We will have more of a chance to debate that over the next couple of days.

It is very important as we come to vote on the amendment of Senator STABENOW to realize what has happened in the last couple of days.

The focus of the underlying legislation—which was originally introduced by Senator SCHUMER, Senator MCCAIN, and then altered or adjusted by Senator EDWARDS and Senator COLLINS—basically addresses the egregious situation taking place today all over our country by unscrupulous brand name drug companies gimmicking the patent laws in order to take unfair advantage of consumers in this country and maintaining higher costs. They are doing it by extending the patent process with a phony regime called ''evergreening'' and also through collusion with certain generic drug companies. This practice is resulting in costs of billions of dollars to our seniors.

If there are people who are watching this Senate proceeding, if there are cancer patients and they have been paying higher prices for various prescription drugs dealing with breast cancer, the fact is the pharmaceutical companies delayed Taxol, the generic drug, for 19 months. That means consumers paid $1.2 billion more because of the delay of competition. If patients suffer from epilepsy, as a result of this system, those patients have paid $1.4 billion more than they otherwise would have paid. That has been true with various brand name drugs for depression, and it also includes blood pressure as well.

In all those areas, there has been a gimmicking of the system, which permitted those companies that had the patents for a period of time, and under the old Hatch-Waxman legislation were going to have their time expired and the generics would be on the market, to be able to compete, and would have saved the consumers billions of dollars. The actions of those brand name companies have been such as to result in higher prices.

That is the basic issue we have before the Senate, whether we will pass that legislation.

The Dorgan amendment was favorably considered in a vote yesterday. It will also have a dampening down in the increase of prices of prescription drugs. And American taxpayers are paying taxes, and those resources go to fund expanded NIH research, which I strongly support.

This is the time of the life sciences, and we will see unbelievable opportunities in the future in breakthroughs with prescriptions. It is an enormously important time. I believe we will see these breakthroughs in the life sciences, as in the physical sciences last century. We have seen what is happening with the analysis of DNA, and the sequencing of the human genome, and all the breakthroughs with unlimited possibilities, using the high technology available and the advancements in biology. The opportunities are virtually unlimited. It is an enormously exciting time.

That is why it is important to have a policy that will make available to all Americans these lifesaving prescription drugs reasonably.

We had the excellent presentation made by our friend and fellow colleague, Senator DORGAN. The vote was a clear indication that the Members of this body are prepared to see that prescription drugs that are FDA approved, produced in an FDA-approved laboratory, imported here with the safety provisions included in the Dorgan amendment, would be available to American citizens.

Today we have the Stabenow amendment. We have had limited debate on the merits of the amendment. I hoped we would have seen an acceptance of the Stabenow amendment. It makes eminently good sense. We have heard a great deal of debate and discussion about the free enterprise system. That is what the Stabenow amendment is all about.

It is the ability of the States to use their economic power in order to negotiate with the various drug companies to try to get the lowest possible price for the neediest individuals, the poorest people in the United States. And the drug companies say no. Yesterday they said: We want to play by the free market system; and now we have a free market system being utilized and they say: No, no, we want to play by our own rules. What does that mean? They have now taken the various States to task and said: We will not permit that because that is government interference in the free market system.

The fact is, what is being tried in the State of Maine and the other States is the same kind of market experience we have seen with an HMO when they negotiate with various brand name companies. It is the same kind of negotiations insurance companies have. It is routine, the same as major companies. General Motors does this when they buy prescription drugs. It is the same element, to use market forces to try to get the lowest possible prices. When they do not want to do that, and companies do want them to do it, there is no reason they have to sell. It is a free and open exchange.

That is not good enough. We have seen where the drug industry has sued the State of Maine, they have sued the State of Vermont, they have sued Michigan, they have sued Illinois, they have sued Florida. The drug industry is waging war against our Governors and our State legislatures to bring them into court.

From the NGA statement of July 15, I quote Michigan Republican Governor Engler:

> The nation's governors are extremely disappointed with the course of action chosen by PhRMA. It is unfortunate that their organization feels compelled to use the court system to manipulate public policy.

I will mention another feature of the attack by the industries on the States. This is what they are about. First of all, the industry sued the State. That probably is not any surprise, given their abuse of the Hatch-Waxman. The drug industry instructed its front group, the so-called Citizens for Better Medicare, to run television, radio, and prints ads in Maine and Vermont attacking the laws. That is what the drug industry does to keep the prices sky high. They sue our State governments, and waste taxpayers' dollars defending against frivolous suits, because the States have to defend themselves; they have to use tax dollars. And then they run attack ads.

Lest anyone question whether the so-called Citizens for Better Medicare is anything but a front group for the drug industry, let me quote the June 18 Wall Street Journal, Tim Ryan: PhRMA's past marketing director founded the grassroots sounding Systems for better Medicare at the expense of the major drug companies.

So it is a phony organization, but they use the phony organization to attack the public officials in those States for resisting their action.

Enough is enough. The American people are sick and tired of the drug industry's abuses.

I have an IG report from the HHS inspector general, who issued a report in August of last year which documents the fiscal crisis of sky-high drug prices. Here is the inspector general's conclusion about the current Medicaid discounts shared by the States and the Federal Government:

> We believe it is not a sufficient discount to ensure that a reasonable price is paid for drugs.

This is done under a Republican administration, a Republican IG, August of last year.

The Department of Health and Human Services, Office of IG, Medicaid pharmacy. This is what he says in paragraph 2:

> Although this discount averaged 10.31 percent nationally, we believe that it is not a sufficient discount to ensure that a reasonable price is paid for drugs.
>
> We believe that there is a critical need for States to better control the costs of their Medicaid drug program because expenditures are rising at a dramatic rate. Medicaid drug expenditures increased by slightly over 90 percent since our previous review in 1994.

I repeat, 90 percent. So says the IG report, a Republican HHS discussing what is happening in the States.

Then we have the Governors try to do something about it and PhRMA comes right in and says no.

Senator STABENOW's amendment will clarify that. It will support the Governors—support Republican Governors, support Democratic Governors—support the findings of a Republican IG to help deal with this issue.

Just in the last day we had a meeting of the Governors, actually, out in the State of Idaho. The Nation's Governors met out in Idaho and the Governors voiced their concern over the lawsuit that seeks to bar the States from dealing with the Medicaid cost-controlling measures.

This is the Governors saying just what Senator STABENOW has been saying, Republican and Democrat alike.

This is a serious amendment. Therefore, I am very hopeful it will be accepted.

Let me bring to the attention of the membership, something that has developed in my own State of Massachusetts, in the U.S. attorney's office. One of the developments in recent times is the development of a health fraud unit, which has been extremely active. I was talking to our U.S. attorney recently up there. We were discussing the situation about health care fraud. He mentioned to me this particular case.

Just last October, the Federal authorities secured the largest health care fraud settlement in history. Not surprisingly, it was against a drug company for overcharging taxpayers through Medicaid—just what we are trying to deal with here in the U.S.

Senate. The Top Pharmaceuticals paid $875 million in criminal and civil fines for overcharging the States and the Federal Government for the cancer drug, Lupron. It is a life-or-death cancer drug, and here you have Top Pharmaceuticals found guilty of overcharging consumers and now having to pay the criminal fines and civil fines of $875 million. There are now class action litigations brought by consumer advocates in Boston to further recover the overpayments to this drug company.

We need to close ranks with our States, Republican and Democratic Governors alike—consumers against high drug prices. The Stabenow amendment is the right tool in the hands of the States to lower drug prices for low-income people and the uninsured.

I want to reiterate two facts. Who are the States looking out for? Are they trying to use their bargaining power in terms of a massive purchase of drugs for all the people in their States? No. They are trying to use it for the most needy people in their States in most instances—and I think in the State of Maine, in every instance—those who are uninsured, the poorest of the poor who cannot get insurance for one reason or another, or are not eligible for Medicaid, in order to get them lower costs. It is the poorest of the poor trying to get life-sustaining drugs, and PhRMA, the industry, is going after that and saying they do not want that to take place. They think that is un-American. They think it is price fixing and so forth.

We have seen, and I have certainly seen it in our committee because it was not believed we would get this legislation out of the committee because we heard the drug industry is strongly opposed to it—and we have certainly heard that from our friends on this side of the aisle—we understand that—they are opposed to it. They are opposed to the Schumer proposal. We understand that. They are opposed to the Dorgan proposal. We heard that yesterday. And they are opposed to the Stabenow proposal.

What we have not heard is what they are for. What we have not heard is what they would do. What we have not heard is their sense of outrage about these abuses. We have not heard that.

We have been here the better part of the day today, yesterday, the day before, and we have not heard that. That is a matter of deep concern to everyone on this side of the aisle. It is the reason the majority leader has brought this up to the Senate, on the floor of the Senate.

I heard my good friend—and he is my friend—the Senator from Tennessee, talk about the process and procedure, about whether we are circumventing the procedure in order to consider the legislation. Of course it did not bother him very much in May of 2000 when they brought up the energy bill, sponsored by Senator LOTT, without committee approval; or brought up, on March 20, a bill to eliminate the earnings test for individuals attaining retirement age, without committee approval. The list goes on. In June 1999, the Republicans brought up Social Security lockbox without committee approval. It didn't bother them at that time.

But what you did not hear about is a prescription drug program for the needy in this country. They were never willing to circumvent the rules to try to protect the seniors or try to get lower prices. No, there is no example for that. We have had legislation in the committees for over 5 years. This is the first time—the first time—the only time that we have had the opportunity to debate.

Next Tuesday will be the first time we have had the opportunity to vote. And people are complaining about process and procedure.

We know what happens. Every Member in this body knows what happens when you get back in those committee rooms, you get out in the corridors—we know what happens. That is the end of the legislation. That is the end of it. We all know it. But we know next Tuesday we are going to have a chance to vote on this. It will be the first time, and we would not have that opportunity unless Senator DASCHLE said: This is a matter of national priority. This is a matter of central concern. This is an issue that ought to be debated and discussed on the floor of the Senate. This is a moral issue of central concern to every family, young and old—not only those who take the drugs but the families who look at their parents and are concerned about whether they have the resources to purchase those drugs.

The parents themselves do not want to burden their children about their own kinds of conditions. They are proud men and women who want to live in dignity and who have paid a price for this Nation—fought in the wars, lifted the country out of the Depression.

The PRESIDING OFFICER. The time allocated to the Senator has expired.

Mr. KENNEDY. The last 5 minutes has expired? I asked to be reminded when I used 15 minutes.

The PRESIDING OFFICER. The Senator can use that time now—5 minutes.

Mr. KENNEDY. The remaining time.

Mr. President, these are people who have built the country. Now we are asking whether they have paid into the system. I was here in 1965 when that commitment was made here on the floor of the Senate, Republicans and Democrats alike. The President who signed it—President Johnson as well—said:

Look, play by the rules, pay under the system, and when you turn 65 you will have health security.

Everyone in this room understands it. This Chamber understands that we failed the elderly people on that promise. We provided physician services and hospitalization but not prescription drugs. That is a three-legged stool. If you only have two and you do not have the third, you do not have health security. Every family understands that, everyone except the Senate.

We are prepared to do something about it. Can you imagine if we had not provided hospitalization or physician services? We would certainly understand it. Would we not be debating that today? Does anybody believe it to be so? Does anybody believe this is not important?

Finally, I remind everyone in this body as we are coming in, and as I intend to remind them next week, every Member of this body has a prescription drug program.

Every Member of this body has a prescription drug program that is paid for by taxpayers by 80 percent. We understand that. Any Member of this body who wanted to go down to the clerk's office could go in there and say: Take my name off that. I don't want it. I don't believe as a matter of principle that we ought to have the Federal Government dealing with this policy.

Anyone could do that. I have checked on it. There isn't a single Member in here who has done that.

All we are trying to do with this particular proposal is to treat the American people the same way Republicans and Democrats and this President are being treated. Is that asking too much for this body to do? I don't believe so.

I withhold the remainder of my time.

The PRESIDING OFFICER (Mrs. CARNAHAN). The Senator from Oklahoma is recognized.

Mr. NICKLES. Madam President, I rise in opposition to the Stabenow amendment. I will mention several reasons.

First and foremost, it is going to increase in the price of Medicaid. I want to make sure our colleagues know that. I am going to say it about 10 times in the course of this debate. If we pass the Stabenow amendment, the price of Medicaid is going up. The price of drugs going into the Medicaid system is going up. That is just a fact that everybody should know.

If we think that we are going to pass this amendment and that this is a great deal for the State—I disagree. The States have to share in the cost of Medicaid, and the cost of Medicaid is going up.

I heard my good friend—he is my good friend—the Senator from Massachusetts say the Governors have united; we need to get cost controls on Medicaid.

This will mean a monumental increase in the cost of Medicaid. I think I can say that very plainly and very easily. I want to make sure everybody is aware of that.

Let me mention a couple of other reasons we should be opposed to this amendment.

Some people say ''process.'' Did we have a hearing on this bill? No. Did we have a markup on this bill? No. Was one even requested? I don't think so. The Democrats are in control of the

Senate. Senator BAUCUS is chairman of the Finance Committee. If he wanted to have a markup on this bill, he could have done that.

I see the sponsor of the legislation. I will ask her. Have we had a hearing on this bill, and have we had a markup on this bill in the Finance Committee?

Ms. STABENOW. Madam President, I think my friend from Oklahoma knows that in fact that did not have a hearing. That is not unusual. That happens sometimes in the process. I have only been here 1½ years. But there are many times when that has occurred. The Senator is correct. That has not occurred on this bill.

Mr. NICKLES. Let me ask another question. Is it not correct that your bill will increase the cost of drugs going into the Medicaid system?

Ms. STABENOW. I would argue that that is not the case, absolutely not. Under the program right now, States operate with companies, and I don't have any indication whatsoever that it is going to increase the cost of Medicaid. I certainly would have to object to that.

Mr. NICKLES. I will make the case that it does. I believe I will show that GAO happens to agree with me. GAO has studied this issue. They basically said it boils down to the fact that if everybody gets a discount, nobody gets a discount. That is the economics of it.

Right now, you have a system where Medicaid gets the best price. Medicaid gets the best price—lowest price—in the country. But if everybody gets it, nobody gets it. If everybody gets a 15-percent discount, that is the price. This is not a discount. That is exactly what we are doing here. You are going to increase the cost of Medicaid by not giving a discount. Does that mean everybody's drug costs are going down? Actually, no. It means the discount or the best price is going up.

Ms. STABENOW. Will the Senator yield?

Mr. NICKLES. I will not yield. I want to make a lot of comments, and I will be happy to discuss it. But I only have limited time. I want to make sure I make all of these points.

No. 1, this is an important issue. It hasn't had a hearing.

This committee is now controlled by the Democrats. It has been for a year and we haven't had a hearing. I don't know that one has been requested. I am on the committee, and I am on the subcommittee.

Some people say that is not insignificant, that we do a lot of things.

When you are talking about major issues—and we are talking about prescription drugs for all of our seniors—we should have a hearing on this. We should have a markup.

There happens to be, collectively, on the Finance Committee hundreds of years of experience dealing with Medicare, Medicaid, and prescription drugs. A lot of us are willing to put some input into it. That is the reason we have the committee process.

I am ashamed of the way the Senate is operating today in this fashion. We are taking probably the most important and most expensive piece of legislation considered in decades and it hasn't had a hearing, it hasn't had a markup, and it hasn't had a scoring by the Congressional Budget Office—none of the above—and yet we are in the process of marking it up. We are going to have votes on Tuesday on a proposal that nobody has a clue about how much it costs.

On one of these proposals, some say it will cost $500 billion. Others say it is closer to $800 billion. Although, they forgot to tell that it only lasts a few years, and it is sunset. Then we will stop paying for prescription drugs. No entitlement sunsets after a few years. If somebody thinks we are going to start paying for prescription drugs and then we are going to stop, that is more than hypothetical. That is misleading.

If we are talking about trying to put corporate officers in jail for misleading financial statements, we ought it be ashamed of what we are doing in the Senate. We are taking up the biggest expansion of an entitlement program, and no one has a clue about how much it costs. And we are going to say we are fiscally responsible? Shame on us. We do it without a hearing, without a markup, and without scoring from the Congressional Budget Office. That is a really poor way to legislate. That is the way you get things started, and you later say: Wow, I had no idea it would cost this much.

Let me be a little more specific about the amendment of my colleague and friends from Michigan.

Very seldom do we legislate by intervening ourselves before a case goes before the Supreme Court and say this is the way we mean for it to be. We usually let the Supreme Court make the decision. This issue is before the Supreme Court. The position of the Senator from Michigan lost at the district court level. Then she won at the circuit court level, which has now brought the case before the Supreme Court. But we are going to intervene before the Court and say: Oh, here is what we mean. Rewrite the law.

Basically, we are going to say: All right, under the Medicaid system, which gives a discount—the best price for Medicaid beneficiaries, low-income beneficiaries—we are going to say that is applicable to anybody the State deems eligible.

Guess what. A lot of States have programs for drugs that have no limitation on income.

Senator KENNEDY mentioned three times that we need this program. He said the Senator from Michigan is trying to help the neediest and the poorest of the poor.

I looked up in the State of Massachusetts. This drug program has no income limitation. You could be a billionaire in Massachusetts and you would be benefitting from this program. This has is no direct relationship to income.

In the State of New York, it is 419 percent of the poverty level. That is about $50,000 for a couple.

So this idea of saying this just applies to the neediest—no, this is hijacking. That happens to be the word used at the district court level—a program that was targeted to benefit the low-income people and say, wait a minute, we want it to apply to a lot of other people who do not need the income eligibility of Medicaid.

We are going to take a discount program that was designed and targeted to help low-income people and say it applies to a lot of people, let's make it apply to everybody.

Really, what you are talking about are price controls. But what you are talking about is saying, we are going to take a discount right now that is targeted towards low-income people, and we are going to spread it around to a lot of other people who aren't low-income, and who in some cases have unlimited income. Does that really make sense?

Let me give you an analogy. Maybe sometimes economics arguments are hard to follow, and maybe with prescription drugs it is harder than others. Let us take an example.

I see my good friend and colleague from New Hampshire. He is the former Governor of New Hampshire. As Governor, he purchased automobiles for the highway patrol and for the State police. My guess is that, as Governors, they get a good deal for the automobiles that are sold to the highway patrol and to the State police. He probably buys hundreds of them. Certainly, in a large State such as New York, or Michigan, they buy hundreds, and maybe thousands. So they get a good discounts. They get a better deal than the average consumer.

But if you are going to say, wait a minute, let us not just give this to the police, and a volume discount to the State, let us just give this to basically anybody in the State. That sounds pretty good, doesn't it? We are all going to get a good deal.

Guess what happens now. The price at which they were selling to the State before has just gone up.

In other words, if everybody gets the discount, nobody gets a discount. You are going to find out that the savings that the highway patrol had by buying several hundred vehicles just disappeared because they are not going to get any better deal than anybody else on the street.

That, in effect, is what is going to happen if we adopt the Stabenow amendment. This is a costly amendment if we are going apply this discount that Medicaid now gives on best price for Medicaid to every State program—and some State programs are quite generous. I mentioned for the State of New York it applies to individuals up to 419 percent of poverty; for a couple, incomes up to $50,000. In Massachusetts, there is no income limit.

So if you make it apply—incidentally, under this amendment, a Governor could say: For any drug sold in my State, I am going to have it come under this agreement because I want to offer low-priced drugs to anybody who comes in the State of Oklahoma. So if that is the State program, then every drug would fall under this program. So the net result is, everybody gets a discount. Let's break out the champagne. This is a great deal.

What you have done is, you have taken away—if that is the case—the discount for the low-income people on Medicaid and just taken it and spread it out to everybody else. Is that really what we want to do?

If we adopt the Stabenow amendment, I am just telling you right now, you are eliminating the discount, you are eliminating the low-targeted subsidy that we are now giving low-income people. So if everybody gets the discount, nobody gets the discount. You have just targeted and, quite frankly, greatly increased the cost of the Medicaid Program. You have increased the cost of what is targeted towards low-income people, the people who really need the help.

Keep in mind, this is not targeted to seniors. I have read the Stabenow amendment very closely, and it does not say anything about income limits. As a matter of fact, it says: Hey, you don't have to meet income limits in Medicaid. You don't have to meet eligibility. You don't have to be unemployed. You don't have to be uninsured to benefit under this amendment. It applies to almost everybody.

If the Governor and the legislature write a program broad enough, anybody can apply. Anybody would. So everybody gets a discount. How great is that? It means that nobody gets a discount. This is the impact of this amendment.

It is going to increase costs, as well as costs to the Federal Government. Maybe this thing will become law. Mark my words, we will just write it down. Today is July 18. DON NICKLES says if this amendment passes, you are going to see Medicaid costs go up. We will find out. Some of us will be here for a while. Sometimes we do things that have results. This will result in Medicaid costs going up.

So the very people we think we are trying to help—whoa, wait a minute, we are not helping Medicaid people; we are hurting Medicaid people because they will have to pay more for their drugs. They will lose their discount. This discount will be spread out amongst a lot of other people.

Let me make a couple other comments.

It not just me saying it. This is not my hypothetical situation: Well, DON NICKLES says: Wait a minute, this may backfire.

The General Accounting Office did a report. I will read part of this and then include it in the RECORD:

In an August 2000 report, the GAO determined:

> The larger the group that would be newly entitled to receive a federal price, the greater the incentive for drug manufacturers to raise that price. The Medicaid rebate experience suggests how federal and nonfederal drug price discounts could change if Medicare beneficiaries had access to the same price discounts available to federal purchasers. Following the enactment of the rebate program, discounts for outpatient drugs decreased significantly because manufacturers raised the prices they charge large private purchasers.

That is from the General Accounting Office. That is looking at the facts after we enacted the discount program some time ago. They are saying, if you expand that base of people eligible for a discount, costs are going to go up. It is just a fact.

The other thing is, the Stabenow amendment harms Medicaid beneficiaries. It will raise drug prices in Medicaid and raise Medicaid Program costs at a time when States can least afford it.

I will mention something from the administration. I have a note from them:

> The administration opposes any change in the Medicaid law that would increase Medicaid drug prices and reduce Medicaid coverage. This is what the Stabenow amendment would do. Medicaid law has always focused on what is best for Medicaid beneficiaries. The administration opposes changes in the Medicaid law that would harm Medicaid beneficiaries. The administration said this is what the Stabenow amendment would do. That is exactly what this amendment would do—exactly.

I do not find this to be rocket science. You just tell everybody they are going to be able to get a discount, then nobody gets a discount. Medicaid? Sorry, you are going to have to pay more. They do get a discount now. They do get the best price. They do get the lowest price of anybody in the country. But if you make that applicable to everybody in the country, then nobody gets it. That is what is going to happen.

I am just kind of against that people think: Oh, yeah, we will just do this, and this will save money. It is going to cost money. It is going to cost money from people who can least afford it. And it is going to greatly exacerbate the problems that many of our States right now are struggling with, and struggling with greatly. So I just wanted to mention that. I think it is important.

I will mention two or three things. Let's not increase the cost of Medicaid. That is what this amendment would do.

No. 2, let's not intervene in a case before the Supreme Court. That is pretty foolish.

How many of us really studied this case? How many of us have studied the Maine law? How many of us have studied the idea that: Oh, yes, we are going to say that this program, that was designed for Medicaid, should really be applicable to all programs?

Is that really a smart thing to do? Does it have some delusion or some negative impact on one small group if you say it applies to everybody? I think it is very shortsighted.

So I urge my colleagues to vote no on this amendment. And if, for whatever reason, this amendment is adopted, I will tell my friend and colleague from Michigan, I am going to offer an amendment, and the amendment is going to have the effect to guarantee that the amendment would not have an adverse impact on Medicaid.

My colleague stated, with assurances: Oh, I am sure it will not increase Medicaid costs. The administration says it would. GAO says it would. I think anybody who looks at it says it would. But if she is that confident, then I hope she will accept my amendment that says the proposal will not be effective if it is proven to have an adverse or increased cost in Medicaid drug prices.

I will have that amendment later should her amendment prevail. I hope it does not prevail. I think it is a mistake.

There is a reason we have a committee process. The reason we have a committee process is we have two different ideas on this and two different opinions. We could have experts come in and testify, and they could say exactly what they think the results would be of the Stabenow amendment.

We have not had that opportunity. I would love to have that. I will be happy to participate in a hearing on it next week, next month, 2 months from now, and find out what the experts think, the people who are in charge of CMS, the old HCFA. Let's see what they have to say. Let's see what other experts say.

Let's hear from Governors who not only have Medicaid that they are wrestling with, but other programs. Hey, there are some pluses and minuses in it for them. After all, they have to pay part of it.

Ms. STABENOW. Will my friend from Oklahoma yield for a question?

Mr. NICKLES. I will be happy to yield.

Ms. STABENOW. I am wondering if you are saying for the future, then, any amendment that comes to the floor that has not gone through a committee or subcommittee, you intend to oppose from here on out? Is that correct, for as long as you and I are here in the Senate, you would, in fact, oppose any amendment that comes before us that way?

Mr. NICKLES. I tell my friend and colleague, I think the committee process is being totally ignored by the present leadership in the Senate.

Ms. STABENOW. But does that mean you will, in the future—as opposed to what has happened in the past—object to anything that comes to the floor, any amendment that comes to the floor that has not gone through the committee process? I would be interested in knowing if, in fact, that is your position.

Mr. NICKLES. I would not go that far. But I tell my colleague, I will be

happy to join her in requesting Senator BAUCUS to have a hearing on her proposal as soon as possible. Let's bring in the experts. Let's see what they have to say.

I am a little bit chapped at the fact that I had been in the Senate for about 16-some years before I even got on the Finance Committee, and now it is not working. It has the reputation of being one of the most powerful, great committees, and it does not meet.

The chairman of the committee does not call meetings on this. We have not had a markup on the prescription drug bill. I would liked to have input. I would like to be able to offer an amendment. And I would like to have testimony so we can find out what the substance of the proposal is, what the impact will be. How much will it cost States? How much will it increase Medicaid costs?

I heard somebody say: Well, we think it would increase Medicaid costs by $1 billion or a couple of billion dollars. I think it may be a lot more than that. But I would like to know. Well, we don't know. We have not had estimates. It would be nice to have CMS give us an estimate.

Have we had the chance to do that? No. Because we have not had a hearing. I don't believe a hearing was requested, but it should have been. And the chairman of the committee should have agreed.

I will just tell my colleague, I am happy to participate in a hearing so we can get the facts out. But to change a program totally, and say, OK, we are going to have price controls and discounts for one group, and now we are going to expand it for everybody, with these great savings, assuming that everybody is going to get the savings—the net result is, nobody is going to get the savings. Instead of everybody getting a discount, nobody is going to get a discount. And that is the unfortunate result.

Ms. STABENOW. Will the Senator yield?

Mr. NICKLES. No, I will not yield.

That is the unfortunate result of her amendment. It is just too bad that we bypassed the committee. I don't know why the chairman of the Finance Committee and the ranking member are not saying: Wait a minute, this might be a good proposal. Let's have a hearing on it. We will mark it up. We will consider it.

We haven't done that; again, for something that involves State after State, a Supreme Court decision that will be made in probably a few months. We are going to interject ourselves with a trivial amount of debate on the floor, and we will have Senators vote on it and probably not half a dozen Senators have looked at the amendment in any detail. That is not a good way to legislate.

I reserve the remainder of my time.

Mr. GRASSLEY. Mr. President, I do not support Senator STABENOW's amendment No. 4305 to S. 812 to amend section 1927 of the Social Security Act. As my colleague Senator NICKLES pointed out during debate, this amendment raises important policy and budgetary questions that have not yet been considered by the Senate during a hearing or a committee mark-up. The far-reaching nature of this amendment deserves serious consideration by Congress prior to a vote. Additionally, at present there are pending legal decisions related to matters addressed in this amendment, and I believe it is worthwhile to await the decision of the courts prior to enactment of this amendment. For these reasons, I do not support this amendment, but I reserve the right to re-evaluate the matter at a later date.

Mr. KENNEDY. Madam President, what is the order now? We were allocated time to different individuals, and then at the conclusion of that we were going to recognize the Senator from Michigan to make final comments. I think Senator GREGG is here.

The PRESIDING OFFICER. The Senator from New Hampshire has 5 minutes and the Senator from Michigan has 5 minutes.

The Senator from New Hampshire.

Mr. GREGG. Madam President, it was my understanding that I had 5 minutes plus 7 minutes which would have been 12 minutes.

Mr. KENNEDY. That was my understanding as well. I think the Senator was recognized for 5 minutes and then when they extended the time of the Senator from Michigan, I think they extended the time of the Senator from New Hampshire as well. I would ask that he be accorded the 12 minutes.

The PRESIDING OFFICER. The Senator is recognized for 12 minutes.

Mr. GREGG. I understand there is a desire not to have us go to a vote until 5:40 or so. So there is extra time here. I would suggest that I take 12 minutes and the Senator from Michigan take 12 minutes, that we equally divide the time between now and 5:40, and then, at 5:40, proceed to a vote.

Mr. KENNEDY. That is satisfactory to me. I generally try to check with our leadership.

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

Mr. KENNEDY. I think, for the benefit of the Members, the time for the vote will be at 5:40.

Mr. GREGG. Let me first associate myself with the excellent comments made by the Senator from Oklahoma who has made most of the points I would have made but made them with more energy and eloquence.

If you look at this proposal which has come forward, offered by the Senator from Michigan, essentially its outcome will be that the discounts allowed under Medicaid, which States get for their Medicaid recipients, which are significant discounts—nobody should underestimate, these are big discounts which drug companies that make your product are required to give to the States through the Medicaid process—those discounts under the proposal of the Senator from Michigan, those discounts will now be transferable to a whole new population of people, a very large, potentially very large population of people.

As the Senator from Oklahoma pointed out rather correctly, that population is not necessarily going to be means tested, not necessarily going to be of need. It could simply be a population which qualifies for this new discount under a State plan.

As a result, what you are going to do is end up for those drugs significantly reducing the revenues which flow to whoever produced that drug. What is the impact of that? Assuming that this is not a situation where the people who produced the drug are charitable organizations but are, rather, organizations which, in order to be able to produce that drug, had to go out and borrow money from somebody through the capital markets or through actual borrowing in order to be able to raise enough money to be able to bring that drug to market, remembering that the average cost to bring a drug to market in America today is somewhere between $500 million and $800 million and it takes somewhere between 10 and 12 years, assuming that this is not a charitable organization, then that company, in order to be successful, those people who invented that drug, who created that drug, who put their life into that drug for 12 years, managed to manufacture it after going through all the hurdles—and believe me, there are an unlimited number of hurdles, an incredible number of hurdles, at incredible expense, had to go out and line up their financing to do this—those people are going to have to raise the cost to somebody else. Because they still have to pay off the people who financed the drug. They have to give a reasonable return to the people who invested in that company or they are not going to be able to produce another drug. The drug that they produce may put them into bankruptcy for all intents and purposes, if they can't get a fair recovery on it.

What is the practical implication? Essentially what we are doing here is another example of saying: The big, bad, greedy drug companies, they can take the hit no matter what. They can take the hit. We have seen it happen out here on the floor. We have heard the argument from the other side. We can just do this because the big, bad drug companies are going to take the hit.

Let's remember what we are talking about. We are talking about one of the most important elements of our society, organizations which are producing products which are making American lives better, longer, and more healthy. Is it our goal to fundamentally undermine the capacity to do that? If we continue on this course—and this is obviously not the most extreme example of it, but this is a clear example of price controls and an attempt to drive

down the return on the ability of somebody to produce a product, which saves lives—if we continue on this process, we are essentially going to be plucking the feathers, rather aggressively, of the guys who are laying the lifesaving drug.

In the end we are not going to have a whole lot of gooses or they are going to be geese that don't have enough ability to produce those lifesaving drugs anymore because they don't have any feathers left on their bodies. This is really pretty obvious, if you think about it logically.

Capital in a marketplace system—I understand this is an elementary concept which has escaped some people in the Government—flows where it gets a return. That is just simple fundamentals. By capital I mean money which allows people to invest in products, which creates jobs, and create items that give us as a nation a better chance to compete internationally but, more importantly, gives our American people a better standard of life.

Capital flows where it gets the best return. If you reduce radically or even if you reduce incrementally but in a way that is basically pyramiding on top of itself like straw on a camel's back, if you continue to reduce the ability of the people who are creating the new drugs which are saving lives to have a viable market to go into and get capital; in other words, to be able to go to somebody who is willing to lend them money or willing to invest in their business and expects a reasonable return, if you reduce their ability to get a reasonable return or to pay that debt, you inevitably reduce the amount of drugs coming to the marketplace that will benefit citizens.

In the process, you cut our productivity, cut our national competitiveness, and take what is a very vibrant part of our economy and undermine it.

I realize it is great politics to come to the floor of the Senate and claim that if we do this we will be helping the poor. We will be helping the indigent, helping people who need help. That is great politics. But if you are not producing the drugs, you are not helping anybody. If that lifesaving drug, that drug that is going to give people a better way of life, isn't going to come to market because the people who produce it can't get the money to make it because they can't go in the capital markets and get a decent return, then you are not helping anybody. It is a fraud to come to the floor and claim you are helping all these people. There was a statistic, which I found most interesting, cited today by a colleague on the other side of the aisle. They said that in the biotech industry today there are a thousand firms, but only a hundred of them have products on the market, and we are really excited to think the next 900 are going to come to market with their products.

Well, if we continue to pluck this goose, those 900 firms are not going to come to market with their products because they are not going to have the financial strength to survive the 9, 10, 11, 12 years it takes to get to market with their product. It takes money, cash, capital flowing into those companies—and paying the employees, by the way. It doesn't happen to go to somebody making a gazillion dollars; it goes to the employee. It takes money, cash, and capital to fund that period from the time you think of the product, from the time you invent that concept, from the time it germinates as an idea in some wonderful scientist's mind, to get it to the market, and $500 million to $800 million. So those 900 companies that are out there that don't have a product on the market, but if those products come to the market—this was their point—those products will save hundreds of thousands of lives.

Those products are not going to be there if we continue on this path of, every time we turn around, taking another nick—a fairly significant nick—out of the ability of those companies to be viable.

Are those companies evil and greedy because they want to bring to the marketplace something that is going to improve the lives, or extend the lives, and improve the quality of life of Americans—and, well, yes, be sold in Canada for less because they take advantage of all our research, in a very mercenary way, as does the rest of the world? No. They want to produce a product that is going to improve the quality of life of Americans; and they are willing to do it, willing to put at risk their time, effort, brain power, and their resources, including cash and capital.

But the argument on this floor is they are greedy, so let's just shut down their capacity to do that. And then, at the same time, we are out here claiming: But we are going to have a wonderful, viable drug industry in this country, and we are going to continue to be on the cutting edge.

Well, we are not. We cannot continue to say to people who are producing products you can't get a fair return on your product and expect that they are going to continue to produce their products.

This amendment is not overwhelmingly egregious, but it is one more straw on the back of the ability of the marketplace to move their capital into the production of quality health care products versus moving it into who knows what—software for video games or movies that are violent or whatever else for which the capital gets a better return.

The basic element of this amendment is that we are going to take a very limited program, which demands that people sell a product at significantly less than what the market will bear, and should bear, in order to give a reasonable return and demand that it be spread across a whole new population. And as a result, that population will get a lower cost drug, no question about it. But somebody else is going to have to pay more for the ones that come to market and are put under that system. It is like a balloon, when you squeeze it in one place, it pops out in another place. Other people—probably those on an insurance program—will pay more. So their insurance will go up and maybe they will become uninsured. We can also talk about that. More importantly, fewer people are going to be willing to pursue the path of producing quality drugs because you are not going to be able to go into the marketplace and get the capital to do it. That is what this debate comes down to—whether this feel good, ''I care about everybody'' concept that says that the way you feel good and you care is you basically say the drug companies are greedy, the production is greedy, the biotechs are greedy, and you drive their price down so they can no longer compete, but for a while at least people get a lower cost drug.

I will admit there will be a window where you will be successful. But 4 or 5 years from now, or 8 years or 10 years from now when that drug that might have addressed the issue of Alzheimer's, or of arthritis or addressed the issue of arteriosclerosis, multiple sclerosis, or any number of diseases, that drug didn't come to the market because the person who had the idea could not get the money in the capital market to finance the 8 to 12 years and the $500 million to $800 million to bring it to market because there was not a market that generated that kind of return. Have we done a lot of good for the American people then? I don't think so.

So as we move down this road, we have to be balanced. Good ideas may flow, things that seem appropriate to the moment. We can throw them out, but let's evaluate them in the context of what their ultimate outcome will be.

How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 10 seconds.

Mr. GREGG. Well, I may use all my 10 seconds. I will reserve that time.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. It is difficult for me to know where to begin with all of this what I view as misinformation. I will at least clarify what I believe to be the facts regarding the situation in the bill and, beyond the bill, the general issue regarding the pharmaceutical industry.

I ask unanimous consent that Senators CLINTON and LEAHY be added as cosponsors of the amendment.

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

Ms. STABENOW. I find it interesting, there is great concern about expanding discounts to people who are not on Medicaid. Do you know what is unfair in this country right now? The only people who pay retail, the only people who pay the highest prices in the world are people who are uninsured. No insurance company pays retail. Every insurance company, including Blue Cross Blue Shield, or any company, gets a discount. The States as well—when we

buy for the VA hospital, the Federal Government—we negotiate a discount. Under Medicaid, we have given the States the ability to get what is, frankly, a modest discount—15 percent on brand name drugs, 11 percent on generics. So they don't pay retail. Nobody pays retail. Everybody gets a discount, except for one group—the uninsured in this country.

The majority of those using prescriptions who are uninsured are our senior citizens—the seniors and the disabled of this country. How unfair that we would think they, too, should get a discount. This amendment only affects those who are uninsured. Why? Because everybody else already gets a discount. So if you vote no on this, you are saying this system right now that allows States to get discounts under Medicaid, the Federal Government for the VA, Blue Cross Blue Shield, and every other system—our own insurance system as Federal employees, we don't pay retail—if you vote no, you are saying the only people who don't deserve a discount from retail are uninsured seniors and families. The folks who are not seniors—most of those who are uninsured work and they work for small businesses. Those small businesses are struggling every day to provide health care and they are seeing premiums go up 30 to 40 percent a year, and most of that is because of prescription drugs.

This is a modest amendment. This is an amendment that simply says our States that are struggling right now, both to pay for Medicaid and also to provide some kind of lower cost prescriptions for their citizens, mostly seniors who don't have insurance, ought to be able to use the creativity of a State, the great ''laboratories of democracy'' that I hear about all the time from my colleagues on the other side of the aisle—let them continue to do what they are doing, be creative to lower prices.

I might just quote something that was quoted earlier today by my colleague from Massachusetts, and that is my own Governor of the State of Michigan, who is leading the National Governors Association. We have meeting now Governors who are concerned about prescription drug costs and wanting to provide programs for their citizens, being sued, many of them, because they want to expand the discount for lower prices, to be creative like Maine and Vermont.

We had from Governor Engler:

> The Nation's Governors are extremely disappointed with the course of action chosen by PhRMA, said NGA chairman Michigan Governor John Engler. It is unfortunate that their organization feels compelled to use the court system to manipulate public policy. With pharmacy costs alone rising 15 to 20 percent each year, all purchasers, including the manufacturers themselves, are using tools that manage costs while maintaining quality and access to affordable pharmaceuticals.

That is about an optional program to say to the States: If you choose to be creative and use your leverage under Medicaid to expand a discount to people who do not get a discount, who are the only people who do not get a discount, who are the uninsured, mostly seniors, that you can do that.

I commend the administration because under this administration, the Bush administration, the Solicitor General, Theodore Olson, went to court in support of the Maine plan. He said in his brief:

> The initiative should be allowed to go forward without further intervention.

Olson argued:

> States enjoy a broad measure of flexibility in tailoring the scope and coverage of their Medicaid plans and that court review of Maine Rx was not warranted.

I commend him and the administration for stepping in on the side of States rights, which is what this is all about. This is about States rights. It is not about concerns about the pharmaceutical industry.

I understand they will fight everything, they have been fighting everything, they will continue to fight everything. There is no question about that. We fully expect their arguments to be put forward on this floor.

I wish to make two other points; that is, when we talk about the industry as a whole and the concern that maybe the uninsured would get the same discounts as people with insurance, and what that would do to the poor pharmaceutical companies, we need to look at what the real picture is today economically with this industry as we are concerned about making sure our seniors pay, when they walk into a local pharmacy, the highest prices in the world.

A study that was put out yesterday by Families USA shows some startling comparisons. We all want research. We want those new lifesaving drugs. Unfortunately, 80 percent of the new patents being approved by the FDA are ''me too'' drugs, not new lifesaving drugs, but we want those.

I am deeply concerned about the direction of the companies. The pharmaceutical company is more about being a sales machine, sales and marketing, quarterly reports and profits than about creating new lifesaving drugs, and that is of deep concern to me as to the future for all of us in health care.

A number of companies were outlined yesterday. As an example, Merck spends 5 percent on research and development; 15 percent profits last year, there were three times more profits than what was spent on R&D; and 13 percent was spent on advertising, marketing, and administration. It is almost three times as much on advertising and marketing and three times more in profits than they are spending on R&D.

Pfizer received 1½ times more in profits than they spent on research and development, more than two times more on advertising, marketing, and administration than on research and development. It is a pattern that continues. R&D is not the top expenditure of the companies today.

When we look at the individuals, it is difficult for me, representing the great State of Michigan where people work hard every day for a living, most people working hard for that paycheck, concerned about their kids, whether they are going to be able to send them to college, whether they can afford their health care, working hard every day, and then we hear we cannot possibly lower prescription drug prices, we cannot possibly even get them down to the rate of inflation—they are going up an average of three times the rate of inflation—we could not possibly give a 15-percent discount to uninsured seniors.

Then we look at the numbers, and we see astounding salaries in the drug companies. I mentioned this morning—not to be personal but this is public information—the comparisons are astounding. The former chairman and CEO of Bristol-Myers, $74.9 million last year in earnings and, in addition, $76.1 million in unexercised stock options.

We have been talking in this Chamber about corporate responsibility and integrity and, I would argue, morality. What is the morality of huge, tens of millions of dollars in salaries and huge amounts of profits, and when we say just get the prices in line so people can afford these new lifesaving drugs so they are not cutting the pills in half, taking them every other day—worst yet, not affording them at all—and we are told, no, nothing can be done, nothing can be done. They fight every single attempt to rein in prices or expand coverage.

This is a fundamental battle, I believe. I think we are needing to help an industry save itself and get back to its soul, which is research and development in new drugs, and to get back in touch with the American people.

I commend the States that are involved right now. They are close to the people. They are close to the people in their States and they know, they hear the stories every day, and they are trying to do something. They want us to act. I do not know if we are going to be able to get this all the way through. I certainly hope so, and I will do everything I can humanly do to work with my colleagues to make it happen.

In the meantime, the States are trying to help. We have 30 States that are doing something in the area of prescription drugs trying to help, and we have States being sued by the drug lobby because they are trying to help.

I will simply say, as we bring this debate to a close, that this is an amendment that does not force a State to do anything. It only affects the States that want to expand their drug discounts to those without coverage. It is an issue of flexibility.

The administration has gone on record in support of the Maine project which we use as an example of what can be done, and we appreciate that. It will stop unnecessary litigation. I know there is a great deal of concern by my colleagues about unnecessary

litigation. It will allow States to stop spending money on litigation and put money in essential services, such as being able to make available prescription drugs to their citizens.

I hope my colleagues will join in support of this bipartisan—tripartisan—amendment this evening and send a message that we support our States and we support their right to be involved in putting together efforts to lower prices and make lifesaving medicine available to their citizens.

I ask for the yeas and nays on my amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

Ms. STABENOW. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

UNANIMOUS-CONSENT AGREEMENT—EXECUTIVE CALENDAR

Mr. REID. Madam President, I ask unanimous consent that the cloture vote on Executive Calendar No. 825, Richard Clifton to be United States Circuit Court Judge, occur immediately following the disposition of Senator STABENOW's amendment. I further ask unanimous consent that following the confirmation of Judge Clifton, the Senate move to proceed to the nomination of Richard Carmona to be United States Surgeon General; that following the filing of cloture on the nomination, the Senate resume legislative session; that the live quorum for that cloture vote be waived, and that the cloture vote on the Carmona nomination occur on Tuesday, July 23, at 10:30 a.m.; and that the preceding all occur without any intervening action or debate.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. REID. Madam President, there is also the possibility of a third vote this evening on confirmation following the two votes previously announced in this unanimous consent agreement.

VOTE ON AMENDMENT NO. 4305, AS MODIFIED

Mr. REID. We are now ready to proceed to the Stabenow amendment. Have the yeas and nays been ordered on Stabenow?

Mr. GREGG. Yes.

The PRESIDING OFFICER. The yeas and nays have been ordered.

The question is on agreeing to amendment No. 4305, as modified. The clerk will call the roll.

The legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from North Carolina (Mr. HELMS) is necessarily absent.

The PRESIDING OFFICER (Ms. CANTWELL). Are there any other Senators in the chamber desiring to vote?

The result was announced—yeas 56, nays 43, as follows:

[Rollcall Vote No. 182 Leg.]

YEAS—56

Akaka	Dorgan	Lincoln
Baucus	Durbin	Mikulski
Bayh	Edwards	Miller
Biden	Feingold	Murray
Bingaman	Feinstein	Nelson (FL)
Boxer	Graham	Reed
Byrd	Harkin	Reid
Cantwell	Hollings	Rockefeller
Carnahan	Hutchinson	Sarbanes
Carper	Inouye	Schumer
Chafee	Jeffords	Smith (OR)
Cleland	Johnson	Snowe
Clinton	Kennedy	Specter
Collins	Kerry	Stabenow
Conrad	Kohl	Torricelli
Corzine	Landrieu	Voinovich
Daschle	Leahy	Wellstone
Dayton	Levin	Wyden
Dodd	Lieberman	

NAYS—43

Allard	Enzi	Murkowski
Allen	Fitzgerald	Nelson (NE)
Bennett	Frist	Nickles
Bond	Gramm	Roberts
Breaux	Grassley	Santorum
Brownback	Gregg	Sessions
Bunning	Hagel	Shelby
Burns	Hatch	Smith (NH)
Campbell	Hutchison	Stevens
Cochran	Inhofe	Thomas
Craig	Kyl	Thompson
Crapo	Lott	Thurmond
DeWine	Lugar	Warner
Domenici	McCain	
Ensign	McConnell	

NOT VOTING—1

Helms

The amendment (No. 4305), as modified, was agreed to.

Mr. DASCHLE. Madam President, I move to reconsider the vote.

Mr. NICKLES. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. DASCHLE. Madam President, there are two additional votes. I ask unanimous consent that they be 10 minutes each.

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

Mr. DASCHLE. Madam President, I would like everybody to stay right here. At the end of 10 minutes, we will go to a third vote. That will be the last vote for the week. I appreciate everybody's cooperation in staying here and voting, and staying here for the second of the two votes. Then we will be finished for the evening.

EXECUTIVE SESSION

NOMINATION OF RICHARD R. CLIFTON, OF HAWAII, TO BE UNITED STATES CIRCUIT JUDGE FOR THE NINTH CIRCUIT

CLOTURE MOTION

The PRESIDING OFFICER. Under the previous order, the Chair lays before the Senate the pending cloture motion, which the clerk will report.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on Executive Calendar No. 825, the nomination of Richard R. Clifton, to be United States Circuit Judge for the Ninth Circuit.

Jeff Bingaman, Patrick Leahy, Daniel Inouye, Harry Reid, Tom Daschle, Dianne Feinstein, Orrin Hatch, Chuck Grassley, Michael B. Enzi, Craig Thomas, Christopher Bond, Jeff Sessions, Jon Kyl, Rick Santorum, Pat Roberts, Trent Lott.

The PRESIDING OFFICER. Under the previous order, the quorum call is waived.

The question is, Is it the sense of the Senate that debate on Executive Calendar No. 825, the nomination of Richard R. Clifton of Hawaii, to be United States Circuit Judge for the Ninth Circuit, shall be brought to a close?

The yeas and nays are required under the rule.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Iowa (Mr. HARKIN) is necessarily absent.

Mr. NICKLES. I announce that the Senator from North Carolina (Mr. HELMS) is necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 97, nays 1, as follows:

[Rollcall Vote No. 183 Ex.]

YEAS—97

Akaka	Dorgan	McConnell
Allard	Durbin	Mikulski
Allen	Edwards	Miller
Baucus	Ensign	Murkowski
Bayh	Enzi	Murray
Bennett	Feingold	Nelson (FL)
Biden	Feinstein	Nelson (NE)
Bingaman	Fitzgerald	Nickles
Bond	Frist	Reed (RI)
Boxer	Graham	Reid (NV)
Breaux	Gramm	Roberts
Brownback	Grassley	Rockefeller
Bunning	Gregg	Santorum
Burns	Hagel	Sarbanes
Byrd	Hatch	Schumer
Campbell	Hollings	Sessions
Cantwell	Hutchinson (AR)	Shelby
Carnahan	Hutchison (TX)	Smith (NH)
Carper	Inhofe	Smith (OR)
Chafee	Inouye	Snowe
Cleland	Jeffords	Specter
Clinton	Johnson	Stabenow
Cochran	Kennedy	Stevens
Collins	Kerry	Thomas
Conrad	Kohl	Thompson
Corzine	Kyl	Thurmond
Craig	Landrieu	Torricelli
Crapo	Leahy	Voinovich
Daschle	Levin	Warner
Dayton	Lieberman	Wellstone
DeWine	Lincoln	Wyden
Dodd	Lott	
Domenici	Lugar	

NAYS—1

McCain

NOT VOTING—2

Harkin Helms

The PRESIDING OFFICER. On this vote, the yeas are 97, the nays are 1. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

Mr. LEAHY. With today's vote, the Senate will confirm its 11th judge to our Federal Courts of Appeals and our 59th judicial nominee since the change in Senate majority little more than

one year ago. The Senate confirmed the first Court of Appeals judge nominated by President Bush on July 20 last year and now, less than one year later we are confirming the 11th. That is almost one per month.

By contrast, the Republican majority that preceded us averaged seven Court of Appeals confirmations every 12 months. During an entire session of Congress, 1996, the Republican majority allowed no circuit court nominees to be confirmed, not one. The Republican majority confirmed 46 Court of Appeals judges in 78 months. While they were in the majority vacancies on the Courts of Appeals more than doubled, going from 16 to 33. Since the change in majority the numbers are going in the right direction—vacancies are going down and confirmations have significantly increased. We would be doing even better with a little cooperation from the Administration and the Republican leadership, which created roadblocks to the consideration of all judicial nominations by the full Senate since May.

The nominee voted on today, Richard Clifton, was one of the 78 nominees to receive a hearing in the first year since the reorganization of the Judiciary Committee on July 10, 2001. In that period, we held more hearings for more circuit court nominees than in any of the prior six years of Republican control. In fact, we have had hearings for more judicial nominees in the past year than in 20 of the last 22 years under Republican or Democratic presidents. Those who wish to paint the Senate as obstructionist ignore the facts and the fair treatment by the Senate of President Bush's judicial nominees. They focus instead on the most controversial nominees who do take more time, rather than the vast majority who have received hearings and been confirmed in bipartisan votes of the Senate. They would rather use misleading percentage calculations that obscure the fact that the Democratic-led Senate is considering President George Bush's nominees at one of the fastest paces in recent history.

I commend Senators Inouye and Akaka for the statesmanship they have shown in connection with this nomination. I remember very well their important efforts to establish the Hawaii seat on the Ninth Circuit and to try to fill it with a qualified nominee. I voted with them and supported their effort to ensure that every State, even States as small as Hawaii and Vermont, are represented on our Courts of Appeals.

I recall the saga of the nomination of James Duffy to fill the Hawaii seat on the Ninth Circuit, how hard they worked to find a consensus nominee and how that nomination was stalled for years. Despite the ''Well Qualified'' rating he received from the ABA and the strong support of both his home-state Senators, Mr. Duffy never received a hearing or a vote. He was nominated at the beginning of 1999 and remained pending for over two full years until it was withdrawn by President Bush in March 2001 without any Senate action of any kind.

Despite that recent history, the Hawaii Senators support Mr. Clifton for that same vacancy. In contrast to the treatment that Mr. Duffy received, Mr. Clifton's nomination was scheduled for a hearing less than 60 days after his file and paperwork were completed. Mr. Duffy waited 791 days and never got a hearing. When partisan critics charge Democrats with tit-for-tat and seeking revenge, they ignore the facts. The confirmation of Richard Clifton is another example of Democrats treating President Bush's judicial nominees far better than Republicans treated President Clinton's.

Today's vote on Mr. Clifton's nomination should provide some relief to the Ninth Circuit, which has four vacancies that have been classified as ''judicial emergency'' vacancies by the U.S. Courts. Two of those vacancies are more than five years old. They date back to 1996 and 1997, and there were two outstanding nominees to those seats. I have mentioned the nomination of James Duffy. The other nominee was Barry Goode of California, whose nomination also languished for years without ever getting a hearing or a vote.

When Barry Goode was first nominated to a Ninth Circuit vacancy in 1998 it was already a judicial emergency. Both of his home-state Senators supported the nomination but the Republican leadership refused to act. Mr. Goode was nominated not once, not twice, but three times to the Ninth Circuit and he never was given the courtesy of a hearing or a vote during almost 1,000 days (998 days). In March of 2001, President Bush withdrew Mr. Goode's nomination but he has not nominated anyone to this judicial emergency vacancy. It remains one of a number of judicial emergency vacancies for which there is no nominee and one of the 43 judicial vacancies for which there is no nominee.

The Ninth Circuit vacancies are a prime and unfortunate legacy of the partisan obstructionist practices during the Republican control of the Senate. Some are now complaining that a few nominees are waiting a year for hearing. Even though the anniversary of the reorganized Judiciary Committee with a Democratic majority was July 10, and we have already held hearings for 16 Court of Appeals nominees among the 78 total judicial nominees who had hearings in our first year.

I also recall how all confirmations to the Ninth Circuit from California were stalled by the demands of a Republican Senator not from that State to be given the ability to name a Court of Appeals judge from his State. With the support of the Republican leadership in the Senate, that Republican Senator succeeded in getting President Clinton to accord him that prerogative in order to break that logjam.

Just as the May 9th hearing on Mr. Clifton's nomination was the first hearing on a Ninth Circuit nominee in two years, earlier this year we had the first hearing for a Sixth Circuit nominee, Judge Gibbons, in almost five years. Similarly, the hearing we held on the nomination of Judge Edith Clement to the Fifth Circuit last year was the first on a Fifth Circuit nominee in seven years and she was the first new appellate judge confirmed to that Court in six years. When we held a hearing on the nomination of Judge Harris Hartz to the Tenth Circuit last year, it was the first hearing on a Tenth Circuit nominee in six years and he was the first new appellate judge confirmed to that Court in six years. When we held the hearing on the nomination of Judge Roger Gregory to the Fourth Circuit last year, it was the first hearing on a Fourth Circuit nominee in three years and he was the first appellate judge confirmed to that court in three years.

Large numbers of vacancies continue to exist on many Courts of Appeals, in large measure because the recent Republican majority was not willing to hold hearings or vote on more than half—56 percent—of President Clinton's Courts of Appeals nominees in 1999 and 2000 and was not willing to confirm a single judge to the Courts of Appeals during the entire 1996 session. Democrats have broken with that recent history of inaction.

I would like to commend in particular the Senators from Hawaii and also the members of the Judiciary Committee for their efforts to consider scores of judicial nominees for whom we have held hearings and on whom we have had votes during the last several months.

Mr. HATCH. Madam President, I rise to support the nomination of Richard R. Clifton to be U.S. Circuit Court Judge for the Court of Appeals for the Ninth Circuit. Before I speak directly about him and his nomination, however, I would like to take just a moment to make a few comments about the Ninth Circuit.

I think it's safe to say that everyone in the Senate agrees that the Ninth Circuit decision in Newdow v. U.S. Congress, striking down the Pledge of Allegiance as unconstitutional because it contains the phrase under God, was out of the mainstream of American jurisprudence. After all, the Senate voted 99 to 0 to reaffirm the reference to One Nation Under God in the pledge of allegiance—right after the decision was announced.

But to me, the decision was more than wrong. It was an outrageous example of judicial activism and overreaching—of inappropriate, results-oriented policymaking from the bench. And it is a clear example of how the Ninth Circuit is failing to serve the best interests of the western states of California, Arizona, Nevada, Idaho, Montana, Washington, Oregon, Alaska, and Hawaii.

The Ninth Circuit has 28 authorized judgeships. There are 23 active judges,

and thus 5 vacancies. Seventeen of those 23 were appointed by Democrat Presidents—14 by President Clinton alone—and only 6 were appointed by Republicans.

The Administrative Office of United States Courts has labeled all five vacancies on the Ninth Circuit as ''judicial emergencies'' given the enormous per-judge caseload on the Ninth Circuit.

The Ninth Circuit takes several months longer than other circuits to dispose of cases. The average time from filing to disposition is approximately 14 months.

In addition, as is well known and has been widely observed, including by several Supreme Court Justices, the Ninth Circuit has often decided cases in a manner that is well outside the mainstream of American law and entirely inconsistent with binding Supreme Court precedent. In 1999–2000, the Supreme Court considered 10 Ninth Circuit cases and reversed 9 of them. In 1998–99, the Supreme Court considered 18 Ninth Circuit cases and reversed 14 of them. In 1997–98, the Supreme Court considered 17 Ninth Circuit cases and reversed 13 of them. And in 1996–97, in an extraordinary Term, the Supreme Court considered 28 cases from the Ninth Circuit and reversed 27 of them.

All of this makes clear why it is so important for the Senate to consider—and confirm—President Bush's nominees to the Ninth Circuit. We have two excellent candidates pending in the Judiciary Committee right now.

Judge Carolyn Kuhl has extensive experience in federal and state government, in the Executive and Judicial Branches, in public service and private legal practice. She has a superb legal background and broad experience that makes her ideally suited to be an excellent circuit judge. And the same goes for Jay Bybee, who currently serves as Assistant Attorney General for the Office of Legal Counsel at the U.S. Department of Justice. I urge the Judiciary Committee to hold hearings on these nominees without further delay.

Now, I would like to turn to the matter directly at hand, the confirmation of Richard R. Clifton to the Ninth Circuit Court of Appeals. Shortly following graduation from Yale Law School, Mr. Clifton moved to Hawaii to clerk for the Honorable Herbert Y.C. Choy of the U.S. Circuit of Appeals for the Ninth Circuit, the first and only Hawaiian to serve on that court. Notably, Mr. Clifton will be the second.

After his clerkship, Mr. Clifton joined the Honolulu law firm of Cades Schuttle Fleming & Wright, one of the oldest and largest firms in Hawaii. He has remained with that firm since then, becoming a partner in 1982. His practice has focused on business and commercial litigation, with an emphasis on complex litigation and appellate practice.

Mr. Clifton has ably handled cases in the areas of condemnation, tax law, securities transactions, class actions, debtor/creditor law, and trademarks.

Mr. Clifton is the sold male director with the Hawaii Women's Legal Foundation, a member of the Hawaii Women Lawyers, a member of the Hawaii Chapter of the American Judicature Society, and director of the Ninth Judicial Circuit Historical Society.

For approximately ten years, Mr. Clifton was an adjunct professor at the University of Hawaii William S. Richardson School of Law, where he taught appellate advocacy. He served as Chairman of Hawaii Public Radio for five years and remains a director and member of its executive committee. He has served as pro bono general counsel to the Hawaii Republican Party since 1991.

Mr. Clifton has a reputation for excellence. Among other honors, Mr. Clifton was named as one of the 18 finest lawyers in Hawaii for business litigation in 2001. He is widely respected by the legal community in Hawaii.

I proudly join my distinguished colleagues from Hawaii, Senators INOUYE and AKAKA, in supporting Mr. Clifton's nomination to the Ninth Circuit Court of Appeals, and I urge my colleagues to do the same. Richard Clifton will serve well on the federal bench in Hawaii.

Mr. AKAKA. Mr. President, I rise today in support of the nomination of Mr. Rick Clifton to the United States Court of Appeals for the Ninth Circuit.

I commend our Majority Leader, the Deputy Majority Leader, and the Chairman of the Judiciary Committee for the progress made on judicial nominations during the 107th Congress. Hawaii has waited a number of years for Senate confirmation of a Hawaii resident for a position on the U.S. Court of Appeals for the Ninth Circuit.

In 1995, I introduced legislation to require representation on the court from each State within the jurisdiction of the court. We have waited many years for this opportunity. I am pleased that Hawaii will finally have a Justice on the Ninth Circuit.

Rick Clifton has had a distinguished legal career. The Hawaii State Bar Association found him to be highly qualified for this position. A graduate of Princeton University, he received his juris doctorate from Yale Law School in 1975. Mr. Clifton has practiced law in Hawaii since 1975 and has been a partner with the law firm of Cades Schutte Fleming & Wright in Honolulu, HI, since 1982. He has extensive legal experience in civil litigation, primarily business and commercial litigation. I believe he will be an asset to the Court of Appeals for the Ninth Circuit and urge my colleagues to support his nomination.

The confirmation of Mr. Clifton will help to alleviate hardships confronting the Ninth Circuit brought about by four long-term vacancies on the Court. A number of these vacancies date back over five years, spanning a period where the previous Senate majority refused to act on these judicial emergencies despite President Clinton's nominations of several well-qualified individuals supported by their home-state Senators and local legal communities.

I congratulate and commend Chairman LEAHY for his leadership in working to confirm qualified nominees to the Federal bench and rectify the doubling in circuit court vacancies that occurred between 1995 and 2001. In this instance, the Judiciary Committee scheduled a hearing on Mr. Clifton's nomination less than 60 days after his file and paperwork were completed. As both Chairman and Ranking Member, Senator LEAHY has worked with Senator INOUYE and me to fill the Hawaii seat on the Ninth Circuit. I appreciate his commitment to ensure that every State is represented on our Courts of Appeals.

As the Chairman recently noted, Mr. Clifton's confirmation concludes a long and regrettable saga in confirming a qualified nominee from Hawaii. In 1999, the President nominated James Duffy of Hawaii to the Ninth Circuit. He was selected after an exhaustive screening process, following an admirable effort by the White House to consult widely with political, legal, and community leaders in Hawaii. Mr. Duffy was endorsed as ''the best of the best'' by the Hawaii State Bar Association. Despite his sterling reputation, the nomination languished for 791 days in the Judiciary Committee without ever receiving a hearing. Mr. Duffy is one of the well-qualified and talented men and women nominated by the President to the Ninth Circuit and other Courts of Appeals, individuals with bipartisan and home-state support whose nominations were never acted on by the Senate.

I mention this unfortunate chapter not to air past grievances, but to underscore the challenges facing the Chairman of the Judiciary Committee and the Majority Leader in bringing nominations before the Senate for action. In an exceptionally evenhanded manner, they have worked to overcome the partisanship and stalling practices that precipitated many of the judicial emergencies and vacancies some of our colleagues on the other side of the aisle have recently come to this floor to decry.

Today's confirmation vote for Mr. Clifton's nomination attests to the fairness that the Majority Leader and Senator from Vermont have restored to the judicial confirmation process in the past year. I thank them for their support.

Mr. LEAHY. Madam President, have the yeas and nays been ordered on the nomination?

The PRESIDING OFFICER. They have not.

Mr. LEAHY. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is, Will the Senate advise and consent to the nomination of

Richard R. Clifton, of Hawaii, to be United States Circuit Judge for the Ninth Circuit? The clerk will call the roll.

The legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from North Carolina (Mr. HELMS) and the Senator from Ohio (Mr. VOINOVICH) are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 184 Ex.]

YEAS—98

Akaka	Dorgan	Lugar
Allard	Durbin	McCain
Allen	Edwards	McConnell
Baucus	Ensign	Mikulski
Bayh	Enzi	Miller
Bennett	Feingold	Murkowski
Biden	Feinstein	Murray
Bingaman	Fitzgerald	Nelson (FL)
Bond	Frist	Nelson (NE)
Boxer	Graham	Nickles
Breaux	Gramm	Reed
Brownback	Grassley	Reid
Bunning	Gregg	Roberts
Burns	Hagel	Rockefeller
Byrd	Harkin	Santorum
Campbell	Hatch	Sarbanes
Cantwell	Hollings	Schumer
Carnahan	Hutchinson	Sessions
Carper	Hutchison	Shelby
Chafee	Inhofe	Smith (NH)
Cleland	Inouye	Smith (OR)
Clinton	Jeffords	Snowe
Cochran	Johnson	Specter
Collins	Kennedy	Stabenow
Conrad	Kerry	Stevens
Corzine	Kohl	Thomas
Craig	Kyl	Thompson
Crapo	Landrieu	Thurmond
Daschle	Leahy	Torricelli
Dayton	Levin	Warner
DeWine	Lieberman	Wellstone
Dodd	Lincoln	Wyden
Domenici	Lott	

NOT VOTING—2

Helms	Voinovich

The nomination was confirmed.

NOMINATION OF RICHARD R. CARMONA, OF ARIZONA, TO BE MEDICAL DIRECTOR IN THE REGULAR CORPS OF THE PUBLIC HEALTH SERVICE

The PRESIDING OFFICER. Under the previous order, the clerk will report Executive Calendar No. 921.

The assistant legislative clerk read the nomination of Richard H. Carmona, of Arizona, to be Medical Director in the Regular Corps of the Public Health Service.

The PRESIDING OFFICER. The majority leader is recognized.

CLOTURE MOTION

Mr. DASCHLE. Madam President, I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on Executive Calendar No. 921, the nomination of Richard H. Carmona, of Arizona, to be the Surgeon General of the Public Health Service.

Edward M. Kennedy, Debbie Stabenow, Tom Daschle, Harry Reid, Jack Reed, Richard J. Durbin, Barbara Mikulski, Patrick Leahy, Jean Carnahan, Tom Carper, Byron L. Dorgan, Paul Wellstone, Jon Corzine, Jeff Bingaman, Daniel Inouye, Kent Conrad.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will now return to legislative session.

GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS ACT OF 2001—Continued

AMENDMENT NO. 4309

(Purpose: To amend title XXIII of the Social Security Act to provide coverage of outpatient prescription drugs under the medicare program)

Mr. GRAHAM. Madam President, I send to the desk an amendment, which reflects the contents of S. 2625, the Medicare Outpatient Prescription Drug Act of 2002.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Florida [Mr. GRAHAM], for himself, Mr. MILLER, Mr. KENNEDY, and Mr. CORZINE, proposes an amendment numbered 4309.

Mr. GRAHAM. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

AMENDMENT NO. 4310

(Purpose: To amend title XVIII of the Social Security Act to provide for a medicare voluntary prescription drug delivery program under the medicare program, to modernize the medicare program, and for other purposes)

Mr. HATCH. Madam President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Utah [Mr. HATCH], for Mr. GRASSLEY, for himself, Ms. SNOWE, Mr. JEFFORDS, Mr. BREAUX, Mr. HATCH, Ms. COLLINS, Ms. LANDRIEU, Mr. HUTCHINSON, and Mr. DOMENICI, proposes an amendment numbered 4310.

Mr. HATCH. I ask unanimous consent that further reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. GRAHAM. Madam President, this amendment represents the essence of S. 2625, which currently, in addition to those who cosponsored this amendment, has 29 other colleagues' sponsorship.

This legislation is designed to provide to American seniors affordable, comprehensive, and reliable universal prescription drug coverage. This coverage will be available to 39 million older Americans and disabled citizens who are covered by Medicare—citizens who voluntarily elect to participate in this new Medicare benefit. More than 2,750,000 of those 39 million live in my State of Florida and, as have citizens across America, been waiting year after year after year for Congress to finally deliver on the commitment that we have made to modernize Medicare through the provision of a prescription drug benefit.

When I made remarks on this issue on Tuesday of this week, I based those remarks on six principles that I believe should be the touchstone for an affordable, comprehensive universal prescription drug benefit for senior Americans. Let me briefly reiterate those six principles.

First, we must modernize the Medicare Program. We must bring Medicare into the 21st century. In my judgment, the provision of a prescription drug benefit is the single most important reform of the Medicare Program that we can make. Why is this benefit so central? Because in the 37 years since the Medicare Program was created, the practice of medicine has been fundamentally altered by the use of prescription drugs.

Prescription drugs have improved the quality of people's lives. They have reduced long recovery periods, and they sometimes can even avoid surgeries and disabling illnesses, such as strokes and heart attacks.

We must convert Medicare from a program which, since its inception in 1965, has focused on sickness. If you are sick enough to go to the doctor or to the hospital, Medicare will pay 77 percent, on average, of your costs. But if you want to maintain the highest level of health, which generally involves screening, early intervention, and prescription drugs to monitor the condition, Medicare will pay nothing.

Medicare must be converted from a sickness program to a wellness program if it is to serve the needs of senior Americans in the 21st century. That is the first principle.

The second principle is that beneficiaries must be provided with a real benefit. To be successful, this program must attract a wide variety of beneficiaries.

The program will be voluntary, so it must attract enrollment with reasonable and reliable prices and a benefit that pays off from day one. In this manner, we will be able to attract all seniors, from those who today have high drug needs to those who are healthy but might be concerned that they, too, could be struck down with a heart attack or other disabling condition.

If we are able to have a program that will attract that broad range of elderly in terms of their current state of health, then we will have a program that will be actuarially solid for years to come.

Seniors must be able to understand the benefit they receive. The coverage should be consistent, and seniors should receive that coverage without any unexpected gaps or omissions. In other words, it should operate as much as possible as the employer-provided coverage which they had during their working years.

The third principle is that beneficiaries must have choice. All Americans deserve choice in how they receive their health care. We must offer choice in who delivers their prescription drugs, which is why we must assure that each region of the country has an adequate number of providers of the prescription drug benefit. This will encourage competition, helping to keep costs down for seniors, as well as the taxpayers of the Medicare Program, and assure a sustainable prescription drug benefit for this and future generations of America's seniors.

Principle No. 4 is we must use a delivery system upon which seniors can rely. It must be a tried-and-true system, not an untested scheme that will turn older Americans into laboratory animals upon which to be experimented. We want to model our delivery system on what private sector plans have used and with what seniors are familiar.

Principle No. 5 is the program must be affordable. The reality is the majority of seniors live on fixed incomes. In my State of Florida, where many people have the idea that all or most of the seniors live at a level of luxury, the median income of our 2,750,000 seniors is $13,982 a year, and 770,000 seniors in our State live on incomes below 150 percent of poverty.

These fixed-income seniors need a prescription drug benefit that has a low premium, that does not require a deductible, has reasonable copayments that are easy to calculate, and will avoid wide variations from month to month in their coverage.

Finally, principle No. 6 is we must have a fiscally prudent program. We must find that balance between giving seniors what they need, that balance between a realistic assessment of what prescription drug costs are likely to be over the next 10 years for our seniors, and, finally, the balance of what our overall Federal budget will allow.

The Graham-Miller-Kennedy-Corzine amendment meets these six criteria. As a result, it has the support of the major organizations that represent America's seniors, including AARP.

I ask unanimous consent to print in the RECORD eight letters of support of this legislation.

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

AARP,
NATIONAL HEADQUARTERS,
Washington, DC, June 12, 2002.

Hon. BOB GRAHAM,
Hon. ZILL MILLER,
U.S. Senate, Washington, DC.

DEAR SENATORS: We are pleased to restate our position on your revised Medicare prescription drug proposal. Action on a bipartisan prescription drug benefit is a top priority for AARP, our members and the nation.

Medicare beneficiaries have waited long enough for access to meaningful, affordable prescription drug coverage. We know from our membership that in order for a Medicare prescription drug benefit comprehensive coverage it must include:

An affordable premium and coinsurance;

Meaningful catastrophic stop-loss that limits out-of-pocket costs;

A benefit that does not expose beneficiaries to a gap in insurance coverage;

Additional assistance for low-income beneficiaries; and

Quality and safety features to curb unnecessary costs and prevent dangerous drug interactions.

AARP supports your initiative to incorporate these goals. We commend you for including key elements in your proposal that Medicare beneficiaries and our members have indicated they find valuable. For instance, your proposal includes a premium that many Medicare beneficiaries view as affordable and a benefit design that does not include a gap in insurance coverage. Your proposal also now includes co-payments specified as dollar amounts, an approach that our research shows our members prefer to coinsurance. In our view, this plan could provide real value to beneficiaries in protecting them against the high costs of prescription drugs.

It is important that any prescription drug benefit be made a permanent and stable part of Medicare, and we want to work with you to achieve this before enactment.

Thank you for your leadership on this issue. We look forward to working with you and your colleagues as the legislation moves forward. AARP will continue to urge Congress to work in a bipartisan manner to enact affordable, meaningful Medicare prescription drug coverage.

Sincerely,

WILLIAM D. NOVELLI,
Executive Director and CEO.

GENERIC PHARMACEUTICAL ASSOCIATION,
Washington, DC, June 12, 2002.

Hon. BOB GRAHAM,
524 Hart Senate Office Building, Washington, DC.

DEAR SENATOR GRAHAM: On behalf of the Generic Pharmaceutical Association (GPhA), we would like to commend you and Senators Miller and Kennedy for your leadership in introducing legislation to create a Medicare prescription drug benefit for our nation's seniors. We agree with you that the passage and enactment of a voluntary Medicare prescription drug benefit is long overdue. We are strongly supportive of your innovative tiered co-pay structure, as well as the other provisions advocated by you and your colleagues, that are designed to increase the utilization of high-quality, affordable generic medicines.

Generic pharmaceuticals have a proven track record of substantially lowering drug costs. Studies have shown that for every 1 percent increase in generic drug utilization, consumer, business, and health plan purchasers save over $1 billion. The increased use of generics can play an invaluable role in helping Medicare, Medicaid, the Federal Employees Health Benefit Plan (FEHBP) and other Federal and private plans assure that beneficiaries have access to quality, affordable medications. A tiered co-pay system with a significant differential between brand and generic pharmaceuticals will ensure an appropriate incentive is in place for seniors to consider more cost-effective options when making choices about pharmaceutical therapies. We believe an explicit dollar co-pay will also provide seniors with the comfort of knowing they will pay a fixed cost to have their prescriptions filled.

With your leadership, the Graham/Miller/Kennedy bill employs a number of private sector best practices that are now widely used to assure access to cost-effective, quality affordable medications. These provisions not only encourage the appropriate and beneficial use of these products, but provide unbiased and greatly needed educational information to the public about the benefits of these medicines.

The Graham/Miller/Kennedy bill adheres to GPhA's principles for creating a Medicare prescription drug benefit and steers the Medicare reform debate down a prudent public policy path. We look forward to working with you, your cosponsors and with other Members of the House and Senate of both parties to further our common objective of providing our nation's nearly 40 million Medicare beneficiaries and the taxpayers who help support them with the most affordable and highest quality prescription drug benefit possible. If the rest of the Congress and the Administration follow your lead in recognizing the role generics must play in reaching this objective, we are confident we will achieve this goal.

Thank you again for your efforts. If we can be of any assistance to you, please do not hesitate to call.

Sincerely,

KATHLEEN JAEGER,
President and CEO.

THE NATIONAL COUNCIL ON THE AGING,
Washington, DC. June 11, 2002.

Hon. BOB GRAHAM,
524 Hart Senate Office Building, Washington, DC.

DEAR SENATOR GRAHAM: On behalf of the National Council on the Aging (NCOA)—the nation's first organization formed to represent America's seniors and those who serve them—I write to commend and thank you for your proposal to provide meaningful Medicare prescription drug coverage to America's seniors. The Medicare Outpatient Prescription Drug Act of 2002 is consistent with the principles supported by the vast majority of organizations representing Medicare beneficiaries. It provides the foundation for a vehicle that we hope can achieve bipartisan consensus on this issue this year.

NCOA is particularly pleased that your legislation would provide prescription drug coverage that is universal, voluntary, reliable, and continuous. Other proposals being offered include significant coverage gaps and would fail to solve the problem. Under such bills, a significant number of beneficiaries would not want to participate in the program, and many of those who do participate would continue to be forced to choose between buying food and essential medicines.

We commend many of the modifications you have made to your Medicare bill from last year. These improvements include a significantly lower premium, the option to provide a flat copayment, an earlier effective date, and assistance with the very first prescription. We believe these changes will make the coverage affordable and attractive to the vast majority of beneficiaries, which is so critical to making a voluntary prescription drug program work. While we have concerns about the need to reauthorize the program after 2010, we understand the budget trade-offs needed to provide meaningful and attractive coverage, and fully expect that the Congress would reauthorize the program.

NCOA is also pleased that your proposal does not include price controls and that the

program would promote stability and efficiency through administration by multiple, competing Pharmacy Benefit Managers (PBMs), using management tools available in the private sector in which PBMs would be at risk for their performance, including effective cost containment.

NCOA deeply appreciates your efforts to move this critical debate in a direction that guarantees access to meaningful coverage—even in rural and frontier areas of the country—and responds in a constructive manner to many of the specific concerns that have been raised regarding other Medicare prescription drug proposals.

It is impossible to have real health security without coverage for prescription drugs. Prescription drug coverage is the number one legislative priority for America's seniors. Virtually every member of Congress has made campaign promises to try to pass a good prescription drug bill. The time has come to get serious and to work together to achieve consensus on the issues in controversy. Your proposal provides us with an excellent starting point.

NCOA looks forward to working on a bipartisan basis with you and other members of Congress to pass legislation this year that provides meaningful, continuous, affordable prescription drug coverage to all Medicare beneficiaries.

Sincerely,

JAMES FIRMAN,
President and CEO.

FAMILIES USA,
Washington, DC. June 13, 2002.

Senator BOB GRAHAM,
524 Hart Senate Office Building, Washington DC.

DEAR SENATOR GRAHAM: We congratulate you and Senators Miller, Kennedy and Rockefeller on the introduction of your bill, ''The Medicare Outpatient Prescription Drug Act,'' which provides prescription drug benefit for Medicare beneficiaries.

This is an issue of utmost important to all Americans who need prescription drugs, especially to seniors and people with disabilities. As you well know senors' ability to afford prescription drugs is a particularly difficult problem today. In our 2001 report entitled, ''Enough to Make You Sick: Prescription Drug Prices for the Elderly, ''we concluded that the 50 top drugs used by seniors rose 2.3 times the rate of inflation between 2000 and 2001. We are in the process of updating this report for last year, and our preliminary data shows that this devastating rate of price increases continues. Millions of seniors have limited income and no, or limited, drug coverage and will find themselves deciding whether to buy drugs or pay for other essentials.

Your bill addressees many important design issue that we care about in a Medicare prescription drug benefit. The benefit is universal, comprehensive, and is delivered through the Medicare program, ensuring that seniors know it will be available to them when it is needed. Low-income people get extra assistance. Also, there are provisions to assure that costs will be contained and quality maintained.

Please let us know how we can assist you to move this bill toward enactment so that all Medicare beneficiaries can have access to the prescription drugs they need.

Sincerely,

RONALD F. POLLACK,
Executive Director.

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE,
Washington, DC. June 12, 2002.

Senator BOB GRAHAM,
Senate Hart Office Building 524, Washington, DC.

DEAR SENATOR GRAHAM: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I write in support of your Medicare prescription drug legislation that will provide much needed relief to seniors. Your bill contains all of the elements that seniors need in a comprehensive drug benefit under Medicare, such as universal, voluntary, affordable, not means tested and most importantly, with a defined benefit, so that seniors can plan accordingly. Prescription drugs prices are increasing over 17% per year (faster than inflation) and seniors are spending more on out-of-pocket drug expenditures than ever. The time is now to enact a drug benefit that will provide the Medicare beneficiary with some assistance.

We are pleased that your plan would be available for seniors, no matter where they live. Our members have expressed to us that a prescription drug benefit must be affordable. We believe that a plan such as yours, with no annual deductible and a $4,000 cap on out of pocket expenditures, is reasonable and one that most seniors would be able to afford.

We applaud you for your leadership in this area. Please let me know how we can further support your efforts.

Sincerely,

BARBARA KENNELLY,
President.

AFSCME®,
AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL–CIO,
Washington, DC, June 12, 2002.

Senator EDWARD KENNEDY,
Senator BOB GRAHAM,
Senator ZELL MILLER,
U.S. Senate, Washington, DC.

DEAR SENATORS: On behalf of the 1.3 million members of the American Federation of State, County and Municipal Employees (AFSCME), I am writing to express our support for the Medicare prescription drug benefit proposal you unveiled today.

AFSCME has long supported the creation of a Medicare prescription drug benefit that is comprehensive in coverage, affordable and voluntary for all Medicare beneficiaries. We believe that your proposal is a solid step forward in meeting these standards.

In particular, we applaud your proposal's provisions for continuous coverage. We believe that it is one of the most critical components of a meaningful prescription drug benefit. Beneficiaries must have coverage they can count on, with no gaps in coverage. Doing anything less would force our seniors to pay all prescription costs out of their own pocket when they will need the coverage the most.

Since Medicare was started over 35 years ago, many illnesses that were once only treatable in a hospital can now be effectively treated with prescription drugs. Adding a drug benefit to the program is the most urgently needed Medicare reform. We applaud you for not holding the prescription drug benefit hostage to force radical privatization proposals that would cut benefits and increase costs for retirees.

We look forward to working with you and the other sponsors of this important legislation. A Medicare prescription drug benefit is long overdue, and our nation's seniors deserve no less.

Sincerely,

CHARLES M. LOVELESS,
Director of Legislation.

LEGISLATIVE ALERT

AMERICAN FEDERATION OF LABOR AND,CONGRESS OF INDUSTRIAL ORGANIZATIONS,
Washington, DC, June 12, 2002.

Hon. BOB GRAHAM,
U.S. Senate, 524 Hart Senate Office Building, Washington, DC.

DEAR SENATOR GRAHAM. On behalf of the 13 million members of the AFL–CIO, I am writing to commend you for your efforts to provide much-needed relief to Medicare beneficiaries. Your proposal to create a voluntary drug benefit within the Medicare program represents an encouraging and solid step toward enacting the one reform most urgently needed for Medicare.

Seniors need a real benefit that provides comprehensive, continuous and certain coverage. The Graham-Miller-Kennedy bill provides that benefit, giving seniors coverage they can count on. A Medicare drug benefit must also be affordable for beneficiaries. The $25 monthly premium and zero deductible in your proposal means seniors need only pay an affordable premium to begin getting coverage immediately. And no senior will have to pay more than $40 for the drugs they need and often will pay less.

In addition, your proposal would not put at risk those retires who currently have some prescription drug coverage through an employer. Retiree heath care is the primary source of prescription drug coverage for seniors, and your proposal rightly provides from relief for employers that choose to continue that coverage.

A proposal widely reported under consideration by House Republican leaders offers only unreliable, expensive and unworkable coverage through private plans, with an enormous gap in coverage that leaves seniors without any coverage at all for drug costs between $2000 and $4500. And the only relief for employers is if they drop the coverage they now offer. Such a proposal will not move us any closer to a real benefit.

As this debate moves forward, we want to work with you and your co-sponsors to enact the best possible Medicare drug benefit. We appreciate your role in advancing that process.

Sincerely,

WILLIAM SAMUEL, *Director, Department of Legislation.*

ALLIANCE FOR RETIRED AMERICANS,
Washington, DC, June 12, 2002.

Senator EDWARD M. KENNEDY,
U.S. Senate, Washington, DC.

DEAR SENATOR KENNEDY: On behalf of the over 2.7 million members of the Alliance for Retired Americans, I want to thank you for your tireless work on behalf of older and disabled Americans to create a Medicare prescription drug benefit program. I also want to express our views on the Medicare prescription drug legislation proposed by you and Senators Graham and Miller. The Alliance supports this proposal as a positive step forward in the effort to create a Medicare prescription drug benefit program.

The Alliance for Retired Americans believes that all older and disabled Americans need an affordable, comprehensive, and voluntary Medicare prescription drug benefit now. Such a benefit program should have low monthly premiums, annual deductibles, and be administered as part of the Medicare program. Your proposed legislation meets these Alliance principles. Unlike other proposals that would begin in 2005, your plan would start in 2004, which gives beneficiaries the coverage they need a full year earlier.

The Alliance will work to enact your legislation. During legislative deliberations, the Alliance will seek to improve benefits because we believe that an 80/20 co-insurance

payment system, like the rest of Medicare, will provide the best benefits for older and disabled Americans. The Alliance also supports a $2,000 annual catastrophic cap. We will continue to work to improve any legislation that moves through Congress in order to reach these goals.

Older Americans will spend $1.8 trillion on prescription drugs during the next decade. The inflation rate for prescription drugs will continue at an annual double digit pace as well. Our members and indeed all Americans simply cannot afford these costs. We look forward to working with you and Senators Graham and Miller to enact a comprehensive Medicare prescription drug benefit as soon as possible.

Sincerely yours,

EDWARD F. COYLE
Executive Director.

Mr. GRAHAM. Madam President, what does our plan provide? Our plan will require of seniors who voluntarily elect to participate a $25 monthly premium to do so. There will be no deductible. There is an easy-to-understand copayment system, which is $10 per prescription for generic medication and $40 per brand name, medically necessary drug.

I will pause at this point and point out the connectedness of this plan and this structure of benefits to the underlying legislation we have been discussing throughout the week to make it easier for all Americans to gain access to generic drugs.

Our legislation has a strong incentive for the use of generic drugs by having the $10 copayment for generics, $40 for brand names. To the extent that more generics are available, which, of course, is the purpose of the underlying bill, we will reduce the cost of this program and make it even more affordable to senior Americans.

We set a maximum out-of-pocket expense of $4,000 per year. Above that, all of the senior's drug cost, including copayments, will be covered. This is the so-called catastrophic coverage.

Seniors with incomes below 135 percent of the poverty level will pay no premiums, and beneficiaries with incomes between 135 and 150 percent of poverty will pay reduced premiums. We want all senior Americans to be able to participate in this program.

Our plan uses the same delivery model that America's private insurance companies utilize. It happens to also be the same model used by the Federal Employees Health Benefits Plan, a plan that covers virtually everybody in this Chamber.

We use pharmacy benefit managers, or PBMs, to deliver and manage prescription drug benefits, just as they do in virtually every major private and public sector employee health insurance plan. PBMs are companies that negotiate with pharmaceutical companies to get discounted prices based on their volume purchase.

We would allow all seniors a choice of which PBM to join. This would give choice to seniors, and it would give them the opportunity to shop among the PBMs that are competing for their business so that they, the senior, can decide which PBM best meets their particular needs, including factors such as the availability of mail order delivery and access to local pharmacies.

PBMs would be accountable to the Medicare Program and to all taxpayers. They would be required to demonstrate their ability to keep costs down through effective purchasing practices and provide quality service in order to win and keep a Government contract.

CBO has given us an estimate of our plan today. CBO estimates that our plan through the year 2010 would cost $421 billion. Taking into account, in addition to the base cost, the benefits that would flow by the adoption of the underlying generic bill, that figure is reduced to $407 billion through the year 2010.

That date is important because part of our legislation is a required reauthorization by the Congress in 2010. In much the same way as we are now reauthorizing Welfare to Work after it has been in place for 6 years, we would require the reauthorization of this prescription drug benefit so we can take into account the experience we will have gained and make an assessment as to what kind of prescription drug benefit we want to carry into the future.

If the program is extended, then the 10-year cost of the plan through the year 2012 would be an additional $173 billion.

Because this prescription drug benefit would represent the largest expansion of the Medicare Program in its 37-year history, we believe it is important for Congress to review the program to see how well it is working and whether it has given seniors the coverage they need.

Madam President, our good friend and colleague from Utah has introduced legislation which has a similar objective to the one we are proposing; that is, to assure that seniors would have access to a comprehensive, universal, affordable prescription drug benefit.

I have comments to make about the plan which has been introduced. I will defer those comments, however, until Monday.

To conclude tonight, I want to say we are still hearing the background noise that all of this is theater, that there is no real commitment to passing a prescription drug benefit in the year 2002, as there was not in 2001, 2000, and on for the many years which seniors have been promised by different people seeking office that if elected they would deliver on a prescription drug benefit.

What we are committed to today—and I believe this feeling also carries to my good friend from Utah and those who have joined him in his legislation—is we are not interested in election year posturing. We want to actually accomplish a result. We want to be able to say to our senior Americans, we have turned the corner. No longer are you participating in a sickness program, but you are now participating in a program which has as its primary commitment assuring that all senior Americans can live in the highest state of good health.

Our Nation's seniors have waited too long for the help they need to purchase their prescription drugs. An unconscionable number of these people are forced every day to choose between filling a doctor's prescription for a needed medication and paying for other basic needs. These people are not numbers in a statistical database. They are not strangers. These people who have been waiting and waiting are our parents and our grandparents. They are our neighbors. They are the people we used to work with. They are our friends. They are the Americans of the great generation.

We now have a challenge, an opportunity, a responsibility to respond to this great need that they have of some assistance in paying for what has become the fastest growing segment of our health care costs—prescription drugs. If we do not act on the prescription drug benefit this year, I fear the American people will lose confidence in the Congress and our ability to make the tough choices necessary to address our country's priority domestic issues.

Certainly, I do not claim that our bill is perfect, but I do suggest that it is as good as our collective efforts have been able to make it at this point. I believe this amendment justifies the support of our colleagues, as it has already received the support of virtually every major organization which represents the interests of America's seniors.

So I look forward to a full discussion and debate in the best tradition of this great deliberative body. I hope at the end of that debate we not only will have a better understanding of the options before us, but we will have reached a conclusion that will command the votes of a sufficient number of Members of this Senate that we can tell our senior constituents we have heard their long call for assistance in paying the costs of increasingly expensive prescription drugs; that we understand the importance of that call, and that we are now responding to that call. That is the challenge and that is my hope of what will be the conclusion of this debate.

The PRESIDING OFFICER (Mr. DAYTON). The Senator from Utah.

Mr. HATCH. I want to express my appreciation to my colleague from Florida. He is an eminent member of the Senate Finance Committee. He is a very serious, reflective Member. He has worked hard to come up with his bill. I respect him for it, and I wish him well with it. However, I will say a few things about Senator GRAHAM's bill before I finish.

Tonight, I introduced an amendment that is called the tripartisan bill. I introduced it on behalf of Senator GRASSLEY for himself, Senators SNOWE, JEFFORDS, BREAUX, COLLINS, LANDRIEU,

HUTCHINSON, DOMENICI, and myself. We believe this tripartisan bill is the only nonpartisan bill being considered by the Senate at this time. It is a very important effort by people of goodwill on both sides and, of course, the only Independent in the Senate.

I want to take this opportunity to talk a little bit about the tripartisan bill. Many of these points were raised two nights ago, when I spoke on the Senate floor about our tripartisan proposal. Tonight, I will raise them again because I believe that all of them are extremely important and worth listening to again.

While drafting this legislation, we tried to reach out to everyone who has an interest in this issue. We have taken this very seriously, and we have worked on it for well over a year. This has required many hours of meetings, among all of the sponsors of the bill and our staffs along with other interested parties. Let me assure everyone that this has been a unified effort, one which has required some give and take from all of us.

We have worked with CBO to come up with a cost-efficient solution. The Congressional Budget Office has told us that our bill will cost $370 billion over 10 years. As far as I know, the Daschle-Graham-Miller bill, S. 2625, does not have a CBO score, but I suspect that it is extremely expensive. The distinguished Senator may have some idea of what that score is because he has indicated that the amendment that he just introduced will cost around $600 billion, if I understand it, over 10 years. The prescription drug program in the Graham legislation would include a sunset at the end of 2010, which is one of the problems with this legislation.

On the other hand, there are no sunsets within our bill. Our tripartisan bill is a permanent solution, not a temporary solution. CBO informs us that once our bill is implemented, 99 percent of all seniors will have drug coverage. That would be truly remarkable. And that is CBO, not us.

Again, this is a nonpartisan approach to providing prescription drugs to Medicare beneficiaries. On the other hand, the Daschle-Graham-Miller bill sunsets after 2010. So in my opinion, that bill is only a temporary solution.

Does a temporary solution truly help seniors in the long run? I do not think it does. Our tripartisan bill provides all Medicare beneficiaries with affordable prescription drug coverage because we let competition determine the prices, not Government bureaucrats. That is how we keep prices of drugs down. It is not a good idea to let the Government set the price, which is what I predict will happen if the Daschle-Graham bill becomes law.

We also provide additional subsidies to low-income seniors so they, too, can afford to pay for their drugs. I find it absolutely appalling that there are people in our country who have to choose between buying food and eating, and having prescription drugs. The tripartisan group's goal is to put an end to that. Through our bill, we will provide additional assistance to those seniors who need it. For example, the 10 million beneficiaries with incomes below 135 percent of poverty will have 95 percent of their prescription drug costs covered by this plan with no monthly premium. They will not have to pay a monthly premium. In addition, these seniors are exempt from the deductible and will pay well under $5 for their brand name and generic prescriptions. Finally, these beneficiaries who reach the catastrophic coverage limit will have full protection against all drug costs, with no coinsurance.

The 11.7 million lower income beneficiaries with incomes below 150 percent of the poverty level are also exempt from the $3,450 benefit limit. Enrollees between 135 percent and the 150 percent of the Federal poverty level will also receive a generous Federal subsidy that on average lowers their monthly premium to anywhere between 0 and $24 a month. The beneficiary's monthly premium will be based on a sliding scale, according to his or her level of income.

It also cuts in half their annual drug bills. All other enrollees will have access to discounted prescriptions after reaching the $3,450 benefit limit and a critically important $3,700 catastrophic limit which protects seniors from high out-of-pocket costs. It is also important to note that 80 percent of Medicare beneficiaries will never experience a gap in coverage.

Let me take a few minutes before we finish this evening to talk about my views on S. 2625, the Daschle-Graham-Miller Medicare Outpatient Prescription Drug Act of 2002. I understand that a new Graham bill has been filed and we are currently reviewing the details. We have not been able to review it very thoroughly, but we have a quick preview of it, and perhaps I can express my thoughts this evening just so people will have something to consider over the weekend.

Again, I commend my good friend, a person I admire greatly, Senator BOB GRAHAM, for his bill. I know he has worked hard. I know he has tried his best. I know he is representing his people in Florida very well and he has worked long and hard on this issue. I respect him for that. I respect him personally. He knows that. He, like those in the Senate in the tripartisan group, has the same goal: To provide Medicare beneficiaries with prescription drug benefits. But that is where the similarities end.

My biggest concern with the new version of the Daschle-Graham bill is still the cost. My understanding is that this bill costs close to $600 billion, over a 10-year period. We all agree a Medicare drug proposal will cost a lot of money, but the Daschle-Graham-Miller bill is, in my opinion, too expensive to both current and future generations because of the magnitude of its costs.

And bear in mind, this bill is still not a permanent program. It sunsets. It sunsets after 2010, which makes it a less than 10 year benefit for approximately $600 billion. That is if I am right on the scoring. I believe having the sunset on such an important bill just to get a decent score from CBO is not being as fiscally responsible as I would like to be. I understand there is some window-dressing language that attempts to address the sunset, but to me that is all it is—window dressing.

Having said that, I am absolutely astounded that the AARP has come out and ask its members to support a bill that does not have a permanent benefit. That is just irresponsible on the part of the AARP. They are, in my opinion, not looking out for the best interests of seniors by asking their members to support this type of a bill. I am very disappointed in the AARP for making what I believe is a poor judgment call.

Again, one of my top concerns with the both versions of the Graham bill is the cost. It is not going to get better as drugs become more expensive and more and more baby boomers retire. I remind my colleagues, our Government is in a Federal deficit. Figures from last week reveal that the Federal deficit could be as high as $150 billion for fiscal year 2002. Passing a bill that I believe could cost well over $600 billion over 10 years is going to increase our deficit. That is, in my opinion, a step in the wrong direction.

The new Graham bill is still a one-size-fits-all bill that very well could lead to having the Federal Government set drug prices, although I know that is not the intention of my dear friend and colleague from Florida. That is, in my opinion, the wrong direction, as well. And why on earth should the Federal Government be making coverage decisions for seniors? I trust senior citizens to make their own decisions about their health coverage. Apparently, the authors of the Daschle-Graham-Miller bill do not agree and that is why they continue to put the Government in charge.

I look forward to the debate on Monday where we can discuss these issues more fully. If I am wrong on some of these suggested interpretations of my friend's bill, I would like him to set me straight on Monday when we debate this bill even further. I would like to know why anybody believes a sunset is necessary. That means the drug benefit ends. I hope we will have a CBO cost estimate we may review regarding the Graham legislation.

Again, I wish to point out that I continue to be concerned that under both versions of the Daschle-Graham legislation, the drug benefit is run by the Federal Government. I don't think that is a good idea, to let the Government run a drug benefit because the Government will end up setting prices for drugs. Keep in mind, Canada sets prices for drugs, and where is their pharmaceutical industry today? They have to look to us because we do not set prices for drugs and we have a competitive

system. Yes, some say it has flaws, but it is the best in the world, bar none. Frankly, with whatever flaws there are, we should be very proud of the system we have in our country.

In the tripartisan Medicare drug bill, we allow Medicare beneficiaries to make choices for themselves. They decide whether or not they want drug coverage. As I mentioned earlier, we allow Medicare beneficiaries to choose from at least two drug plans, and it maybe more, but at least two, competing plans, allowing them to select a plan that best suits their own personal needs.

Another difference between the Daschle-Graham bill and our Tripartisan bill is that we include reforms to the Medicare program and they do not. The current Medicare benefit package was established in 1965. While the benefits package has been modified occasionally, it now differs significantly from the benefits offered to those in private health plans. Our plan gives seniors a choice in their Medicare coverage seniors may remain in traditional Medicare or they may opt for the enhanced Medicare fee for service option which is similar to private health insurance. We do not force seniors to enter into the new enhanced fee for service plan. It is just an option. If beneficiaries want to stay in traditional Medicare that is fine.

We need to give seniors choices concerning their health care coverage. Seniors must be given improved health care choices through the Medicare program. It is extremely unfortunate that the Daschle-Graham-Miller bill does not recognize that the Medicare program needs to be improved so seniors can take advantage of the benefits that are offered by private health insurance. Keep in mind, our bill only costs $370 billion as scored by the Congressional Budget Office. Yet we still reform Medicare in addition to providing high quality prescription drugs to our people. There is nothing in the Daschle-Graham-Miller bill to improve the Medicare program. It just tacks on a prescription drug program and ignores the larger problem. Medicare beneficiaries deserve better.

Senator BREAUX deserves an awful lot of credit for our bill in this area. He has wanted to reform Medicare for a long time and has come close from time to time. This is the best opportunity to do it. I think he sees the value of what we have tried to do. He not only sees it, he helped implement it.

The larger problem is the overall Medicare benefits package which is outdated, inefficient and it does not provide seniors with decent health care options. Let me give you an example. Today, Medicare beneficiaries do not have any serious illness protection. Beneficiaries who are seriously ill end up paying a lot of money out of pocket for their health care coverage each year. In our Tripartisan legislation, if a beneficiary is covered under the new enhanced fee for service program, once that beneficiary reaches a catastrophic limit of $6000, the Medicare program pays 100 percent of any costs incurred by the Medicare beneficiary. I feel that is only fair. Those Medicare beneficiaries with serious health conditions should be offered a choice in benefit coverage so if they want serious, illness protection, they may have it. The Graham-Daschle-Miller bill does nothing to assist Medicare beneficiaries in these types of situations. The Daschle-Graham-Miller bill's answer is to provide seniors with a government-run prescription drug benefit that is extremely expensive, and, isn't even permanent. That just is not enough.

These issues that I have raised about the Daschle-Graham-Miller should have been debated by the Finance Committee. I admit the issues we have raised by the Tripartisan bill should have been debated by the Finance Committee. Who knows, maybe we could have come to some resolution. Maybe the authors of the Tripartisan bill and the Daschle-Graham-Miller bill could have come to some agreement through the Committee mark-up process. Maybe not. Sadly, we will never know because the majority leader wouldn't even give us an opportunity to mark-up a prescription drug bill in the Finance Committee.

I have been here for 26 years and, trust me, it is rare for the full Senate to be considering such an important bill before it is even considered by the Committee of jurisdiction. I am bitterly disappointed at how much the Senate has changed.

At the beginning of the 107th Congress, we all talked about working together in a bipartisan spirit because that is truly what the American people want from us. What happened to that bipartisan spirit? Why are we on the floor debating a bill that will affect the lives of over 33 million Medicare beneficiaries and millions of future beneficiaries without a Finance Committee mark-up? I just do not understand why members of the Finance Committee were not even given that opportunity and, in fact, completely excluded from the process, other than that we can file whatever bill we want to, which we have done.

I want to do everything I can to pass a Medicare prescription drug bill into law this year. But it appears that election year politics are more important than passing a well-thought out prescription drug bill which is extremely unfortunate.

I stand ready to work with my colleagues so that we can provide affordable prescription drug coverage to our Medicare beneficiaries this year. We need to have Medicare available for today's seniors, our children and our grandchildren. So let's stop playing politics and start working on getting a Medicare prescription drug bill signed into law this year. I have no doubt if the distinguished Senator from Florida and I could sit down together we could just work it out—I have no doubt about that. Unfortunately, it has gotten embroiled in some political aspects.

Again, I call attention to the tripartisan bill which has Democrats, Republicans, and the sole Independent. I believe that bill literally could provide an affordable drug benefit for Medicare beneficiaries, although it is still expensive. It could do what we really need to have done—not only on the prescription drug benefit aspect of this matter but also on the Medicare reform as well—and Medicare+Choice as well. To me, that is very important.

I look forward to working with my colleague from Florida and others on the floor and hope we can come to a resolution this year, so the millions of American citizens will have the benefits that we really should be delivering to them and which they need and which are right and just.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. Mr. President, as I indicated, I restricted myself this evening to discussing the essence of our proposal and what I think are the six principles against which every proposal should be evaluated. I defer until Monday a close evaluation of the legislation that has been introduced by our good friend from Utah and others. One of the things I do not want to do is to create a poisoned environment which will make it difficult, if not impossible, to do what I think seniors want, which is to arrive at a reasonable compromise that will provide them with a prescription drug benefit.

They have heard us too many times, as candidates, place in their living rooms on their television screens ads that pronounce our commitment to a prescription drug benefit for senior Americans.

Now is the time to deliver. I recognize that in a democracy that means we have to have at least a majority, and probably under the rules of the Senate not just a majority but three out of every five Senators be prepared to vote for a single piece of legislation.

Therefore, I reach my hand out across the aisle to two of my favorite colleagues, the Senator from Utah, who is now being joined by the Senator from Iowa, with whom I worked on many issues in the past, to say we look forward to engaging in that compromise.

I do want to have printed in the RECORD, and I ask unanimous consent to do so, the CBO estimate of our bill.

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

Democratic Drug Bill—Preliminary CBO Estimates

[In billions of dollars]

Full Score (2005–12)	
Gross estimate	594
Score with % drug reduction from GAAP[1]	584
Score with Federal GAAP savings[2]	576
Score with Contingency (2005–10)	
Gross estimate	421

Score with % drug reduction from GAAP[1]	415
Score with Federal GAAP savings[2]	407

[1] CBO estimate of Democratic drug bill assuming lower drug prices for Medicare beneficiaries that would result from enactment of the GAAP bill (S. 812).

[2] Estimate of Democratic drug bill assuming lower drug prices for Medicare beneficiaries that would result from enactment of the GAAP bill (S. 812) and savings from lower costs associated with prescription drugs that the government current pays for under the Medicaid, veterans, and other programs.

Mr. GRAHAM. Mr. President, the estimate of our bill is that, in conjunction with the underlying generic drug bill, if that passes and makes generic drugs more available, our bill, which would only charge a $10 copayment for generic drugs as opposed to a $40 copayment for brand name drugs—our bill would have a cost over the next 8 years of $407 billion—not $600 billion, or $800 billion, or, as some have even said, $1 trillion—and over the next 10 years would have a cost of $576 billion.

I might point out that this is the same program for 8 years that will cost $407 billion, and for 10 years will cost $576 billion.

That differential is a reflection of how significant two factors are: One, inflation of prescription drug costs; and, second, the change in the demographics of Medicare beneficiaries.

I happened to have been born in 1936. I was 65 years old on November 9 of last year. I belong to the second lowest birth rate year in the 20th century. Only 1933 had a lower birth rate than 1936. Therefore, there are not very many people my age. We are not putting a particular demand on Medicare or on the Social Security Program. But, in 10 years, it will be the people who were born in 1946—not 1936—which was the beginning of one of the greatest demographic revolutions in America history.

We are going to begin to feel the impact of that revolution at the outer years of the 10 years. We are now calculating the cost of this program. It is my judgment that it is critically important that we now get started on this prescription drug benefit so that we can learn as much as we possibly can about what the implications are of delivery systems, of methods of providing benefits, and how to attract healthy, older citizens to participate in a prescription drug benefit—all the things that will be critical to the long-term stability of a prescription drug benefit. We need to start that process today when the demand is relatively low—not 5 or 10 years from now when the demand will begin to rapidly escalate.

We have before us two different visions of how to get to the same destination. The Senator from Utah has outlined a number of issues of concern to him. I look forward to having a full debate on Monday. Hopefully, we can frame each one of these issues, such as the relative benefits of using the Medicare system as a means of delivering prescription drugs, or delivering it through subsidized private insurance policies—the relative benefits of having what I call a ''defined benefit plan'' where seniors would know what they are buying as opposed to a defined contribution plan where there would not be that assurance.

Those are all legitimate issues for us to debate.

I suggest to my colleagues that they might take the time over the weekend to read the letters of endorsement from groups such as the AARP, which clearly has no interest other than representing the best interests of their millions of members—most of whom are part of this 39 million Americans who are Medicare participants because they are over the age of 65. There is no reason to suspect their motives, or that they have some hidden agenda other than what they think is in the interest of senior Americans.

I recommend reading their rationale for reaching the conclusion of their support for our proposal.

I conclude tonight with a sense of optimism. We have gotten further this week than we have gotten in a decade in terms of closure on providing our older Americans with a key but missing part of their health care coverage; that is, assistance with their prescription drug costs.

I hope next week we can complete this by the passage of a prescription drug bill recognizing that we have to negotiate with the House, and then secure final passage, and hopefully gather in the Rose Garden where I suspect that the President will, with great enthusiasm, be there to sign this bill into law and provide what America's older citizens have so long sought, an affordable, comprehensive, and universally available prescription drug benefit.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I am surely glad that this debate has begun. It is too bad we could not have started the debate on this bill on Monday or Tuesday of this week when the majority leader led us to believe that we would be doing nothing but prescription drugs until we got it done.

I am glad that we now have Senator GRAHAM's alternative before us.

I thank Senator HATCH, who took the position as manager, while I was on the CNN program just a few minutes ago, to introduce the tripartisan bill on my behalf. That bill is a comprehensive prescription drug bill that represents a year of hard work by dedicated members of the Finance Committee, the committee that has jurisdiction over Medicare.

We have Senator GRAHAM's bill that you have heard about tonight. Then we have this tripartisan bill. People wonder what the term ''tripartisan'' means. It means three Republicans, one Democrat, and one Independent in the Senate, but it also implies bipartisanship, or across-party cooperation that must be done to get any bill passed in the Senate.

Our legislation is called the 21st Century Medicare Act. It makes essential improvements to Medicare by adding the comprehensive prescription drug benefits, and a new Medicare fee-for-service option to the 1965 program. These are all first improvements in Medicare since it was introduced in 1965.

As I indicated to you, I have been honored to work with a top-notch group of Senators on this bill. That tripartisan group is OLYMPIA SNOWE, a Republican; JOHN BREAUX, a Democrat; JIM JEFFORDS, an Independent; and ORRIN HATCH, a Republican. The group has dedicated countless hours to this effort.

I must express my disappointment that the Senate Finance Committee has not had an opportunity to consider legislation as part of the committee process. I trust that Senator GRAHAM of Florida will feel the same way. However, the bottom line is America's seniors have waited too long—and too long already—for Medicare prescription drug coverage.

The House has acted in their fashion. The Senate must act as well. We cannot afford to waste a single day.

I look forward to debating this important issue over the next few days and hope that the same bipartisan spirit of cooperation and compromise that guided the tripartisan group over the last year to write this bill will guide all Senators in this Chamber to an agreement that will give long overdue help to our seniors.

Since the tripartisan bill is now introduced, since we have the Democrat version, and Senator GRAHAM's bill is introduced, and since there is some misunderstanding of the differences between the two, I will take just a little bit of time to go over those. I also will take just a little bit of time to express some differences between the bill that passed the House of Representatives because some people have alluded to that bill as something just exactly like the tripartisan bill, which it is not.

In regard to differences between Senator GRAHAM's proposal and the tripartisan proposal that I have offered, the first would be cost.

The sheer magnitude of Federal spending in the Senate Democrat bill—an amount that is obscured by a sunset provision that kills the benefit in 2010—threatens Medicare's long-term stability. As such, the Senate Democrat bill gives seniors temporary help, not a permanent entitlement.

By contrast, the Congressional Budget Office official estimate concluded that the tripartisan 21st Century Medicare Act totals $370 billion over 10 years, a figure that guarantees permanent, affordable drug coverage without breaking the Medicare bank.

There is also the issue of choice that separates the tripartisan plan from the Democrat plan. The Democrat plan relies on the Government to pick one standard prescription drug plan for over 40 million seniors with Medicare. The one-size-fits-all approach means seniors cannot shop for a prescription drug plan that best suits their needs.

Under the tripartisan 21st Century Medicare Act, seniors are guaranteed to have at least two competing prescription drug plans in their community, even in rural areas, using local pharmacies as well. Seniors will have the choice of picking plans on the basis of cost, benefits, and quality. All plans will be required to meet Federal quality standards and to provide a standard benefit package, or its actuarial equivalent, including a $3,700 cap on out-of-pocket drug expenses for seniors.

There is a difference in drug pricing. Because the Democrat plan is overly bureaucratic and excessively generous, that plan does nothing to curtail or even slow skyrocketing prescription drug costs. That is why it is essential that any new prescription drug benefit contain cost management controls that moderate growth in price.

While guaranteeing a comprehensive drug coverage for all citizens, the tripartisan 21st Century Medicare Act imposes reasonable cost-sharing obligations on beneficiaries and promotes competition among prescription drug plans. And with competition being promoted in the bill, that then leads to a better overall effect on drug prices. And that, again, is according to the nonpartisan Congressional Budget Office that does policy analysis and scoring for the Senate.

The other issue is affordability, affordability for seniors. Under the Senate Democrat plan, seniors face fixed copayment amounts that, in many instances, mean they will actually pay more for many of the most commonly prescribed drugs than they would under a system that gives prescription drug plans more flexibility to offer lower cost copayments.

That flexibility is a feature of the tripartisan 21st Century Medicare Act because it gives plans the freedom to offer copayments and deductibles that save seniors more money. Moreover, the tripartisan proposal has a lower average premium than the Democrat plan, and that would be $24. Again, this is according to a Congressional Budget Office estimate.

We have Medicare enhancements in the tripartisan bill that the Senate Democrat plan does not have because that plan leaves current Medicare as it is and simply dumps a massive entitlement expansion, which would be the prescription drug plan, into the old 1965 model.

The tripartisan 21st Century Medicare Act takes long overdue steps to strengthen and improve Medicare's basic benefit package. In addition to adding prescription drug coverage, the bill offers seniors a new enhanced option, including catastrophic protection and free—let me emphasize, free—preventive care; in other words, adopting the principle that an ounce of prevention is worth a pound of cure.

This entire enhanced option is voluntary. If seniors like what they have had since 1965, they do not have to sweat it. They do not have to do it. They can keep what they have. Even 50 years from now they will still have that same choice, but they can also have the enhanced coverage as well. So it is voluntary. And Medicare, as we know it today, will always remain available to seniors who prefer to keep what they have, if they like it.

Improvements are made to yet another coverage option. That coverage option exists today. Medicare+Choice plans are also included. Beneficiaries need not elect the enhanced option in order to have access to the drug benefit plan.

I will finish, then, with a short description of why what the House of Representatives passed has nothing to do with the tripartisan plan.

The tripartisan plan was adopted on principles and pricing and costs, the way the five of us decided to do it. For instance, the House bill has a higher average premium. This is according to the CBO estimate. The average premium under the House bill is $34 per month. The average premium under the tripartisan 21st Century Medicare Act is substantially more affordable, at just $24 per month.

We have a much better benefit. The House bill limits the initial prescription drug benefit to $2,000 before exposing seniors to a gap in coverage. The tripartisan 21st Century Medicare Act basic drug benefit is better and is richer than that in the House bill. Seniors will have drug coverage under the tripartisan plan worth 50 percent of their drug spending up to $3,450 after the deductible is met, and that is $1,450 more than what the House bill offers, even in its initial benefit.

We have greater protection for low-income seniors in this Senate version. The tripartisan 21st Century Medicare Act steps in to give more help to low-income seniors where the House bill does not. It provides full assistance with premiums and substantial assistance with cost sharing for seniors below 135 percent of poverty with no gaps in coverage. For seniors between 135 percent and 150 percent of poverty, assistance with premiums and cost sharing is provided on a sliding scale, also with no gaps in coverage. This critical additional coverage for our most vulnerable seniors is an important distinction that reflects the tripartisan commitment to universal, affordable drug coverage for all.

And then, lastly, I will speak about our enhanced option to which I have already referred. The House bill leaves the 1960s-style Medicare largely as it is today. It does provide $30 billion in additional funds to Medicare providers, but it does little to strengthen or improve Medicare's basic benefit package.

Rather than addressing provider payment issues, the tripartisan 21st Century Medicare Act addresses Medicare's benefit flaws. It offers seniors a voluntary enhanced option, including catastrophic protection, free preventive care, and better Medigap plans.

The new option would be offered alongside current fee-for-service Medicare and a strengthened Medicare+Choice. Seniors can keep what they have if they like it or choose the new option. In all three settings, access to affordable prescription drug coverage would be guaranteed.

I just mention the difference, that the House bill does not have a new and improved and modernized Medicare option that we have in the tripartisan bill.

(Mr. JEFFORDS assumed the Chair.)

Mr. GRASSLEY. Since the distinguished Senator from Vermont has now come to the chair to be the Presiding Officer of the Senate, it gives me an opportunity to say that this provision in the tripartisan bill, of improving Medicare, bringing Medicare from a 1965 model to a 21st century model, improving it beyond the prescription drug provisions, was very much a concern of the Senator from Vermont, the Independent member of the Senate, Mr. JEFFORDS. I thank him very much for his contribution to that.

It really has probably done as much for Medicare as the prescription drug provisions will, as we look to the day when we have baby boomers going into transition from their employer's health plans to Medicare. There will be a smooth transition if they choose the enhanced option; whereas all the other plans, including the Republican plan in the House of Representatives, including even the President's plan, Medicare will still be a 1965 model. And for baby boomers going from their modernized employer's health plan to the 1965 model of Medicare, if that is the only choice they had, it would not be a very good day for those baby boomers going into retirement.

It has been such a pleasure to work with Senator JEFFORDS on this whole package, but most importantly, to have his leadership on this part that deals with the enhanced option, the new and improved and strengthened Medicare.

Mr. KENNEDY. Mr. President, I ask unanimous consent to have printed in the RECORD this letter to Mr. Carl Feldbaum of the Biotechnology Industry Organization.

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

U.S. SENATE,
Washington, DC, July 18, 2002.

Mr. CARL B. FELDBAUM,
President, Biotechnology Industry Organization, Washington, DC.

DEAR MR. FELDBAUM: I was surprised to receive you letter of July 15, 2002, opposing S. 812. The Greater Access to Affordable Pharmaceuticals Act (the GAAP Act or Schumer-McCain). The record is abundantly clear that the pharmaceutical industry is exploiting loopholes in our Hatch-Waxman drug patent laws to block less costly generic drugs from coming to market. As our hearings revealed, these actions hurt millions of American patients who are burdened with rising health care costs.

The exciting new cures brought forward each day by America's biotech companies are paving the way for what I believe is the new

century of the life sciences, and I remain a proud champion of the biotechnology industry in Massachusetts and across the nation. It is important, therefore, as an industry concerned about the health of all Americans, for BIO to acknowledge the harm to American patients and consumers caused by today's Hatch-Waxman abuses. Clearly, collusive agreements between brand-name companies and generic companies to block cheaper generic drugs from coming to market do not serve the public interest. Similarly, patients are harmed when generic drugs are stymied year after year by unfounded patent evergreening for brand name drugs. I would strongly encourage BIO to be part of the solution to these challenges.

The Schumer-McCain legislation addresses these abuses and restores the balance intended under the Drug Price Competition and Patent Term Restoration Act of 1984 (the Hatch-Waxman Act). As your letter expresses concerns about the legislation, this letter describes in further detail the Committee's intent in addressing them,. The issues you raised include incorrectly listed patents or patent information with the Food and Drug Administration (FDA), use of patents to trigger multiple thirty month stays that delay effective approval of generic drugs, collusive agreements between brand and generic pharmaceutical companies to block subsequent generic applicants from gaining effective approval of their drug products and litigation attacking FDA's bioequivalence regulations that have delayed entry of generic versions of drugs.

THE 45 DAY PERIOD TO ASSERT PATENT RIGHTS

You express concern that a patent owner's rights will be forfeited under Schumer-McCain. I want to reassure BIO that this is not the case.

Section 4 of Schumer-McCain says that a patent owner that does not sue within 45 days of receiving notice that a generic drug applicant has challenged its patent will be barred from suing that generic drug later.

This provision provides the patent owner with the opportunity to protect its patent rights. It also clarifies those rights in relation to the generic drug product at issue if the patent is not defended, thereby enabling the generic drug product to be marketed immediately. The 45 day period may be thought of as a statute of limitations, and Congress has plenary authority to establish statutes of limitations for federally created rights such as patents. In addition, comparable periods of time for claiming or defending property rights have been upheld by the Supreme Court.

This provision does not eliminate the patent owner's rights against the generic drug applicant and its generic drug product. Rather, it specifies the time within which the patent owner must assert those rights against that applicant and its drug product.

I cannot overemphasize that the bar on enforcing the patent right under this 45 day rule applies only to the particular generic product of the particular generic company that has challenged the patent in its generic drug application. It does not affect the ability of the patent owner to enforce its rights with respect to any other generic company, or with respect to a licensee who strays beyond the bounds of a licensing agreement under which the patent owner has licensed use of the patent.

That being said, I also point out that the bar does protect downstream distributors of the particular generic drug product, such as wholesalers and pharmacies, as well as doctors and patients who will use the generic drug product for treatment.

ENFORCEMENT OF THE PATENT LISTING REQUIREMENT

Seciton 3 of Schumer-McCain says that a patent owner cannot enforce its patent against a generic drug company, or a person who manufactures, develops, uses, offsets to sell, or sells a generic drug, if the patent owner has failed to list the patent information at FDA. This provision provides an effective enforcement tool for a current requirement.

Drug companies are required currently to list patents at FDA, and I am not aware of any complaints about this requirement from the brand pharmaceutical industry. We understand that now companies generally comply with this requirement because patents can trigger 30 month stays of the effective approval of generic drugs.

As you know, however, Section 4 of Schumer-McCain limits 30 month stays to one per generic application, and on only certain patents. The Committee's concern was that limiting 30 month stays in this way reduces the incentive to list patents. We therefore concluded that we needed to provide an effective incentive for compliance with the current requirement to list patents at FDA. Otherwise, we were concerned about increased abuses of the listing requirement.

Currently, under section 505(e)(4) of the Federal Food, Drug, and Cosmetic Act (the FFDCA), FDA can withdraw a drug from the market if the patent information is not filed after the agency gives written notice of failure to file the information. FDA has never used this enforcement tool, and it would not withdraw a drug from the market for this reason when the drug presumptively is being used safely for treatment of patients by health care providers. I believe that Section 3 of Schumer-McCain provides effective enforcement of the FDA listing requirement.

Your letter raises the real concern about situations in which a patent is not listed, or the information is incorrect, because of an oversight or a clerical error. But Schumer-McCain addresses this problem as well.

Section 3 of Schumer-McCain allows FDA to extend the date for listing patents if there are extraordinary or unusual circumstances. An honest administrative or clerical error is clearly such a circumstance. Because FDA publishes patent information immediately upon receipt, the drug company and the patent owner can promptly check that patent information is published and that it is correct. If there is an error, or a patent was not listed, the error can be spotted quickly and immediately corrected. Accordingly, Schumer-McCain allows patent owners to avoid the consequences of the inadvertent failure to list a patent with the FDA.

THE CAUSE OF ACTION TO DELIST OR CORRECT A PATENT

Your letter also raised questions about the cause of action in Section 3 of Schumer-McCain to delist patents from FDA's Orange Book or to correct patent information. In particular, BIO is concerned that generic companies will bring these cases unnecessarily, to harass a drug company or patent owner. I do not believe that this will be the case.

A generic drug company must certify to the patents listed on a drug when it files a generic drug application. A generic company must do so even if it intends to seek the correction or delisting of a patent.

If a generic wants to delist a patent or correct information, it will likely chose to make a paragraph III certification to the patent, saying that the applicant does not contest the patent and requesting that its drug approval be made effective when the patent expires. The generic applicant will then sue to have the patent delisted or corrected.

If it wins, the patent is delisted, or the patent information is corrected so that the generic applicant may make a statement that the applicant is not seeking approval for a use claimed in the patent. In either case, no certification is necessary and the paragraph III certification essentially goes away.

Should the generic applicant lose a delisting case, however, it will have to recertify and challenge the patent under paragraph IV. This could trigger a 30 month stay, and at a minimum would delay the resolution of the patent issues involved. It is therefore my view that there are strong incentives for generic applicants to bring these delisting cases only when there is strong merit to the case. Because this is the case, it is difficult to argue that delisting cases will be either unnecessary or harassing.

To the contrary, in such cases, the delisting of a patent, or correction of patent information, serves a public good. This is because a patent to which other generic drugs would otherwise have to certify is instead either delisted or corrected so that no certification is necessary. In such cases, generic drugs may get more quickly to market, to the great benefit of consumers.

BIOEQUIVALENCE

BIO requests that section 7 of Schumer-McCain be stricken in its entirety. I do not believe this provision raises the concerns that BIO thinks it does.

Section 7 allows FDA to amend its regulations, but it does not say that those amended regulations are legitimate exercises of authorities under the FFDCA. Only the current regulations are identified as continuing in effect as an exercise of authority under the FFDCA. Should FDA ever amend its bioequivalence regulations, they would be subject to judicial review under the Administrative Procedure Act.

Indeed, earlier drafts of section 7(a) covered the FDA's current regulations and successor regulations. But we did not intend to protect amended regulations from judicial review, so the language on successor regulations was removed.

Also, under section 7(a), the application of the current regulations in any particular case would be legitimate issues for judicial review under the Administrative Procedure Act. So FDA can be challenged if its application of those regulations will pose potential risks to patients or to public health.

Finally, BIO believes that section 7(c) is inadequate. This language, which we added in part in response to concerns from BIO, says that section 7 shall not be construed to alter the authority of the Secretary of Health and Human Services to regulate biological products under the Federal Food, Drug, and Cosmetic Act. Any such authority shall be exercised under that Act as in effect on the day before the date of enactment of this Act.

This language is very similar to a statement that Senator Jeffords and I made on December 3, 1997, in a letter to Michael Friedman, then Lead Deputy Commissioner at FDA. It makes it clear that we are not changing FDA's authority under the FFDCA over biological products—in particular that we are not making changes to newly authorize the approval of generic biologics under the FFDCA. That was good enough in 1997 and should be good enough today.

I remain committed to the reforms of the Hatch-Waxman Act provided for in Schumer-McCain, just as I remain committed to a strong and vibrant biotechnology industry, both in Massachusetts and throughout the nation. I believe that the adjustments to the Hatch-Waxman Act found in Schumer-McCain correct imbalances in and will stop abuses of the generic drug approval process that have arisen in recent years. I do not believe that these reforms will adversely impact in any way a company or patent owner

that diligently sees to its legal rights and obligations under Federal law.

I hope that this letter addresses your concerns, and I remain willing to work closely with my many friends in the biotechnology industry in Massachusetts and elsewhere as this legislation moves forward.

Sincerely,

EDWARD M. KENNEDY.

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

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

MORNING BUSINESS

Mr. REID. Mr. President, I ask unanimous consent that the Senate now proceed to a period of morning business with Senators permitted to speak for up to 5 minutes each.

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

UNANIMOUS-CONSENT REQUEST—H.R. 3210

Mr. REID. Mr. President, I ask unanimous consent that the Senate proceed to immediate consideration of Calendar No. 252, H.R. 3210, the House-passed terrorism insurance bill; that all after the enacting clause be stricken, and that the text of S. 2600, as passed the Senate, be inserted in lieu thereof; that the bill, as amended, be read a third time, passed, and the motion to reconsider be laid on the table; that the Senate insist on its amendment, request a conference with the House on the disagreeing votes of the two Houses; and that the chair be authorized to appoint conferees on the part of the Senate with the ratio of 4 to 3; all without intervening action or debate.

I have indicated I was going to propound this. I know there is no one present from the other side. I object on behalf of the minority, the Republicans. I do that with some reluctance because we have to move this legislation forward. It is important. I don't do this to embarrass anyone or to try to minimize what is taking place. In fact, it is just the opposite. We have to move forward on terrorism insurance.

I get calls in my office every day saying: Why can't you move this bill? The reason we can't move it is because we have an objection. I repeat what I said yesterday and the day before and the day before: We fought to get this bill on the floor. We were held up getting the bill on the floor. Once we got the bill passed, then we have fought to get conferees appointed.

The sad part about this is we were told initially: We don't like the ratio; the ratio is three Democrats to two Republicans.

We said: What do you want?

They told Senator DASCHLE: We want four Democrats, three Republicans.

We said: Fine, we will go for that.

They still won't let us clear this. It is my understanding the House is going out of session for the summer next Friday. So we have just a few days to do this. Everyone should understand why it is not being done.

The PRESIDING OFFICER. Objection is heard.

Mr. REID. I will put it back on my desk, and I will return with this in the future.

TRIBUTE IN REMEMBRANCE OF DAVIS O. COOKE

Mr. THURMOND. Mr. President, I rise today to pay tribute to the late David O. Cooke, Defense Department Director of Administration and Management. I would like to offer my condolences to Mr. Cooke's three children, Michele, Lot and Davis, along with his other family members, friends, and coworkers. Mr. Cooke has truly imprinted an everlasting legacy on the American defense system and our great Nation. Although our Nation mourns for this tragic loss, we must remain strong in honoring such an outstanding individual. For six decades, David O. Cooke served the federal government distinguishing himself as one of the most exceptional and honorable civil servicemen of our time. He was truly a visionary, epitomizing the core values of exemplary public service. I ask unanimous consent to have printed in the Record an article from the Washington Post.

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

[From the Washington Post, June 27, 2002]

DAVID COOKE, 'MAYOR OF THE PENTAGON,' DIES

(By Graeme Zielinski)

David O. ''Doc'' Cooke, 81, the high-ranking administrative director who was known as the ''Mayor of the Pentagon'' for his work over six decades to keep the gargantuan complex humming, died June 22 at the University of Virginia Medical Center.

He died of injuries received June 6 in a car accident two miles north of Ruckersville, Va., when his vehicle veered off Route 29 and rolled over several times, Greene County Sheriff William Morris said yesterday. It wasn't known what caused the accident, Morris said.

Mr. Cooke had served at the Pentagon since the late 1950s and as its top civil servant had a hand in every major Defense Department reorganization during that time. He knew virtually every inch of the 20 miles of corridors in the building and was the department's highest-ranking career civil servant.

As Defense Department director of administration and management, he had a vast institutional memory and numerous friends spread throughout Washington's power structure. It meant that he had the ear and respect of flag officers, members of Congress and Cabinet officials—and not only because he dispensed office space and the Pentagon's 8,700 parking places.

In a 2001 edition of Government Executive Magazine, editor Timothy B. Clark called Mr. Cooke ''a force for good in the federal government.''

Mr. Cooke's many honors included seven awards of the Defense Medal for Distinguished Civilian Service. In 1999, he was given the President's Award for Distinguished Federal Service, the highest government service award.

Mr. Cooke called in some of his considerable chits in the late 1980s and early 1990s as he argued vociferously for a billion-dollar renovation of the Pentagon. Up until Sept. 11, it was scheduled for completion in 2004.

The hijacked airliner that slammed into the side of the building that day, killing 189 people, hit a wedge of the Pentagon that had undergone upgrading. Some of those features supported by Mr. Cooke have been credited with saving many lives.

''The steel that we used to strengthen the walls, the blast-resistant windows, the Kevlar cloth, all those things working together helped protect countless people,'' Walker Lee Evey, the program manager for the Pentagon renovation, said. ''Doc Cooke strongly supported all of these.''

Mr. Cooke also was a strong supporter of the government as an institution and was active in good-government groups and community service projects.

He served on the President's Interagency Council on Administrative Management and was a leader of the Combined Federal Campaign and an active member of the American Society for Public Administration.

In the early 1990s, he worked to create a Public Service Academy at Anacostia High School that has been credited with improving the school's graduation rates. He also was known in the Pentagon as a strong promoter of employment opportunities for minorities, women and disabled people.

Mr. Cooke was born and raised in Buffalo, where his parents were teachers. He began following their path, receiving a bachelor's degree from the New York State Teachers College at Buffalo and later a master's degree in political science from the State University of New York at Albany.

His teaching career was interrupted by World War II, when he served as an officer aboard the USS Pennsylvania, a battleship that saw action in the Pacific.

Mr. Cooke returned to teach high school in Buffalo in the late 1940s, but was recalled to the Navy during the Korean War. After getting his law degree from George Washington University in 1950, he served as a Navy attorney and instructor.

His Pentagon career began in 1958, when he was assigned as a civilian to a Defense Department reorganization sought by then-Secretary Neil McElroy.

Mr. Cooke retained his professorial ways throughout his career, but his humor often helped leaven the serious atmosphere in the Pentagon. Mr. Cooke was just as likely to quote a Greek philosopher as a pithy joke or homespun tale.

Evey, the Pentagon renovation manager, recalled an aside at a dedication ceremony last summer. ''He said that he took it as a sign that the building needed to be renovated when the fungus on the wall took the shape of Elvis,'' he said.

Mr. Cooke was not laughing when he argued in the 1980s for the renovation and for the Pentagon to be transferred from under the auspices of the General Services Administration to the Defense Department. He said it was a crucial step in rehabilitating the world's largest office building.

Mr. Cooke would make routine trips to Capitol Hill with what he called his ''horror board,'' a convincing collage of fallen asbestos or rotted piping from the Pentagon.

In 1998, Mr. Cooke testified before a federal grand jury about alleged leaks by then-Assistant Defense Secretary Kenneth Bacon of

personnel information about Linda Tripp to a reporter. With characteristic good humor, he told reporters after he testified that Tripp's name came up ''now and again.''

Mr. Cooke was a presence on Sept. 11, rushing to aid rescue and recovery operations. In the months after the rebuilding began, the usually low-key administrator began making more public appearances, speaking in memory of the victims.

At a speech in November, he told an Albany, N.Y., crowd: ''The damage to the building will be rebuilt. You'll never know the difference eventually.''

His wife of 52 years, Marion McDonald Cooke, died in 1999.

Survivors include three children, Michele C. Sutton of Springfield and David Cooke and Lot Cooke, both of Fairfax; and four grandchildren.

TRIBUTE TO DR. DONALD L. DURHAM

Mr. LOTT. Mr. President, I wish to take this opportunity to recognize and say farewell to an outstanding leader, Dr. Donald L. Durham, upon his retirement from the Senior Executive Service as Deputy Director of the Naval Meteorology and Oceanography Command at the John C. Stennis Space Center. Throughout his career, Dr. Durham has served with distinction. It is my privilege to recognize his many accomplishments and to commend him for the superb service he has provided the Navy, the great State of Mississippi, and our Nation.

Dr. Durham received a Bachelor of Science Degree in Physics and Mathematics from Centre College, Danville, KY in 1964; a Master of Science Degree in Oceanography, Math, from Texas A&M University in 1967; and a PhD in Physical Oceanography, Geophysics and Math, from Texas A&M University in 1972.

Following his doctoral thesis, Dr. Durham joined the Army Corps of Engineers as a research oceanographer at its Waterways Experiment Station in Vicksburg, MS. In 1978, he joined the staff of the Naval Oceanographic and Atmospheric Research Laboratory, NOARL, at the John C. Stennis Space Center, MS as an oceanographer responsible for analyzing and assessing numerous Navy oceanographic research programs and special projects, including several environmental acoustic/oceanographic studies and tactical fleet exercises. From 1981–1986 at NOARL, Dr. Durham was Head of the Mapping, Charting and Geodesy, MC&G, Division, which was responsible for project management and technical performance of the integrated Navy Research Development, Test and Evaluation, RDT&E, program in MC&G.

In 1986, Dr. Durham joined the staff of the Naval Meteorology and Oceanography Command, Stennis Space Center, MS and served as Assistant Chief of Staff for Program Integration until his selection as Technical/Deputy Director on January 1, 1989. As Technical/Deputy Director, Dr. Durham was the senior civilian manager and top scientific advisor responsible for the planning, coordination, management, direction and administration of broad, multi-disciplinary scientific, engineering and technical programs of the command. Under his guidance, the command has made tremendous inroads in the fields of basic and applied Oceanography through the application of supercomputing technology, providing detailed environmental analysis that our naval forces could have only dreamed about a few years ago. His persistence towards achieving excellence in his field of expertise is highly commendable.

Dr. Durham's many awards include the Distinguished Executive Presidential Rank Award, Meritorious Executive Presidential Rank Award, DoD Secretary of Defense Meritorious Civilian Service Award, Secretary of Navy Distinguished Civilian Service Award, Department of the Navy Meritorious Civilian Service Award, three Army Corps of Engineers' Special Act/Service Awards, Presidential Letter of Commendation, two Navy Commendations for Special Achievement, Marine Technology Society Special Commendation Award, Defense Mapping Agency Research and Development Award, Kiwanis International Distinguished Service Award, Center College Distinguished Alumnus Award, Danville High School Distinguished Alumnus Award, Mississippi Academy of Sciences Research Award, Who's Who in the South and Southwest, International Who's Who of Professionals and the International Who's Who of Intellectuals. In addition, he has published over 50 professional papers, technical reports and presentations and served twice as guest editor for Marine Technology Society Journals. His professional affiliations include the Marine Technology Society, The Oceanography Society, The Society of Research Administrators, The Hydrographic Society of America, International Oceanographic Foundation, Mississippi Academy of Sciences and Sigma Xi. Also, he has served as Vice Chair and Chair of the Mississippi Science and Technology Commission; Member of Mississippi State University's External Research Advisory Council and Mississippi Economic Development Special Task Force; and board member of Mississippi Enterprise for Technology, Inc. and Mississippi Technology Alliance.

Throughout his very distinguished career, Dr. Durham has served our great Nation with pride and excellence. He has been an integral element of, and contributed greatly to, the best-trained, best-equipped, and best-prepared naval force in the history of the world. Dr. Durham's superb leadership, integrity, and limitless energy have had a profound impact on our Nation's Oceanography community and he will be greatly missed in the Navy's Senior Executive Service. Dr. Durham retires as an SES–5 on August 3, 2002. On behalf of my colleagues on both sides of the aisle, I wish Dr. Durham all the success in his future and thank him immensely for the invaluable 30-years of service he has provided to the United States of America.

PEOPLE PEDALING PEACE

Mr. LEVIN. Mr. President, last month more than 25 cyclists made the 190-mile trip from Hampton, VA, to Washington, DC, to honor and remember victims of gun violence. According to the Brady Campaign to Prevent Gun Violence, the People Pedaling Peace cyclists rode not only in honor of the victims of gun violence, but they rode for stronger, more sensible gun safety laws in America.

Sandra and Mike McSweeney started People Pedaling Peace last year after their daughter, Stephanie, was killed while walking out of a roller rink in Hampton, VA. Money raised by this year's bike ride will be used to build a new playground in Stephanie's neighborhood so children can have a safe place to play. Elisha Encinias, a Columbine survivor who narrowly escaped the two gunmen in her classroom that tragic day in 1999, and Amber Hensley, who witnessed the 1999 rampage at Thurston High School in Springfield, OR, also joined in this year's bike trip. Unfortunately, the number of people like them is likely to grow. They represent only a small number of Americans who have lost family and friends to gun violence.

According to the Detroit Free Press, through July 14th of this year, 10 children under the age of 16 have been killed by gun fire and 25 children have been wounded by gunfire in metro Detroit. This past Sunday, a 3-year-old boy found a shotgun, picked it up, and it discharged. He wounded two other children, his 11-year-old sister and 9-year-old cousin. A week ago on Detroit's east side, an 11-year-old boy was accidentally shot in the chest by his 13-year-old neighbor after they found a handgun. Last month, a 14-year-old boy shot a 13-year-old girl while the two were arguing in a Detroit home. Thankfully, they all survived, but many have not. The need for sensible gun safety legislation and vigorous enforcement of our gun laws is desperately needed.

I know my colleagues will join me in recognizing the participants in the People Pedaling Peace bike ride and expressing our thoughts and prayers to family, friends, and communities across America that have been affected by gun violence. And I urge my colleagues to join me in supporting sensible gun safety legislation.

LOCAL LAW ENFORCEMENT ACT OF 2001

Mr. SMITH of Oregon. Mr. President, I rise today to speak about hate crimes legislation I introduced with Senator KENNEDY in March of last year. The Local Law Enforcement Act of 2001 would add new categories to current

hate crimes legislation sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred April 13, 2001 in San Antonio, TX. A 39 year old man was attacked because he was thought to be a homosexual, according to police. The victim was attacked in a park by a man with a knife. The man held the victim in a bear hug before stabbing him in the chest with what was described as a three-inch Buck knife. The suspect was heard to call the victim anti-gay names as he stabbed him.

I believe that 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 of 2001 is now 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.

DROUGHT EMERGENCY IN NORTH CAROLINA

Mr. EDWARDS. Mr. President, I rise today to draw attention to a dire situation in my state. North Carolina is in the midst of a severe drought, and there is no significant rainfall in sight.

North Carolinians are used to hot, dry summers. But the dry spell has lingered and transformed itself into one of the worst droughts in the state's history. The entire State is under drought condition and most areas are experiencing ''extreme drought.'' A significant portion of the Piedmont is experiencing an ''exceptional drought,'' according to the U.S. Geological Survey. In fact, the Piedmont is short almost a full year's worth of rain and the city of Greensboro has a little more than 100 days supply of water.

The damage estimates are already staggering. This drought has put many of our farmers on the edge of financial ruin. At a time of the year when you can drive down any rural North Carolina road and see lush, green crops ready for harvest, farmers are struggling to find enough water to save what hasn't already withered in the blazing sun. Farmers in more than half of North Carolina's 100 counties have already experienced more than 35 percent crop loss and it is still early in our growing season.

But it is not just North Carolina's farmers that are suffering. Small businesses are particularly impacted by the mandatory water restrictions. Believe it or not, drought is not a recognized disaster under the Small Business Administration's Disaster Assistance Program.

Of course, we can't make it rain. We can't cool the weather and slow the evaporation of our lakes and streams. But there are things we can do to help those impacted by this disaster. There are steps we should take immediately. I have asked Secretary Ann Veneman to certify our counties as disaster so our farmers can get the crop loss assistance it is clear they will so desperately need. I urge the administration to quickly act to help my farmers. President Bush is scheduled to travel to Greensboro, one of the most parched areas of North Carolina next week. I hope by then his administration will have recognized the dire conditions and approved my State's request for help.

In the meantime, I am proud to cosponsor the Small Business Drought Relief Act, S. 2734. This is a straightforward measure that will bring important relief to thousands of small business owners by expanding the Small Business Administration's definition of disaster to include droughts.

Another measure that I am supporting is the National Drought Preparedness Act of 2002, S. 2528. This measure creates a Federal drought preparedness and response policy, one that is so obviously needed. We in North Carolina know all too well the expertise and assistance the Federal Emergency Management Agency provides following a hurricane or tornado. We need that same clear, concise policy for droughts.

But these measures can't help with the impact this drought is having on my State right this moment. North Carolinians are doing their part. Under the leadership of Governor Easley, cities and towns are advancing reasonable water-use restrictions. Residents are conserving, and we are all hoping and praying for a good rain.

We need the administration to act quickly on the state's disaster requests. We need to get these residents the help they need.

PESTICIDE HARMONIZATION ACT OF 2002

Mr. JOHNSON. Mr. President, I rise today to thank Senators CONRAD and ROBERTS for holding an important hearing today in the Senate Agriculture Production and Price Competitiveness Subcommittee concerning S. 532, the Pesticide Harmonization Act. It is my pleasure to cosponsor this important legislation.

Differences in the prices of agricultural pesticides in the United States and Canada are one of the most important issues in bilateral trade discussions. Grains harvested in the United States compete on the open market against grains grown in Canada. Much of Canadian grain is treated with pesticides substantially less expensive than those used in the United States. I feel it is necessary for the United States to allow growers to access Canadian pesticides in order to remain competitive on the open market. I commend Senator DORGAN for his leadership on this issue, as lead sponsor of this legislation, which would allow U.S. farmers to access chemicals approved in the U.S. but sold at discounted rates in Canada.

Currently, farmers pay 117 to 193 percent higher pries in the U.S. than in Canada for virtually identical products. Canadian producers are applying less expensive pesticides to their crops and exporting their commodities to the U.S., where the same chemicals cannot be legally purchased at the Canadian reduced price by American producers. Our farmers are not allowed access to these pesticides, but must still compete with Canadian crops grown with these products.

American farmers are at a clear disadvantage to Canadian farmers due to the price differences in agricultural pesticides. This is another example of how NAFTA has put American producers at a disadvantage. I did not support or vote for NAFTA, even though supporters claimed that the trade agreement would create free, equal trade between the U.S., Canada and Mexico. In fact, NAFTA contributes to the present agricultural pesticide differential pricing problem. Allowing Canada to export millions of bushels of grain into the U.S. without restriction was intended to create equal trade, but has instead placed our agricultural industry at a disadvantage.

Furthermore, the agricultural disadvantage that hinders American farmers in this situation, benefits no one other than the pesticide industry. This industry sells the same product to Americans for twice the price that it is sold to the Canadians producers across the boarder.

S. 532 would eliminate the competitive advantage Canadian producers have over American producers by amending the Federal Insecticide, Fungicide, and Rodenticide Act. This legislation would permit a State to register a Canadian pesticide for distribution and use within that State if the pesticide is substantially similar or identical to one already registered in the U.S.

I am confident the time to act on this matter is now.

THE NATIONAL FARMWORKER JOBS PROGRAM

Mr. CORZINE. Mr. President, I rise today to urge Congress to support full funding for the National Farmworker Jobs Program.

Zeroing out funding for the National Farmworker Jobs Program as proposed in the Bush Administration's Fiscal Year 2003 budget would be wrong for our country and wrong for New Jersey. Close to 600 migrant workers make Cumberland County in southwestern New Jersey their permanent residence, with another 6,500 migrant workers estimated to arrive in the county for farm work each year. If the proposed cut is ultimately enacted, I am convinced that the quality of life for these workers and workers throughout the State and country will fall substantially.

The National Farmworker Jobs Program was created in 1964 to address the specific problems migrant workers face. By the very nature of their employment, migrant workers often find

themselves unemployed or underemployed, scraping by on an income well below the poverty line. Language and educational barriers often prevent these workers from receiving permanent employment or attaining economic self-sufficiency.

Because their work takes them across various State and municipal borders, only a national program can address the problems faced by the migrant farmworker population. The National Farmworker Jobs Program provides housing, healthcare, and childcare assistance to workers they can remain employed and provide for their families. Considering that many of these hardworking families are not fluent in English, obtaining these services would otherwise be a daunting if not impossible task.

The National Farmworker Jobs Program has assisted migrant workers with education and job training since its inception. It has also played an active role in job placement, minimizing the amount of time migrant workers remain unemployed. In the fiscal year ending June 30, 2000, 85 percent of the National Farmworker Jobs Program enrollees received services that enabled them to retain or enhance their agricultural employment or secure new jobs at better wages. And that is with a budget of just $80 million.

The National Farmworker Jobs Program services a vital social role, and I urge my colleagues to support it.

HONORING GENERAL BENJAMIN O. DAVIS, JR.

Mr. EDWARDS. Mr. President, 2 weeks ago as America celebrated the birth of our Nation, one of its greatest military leaders passed away. General Benjamin O. Davis Jr., 89, the legendary commander of the Tuskegee Airmen, died at Army Reed Medical Center on the Fourth of July. Yesterday, General Davis was laid to rest in Arlington National Cemetery.

From his youth Davis knew that he wanted to become a pilot and serve his country. In 1932 he entered the U.S. Military Academy at West Point. Throughout his years at West Point he was shunned by his fellow cadets who refused to speak with him. Think of it, 4 years at one of the Nation's best institutions of higher education where no one spoke to you and you ate all of your meals alone. Davis once spoke of the intimidation and harassment he endured at the academy, saying, ''I wasn't leaving, this is something I wanted to do and I wasn't going to let anybody drive me out.'' In 1936, Davis became the first African American in the 20th century to graduate from West Point.

After graduation Davis applied for the Army Air Corps but was rejected because of his race. He became professor of military science at the Tuskegee Institute in Alabama. In 1940, President Roosevelt issued an order allowing African Americans to fly for the military, and Davis immediately began his training at the Tuskegee Army Air Base. In 1942 he took command of the first all-black air unit, the 99th fighter squadron. Due to his excellent service in North Africa and Italy during World War II, he was promoted to colonel of the 322nd fighter group. As a colonel, Davis led 200 air combat missions. Davis would tell his men, ''We are not out looking for glory. We're out to do our mission.'' During his first mission, his 38 pilots held off over 100 German fighters. Davis's fighter group boasted an inspiring 100-percent success rate. None of the bombers he protected was ever lost to enemy fire. Despite his success, he was not allowed to command white troops and was turned away from segregated officers' clubs.

After World War II, Davis led a fighter wing in the Korean War and, in 1953, was promoted to brigadier general, becoming the first black general in the Air Force. Over the next 13 years he would rise in rank to lieutenant general and serve as deputy-commander-in-chief of U.S. Strike Command. When Davis retired from the Air Force in 1970, he was the highest-ranking African American officer in the military.

After hanging up his uniform Davis continued serving our country. He supervised the Federal Air Marshal Program and, in 1971, was named Assistant Secretary of Transportation.

In 1998 President Clinton awarded Davis his fourth star. ''One person can bring about extraordinary change'' President Clinton said when speaking of the general. At the White House ceremony then-Defense Secretary William S. Cohen stated that ''General Davis is often held up as a shining example of what is possible for African Americans. But today we honor him not only as a great African American. We honor him because like his father before him, he is a great warrior, a great officer, and a great American.'' Indeed like his father, General Benjamin Oliver Davis Sr., he served his country with great patriotism in the face of discrimination. His father was the first African-American general in the U.S. Armed Forces.

Even in his 80s, General Benjamin Oliver Davis Jr. still spoke with the strong, dignified and commanding manner he was known for during his professional career. Steve Crump, an Emmy-Award-winning journalist in Charlotte, NC who did a documentary on the Tuskegee Airmen, recalled a speech by General Davis to many of his fellow airmen. Crump said that the general's attendance was a surprise to the audience and that upon seeing him walk out on to the stage, they snapped to attention just as they had done more than 50 years earlier.

At Seymour Johnson Air Force Base in Goldsboro, NC there is a KC–135 tanker with a portrait of Davis on its nose. The aircraft is dedicated to all the Tuskegee Airmen.

One of the greatest of the greatest generation is gone. As those who passed on before him did, General Benjamin O. Davis, Jr. left us with a simple template on how to conduct ourselves in service to our country. Be of great courage, character and humility.

ADDITIONAL STATEMENTS

TRIBUTE TO LARRY BROWN

• Mr. SMITH of Oregon. Mr. President, ever since the days of the pioneers, when folks from miles around would gather to participate in community barn-raisings, the spirit of neighbor helping neighbor has been part of the Oregon story. That spirit is alive and well today, as in every Oregon community you can find individuals who give their time and their talent to make that community a better place in which to live, work, and raise a family. For the past 35 years, in the community of Grants Pass, that individual was Larry Brown, who passed away last week after a courageous fight against cancer.

Larry was a forester by profession, and served in leadership positions for the Southern Oregon Timber Industries Association, the Oregon Small Woodland Owners Association, and the Oregon Board of Forestry Forest Practices Commission.

Larry was not only dedicated to growing healthy trees, he was also dedicated to growing healthy children. He served 5 years on the Grants Pass School Board, and was a passionate advocate for programs benefitting youth during his many years of service and leadership in the Grants Pass Rotary Club.

Larry's love for his country could be seen in his 20 years of service in the Oregon National Guard. Larry retired from the National Guard as a major in 1982, and during his service he was awarded the Meritorious Service Medal and the Army Commendation Medal with 5 bronze oak leaf clusters.

Larry was also a passionate Republican. I am just one of many elected officials who was constantly calling on Larry to organize an event or a meeting. I knew that when I called on Larry, I was calling on someone who knew and loved his community, and who would get the job done right.

Oliver Wendell Holmes once said, ''To live fully is to be engaged in the passions of one's time.'' There can be no doubt that Larry Brown lived a full life, because he truly made a difference in the passions of his time.

I extend my condolences to Larry's wife, Georgette, who continues the family tradition of public service through her service as Josephine County Clerk, and to his daughters Monique and Martie.

I am just one of many elected officials who relied on Larry's counsel, advice, and friendship.•

HONORING MAJOR W. WHEELOCK

• Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to a man that has dedicated the last 7

years of his life to helping those less fortunate than himself, Major W. Wheelock.

Among his many accomplishments, Major Wheelock has most recently served as the President/CEO of Crotched Mountain foundation in Greenfield, New Hampshire and has previously served as Executive Vice President/Treasurer of Franklin Pierce College. Major Wheelock retired in June of this year. As part of his tireless service to others, Major participates in the River Mead Retirement Community as a board member; the Yankee Publishing, Inc. as a board member; New Hampshire 2002 Health and Educational Facilities Authority as Board Vice Chair; and New Hampshire Hospital Association as a Board Vice Chair.

The service Major Wheelock has provided Crotched Mountain School was doubtless a devotion to those that receive an education there. Crotched Mountain School provides outstanding rehabilitative programs for students with disabilities in Kindergarten through twelfth grade. His duty and service are apparent through his love and devotion for the students at Crotched Mountain.

More than doing an exceptional job, Major Wheelock is to be commended for his service to such a worthy organization. A man of better character, I rarely meet. It is an honor and privilege representing Major Wheelock in the U.S. Senate.●

CELEBRATING THE LIFE AND ACHIEVEMENTS OF WILLIAM BATTERMAN RUGER

● Mr. SMITH of New Hampshire. Mr. President, I rise today to honor the life of a dear friend William Ruger, one of the greatest gun designers and manufacturers in the nation.

Joining with Alexander McCormick Sturm in 1949 Ruger founded Sturm Ruger & Co., the largest firearms designer, manufacturer, and distributer in the United States. At the time Ruger's company produced more varieties of sport firearms than any other firm in the world. Turning out his first design in 1949, Ruger's pistol soon became one of America's favorite hand guns, still widely used by many gun owners today.

Ruger would soon design a light machine gun for the United States Army and would continue designing and patenting dozens of guns throughout the last 53 years. ''Ruger was a true firearms genius who mastered the disciplines of inventing, designing, engineering, manufacturing and marketing better than anyone since Samuel Colt,'' said R.L. Wilson, a firearms historian and Ruger Biographer. ''No one in the 20th century so clearly dominated the field or was so skilled at articulating the unique appeal of quality firearms for legitimate uses.''

Recently as chairman emeritus Ruger oversaw the manufacturing of high-quality rifles, shotguns, pistols, and revolvers that law enforcement and sporting enthusiasts have come to expect. Ruger kept a watchful eye on the company as it prospered, building manufacturing facilities in a number of New Hampshire's towns providing work for many.

I have found great friendship with Ruger throughout the last years of his life and continue to admire and cherish the friendship that I have with his family. He was not only a great husband and father but a great businessman, American patriot, and friend.

It was an honor representing William Ruger in the U.S. Senate and remains a distinct privilege in serving his family.●

THE MOUNT WASHINGTON HOTEL & RESORT CELEBRATES A CENTURY OF GRANDEUR

● Mr. SMITH of New Hampshire's. Mr. President, I rise today to congratulate The Mount Washington Hotel & Resort on 100 years of New England splendor.

Located in New Hampshire's White Mountains, The Mount Washington Hotel & Resort emanates the elegance and style of a bygone era. Beginning as a dream of Joseph Strickney in 1902, this superlative of Spanish Renaissance architecture quickly became the place to hobnob with poets, presidents and princes. Serving the wealthiest of patrons, The Mount Washington was the vacation resort of choice, finding appeal by epicureans of the era.

The picturesque National Historic Landmark was once the meeting place for more than 44 nations as they discussed the creation of the World Bank and International Monetary Fund in 1944. The formal signing of the Bretton Woods International Monetary Conference took place in the now historic Gold Room located off the Hotel Lobby.

Continuing the opulence and grandeur of the The Mount Washington Hotel & Resort was at the forefront as five entrepreneurs, Joel Bedor, Wayne Presby, Jere Eames, Robert Clement, and Bill Presby, rallied to purchase the property off the FDIC auction block in 1991. This would be the first time since Stickney that the property would be in the hands of New Hampshire owners.

One hundred years after the 250 master craftsmen began construction on the grand hotel of yesteryear, The Mount Washington Hotel & Resort carries on the timeless beauty and tradition of cordial service spanning the decades.

I recommend Joel Bedor, Wayne Presby, Jere Eames, Robert Clement, and Bill Presby on their commitment to preserving the glory and vintage of the early 1900's in The Mount Washington and for receiving the ''Business of the Decade'' award by Business New Hampshire Magazine.

It is truly an honor and privilege representing these fine men in the U.S. Senate.●

HONORING NEW HAMPSHIRE REVENUE COMMISSIONER STANLEY ARNOLD

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to a colleague for his service to the citizens of New Hampshire, Mr. Stanley Arnold.

After 19 years of service to New Hampshire Stanley will be retiring in September 2002. His service as commissioner began in 1988 when appointed, by then Governor, John Sununu. Prior to becoming commissioner Stanley was an auditor in the Department of Revenue. Praised by Governor Jeanne Shaheen as, ''Essential in difficult and complicated policy debates,'' . . . ''Arnold has been a straight shooter through the five years that I have worked with him.'' Stanley has always strived to provide the best possible service to the people of the community.

Lauded as one of Governor Shaheen's most trusted advisers, Stanley increased use of technology and established a unit to focus on businesses not filing tax returns.

It is an honor to represent Mr. Stanley Arnold in the U.S. Senate.●

LAUD FOR DR. JOAN LEITZEL

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to the outstanding successes of a friend and colleague in the field of education, the President of the University of New Hampshire, Dr. Joan Leitzel.

As UNH's 17th President, Dr. Leitzel began her term by renovating buildings, adding a diverse program list and developing key buildings that provided needed space for classes and research. Thanks to Dr. Leitzel's work, the number of donors increased substantially to support the beloved University. Dr. Leitzel also increased enrollment for subsequent years.

A large portion of her success is attributed to her attention to the needs of New Hampshire's business by providing a quality professional workforce. By working with businesses in the area, Dr. Leitzel better prepares students for the competitive job market. Dr. Leitzel more than doubled research funding from $43 million in 1996 to $82 million in 2001 by making the research proposals more competitive. Greater funding from the state and forthcoming building projects help add to the University's prominence. It is so small accomplishment to steer a University to the level that has been reached under Dr. Leitzel.

I commend Dr. Joan Leitzel on receiving magna cum laude status for her leadership and for her many accomplishments that have put the University of New Hampshire on track to a successful future. I wish her all the happiness life can bring in her retirement.

It is an honor and privilege representing her in the U.S. Senate.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the PRESIDING OFFICER laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 1:45 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 5093. An act making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 2003, and for other purposes.

The message also announced that the House disagrees to the amendment of the Senate to the bill (H.R. 3763) to protect investors by improving the accuracy and reliability of corporate disclosures made pursuant to the securities laws, and for other purposes, and agrees to the conference asked by the Senate on the disagreeing votes of the two Houses thereon; and appoints the following Members as the managers of the conference on the part of the House:

From the Committee on Financial Services, for consideration of the House bill and the Senate amendment, and modifications committed to conference: Mr. OXLEY, Mr. BAKER, Mr. ROYCE, Mr. NEY, Mrs. NELLY, Mr. COX, Mr. LAFALCE, Mr. FRANK, Mr. KANJORSKI, and Ms. WATERS:

That Mr. SHOWS is appointed in lieu of Ms. WATERS for consideration of section 11 of the House bill and section 305 of the Senate amendment, and modifications, committed to conference.

From the Committee on Education and the Workforce, for consideration of sections 306 and 904 of the Senate amendment, and modifications committed to conference: Mr. BOEHNER, Mr. SAM JOHNSON of Texas, and Mr. GEORGE MILLER of California.

From the Committee on Energy and Commerce, for consideration of sections 108 and 109 of the Senate amendment, and modifications committed to conference: Mr. TAUZIN, Mr. GREENWOOD, and Mr. DINGELL.

From the Committee on the Judiciary, for consideration of section 105 and titles 8 and 9 of the Senate amendment, and modifications committed to conference: Mr. SENSENBRENNER, Mr. SMITH of Texas, and Mr. CONYERS.

From the Committee on Ways and Means, for consideration of section 109 of the Senate amendment, and modifications committed to conference: Mr. THOMAS, Mr. MCCRERY, and Mr. RANGEL.

At 5:13 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 5121. An act making appropriations for the Legislative Branch for the fiscal year ending September 30, 2003, and for other purposes.

MEASURES PLACED ON THE CALENDAR

The following bills were read the first and second times by unanimous consent, and placed on the calendar.

H.R. 5093. An act making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 2003, and for other purposes.

H.R. 5121. An act making appropriations for the Legislative Branch for the fiscal year ending September 30, 2003, and for other purposes.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. INOUYE, from the Committee on Appropriations, with an amendment in the nature of a substitute:

H.R. 5010: A bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2003, and for other purposes. (Rept. No. 107–213).

By Mr. LEAHY, from the Committee on the Judiciary, without amendment and with a preamble:

S. Res. 293: A resolution designating the week of November 10 through November 16, 2002, as ''National Veterans Awareness Week'' to emphasize the need to develop educational programs regarding the contributions of veterans to the country.

By Mr. LEAHY, from the Committee on the Judiciary, without amendment:

S. 862: A bill to amend the Immigration and Nationality Act to authorize appropriations for fiscal years 2002 through 2006 to carry out the State Criminal Alien Assistance Program.

By Mr. LEAHY, from the Committee on the Judiciary, with an amendment in the nature of a substitute:

S. 2395: A bill to prevent and punish counterfeiting and copyright piracy, and for other purposes.

S. 2513: A bill to asses the extent of the backlog in DNA analysis of rape kit samples, and to improve investigation and prosecution of sexual assault cases with DNA evidence.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. CRAPO (for himself and Mr. CONRAD):

S. 2750. A bill to improve the provision of telehealth services under the medicare program, to provide grants for the development of telehealth networks, and for other purposes; to the Committee on Finance.

By Ms. LANDRIEU:

S. 2751. A bill to amend title 10, United States Code, to revise the age and service requirements for eligibility to receive retired pay for non-regular service; to the Committee on Armed Services.

By Mr. JEFFORDS (for himself, Mr. FRIST, Mr. GREGG, Mr. BREAUX, and Mr. FEINGOLD):

S. 2752. A bill to amend title XVIII of the Social Security Act to provide for the establishment of medicare demonstration programs to improve health care quality; to the Committee on Finance.

By Mr. KERRY (for himself, Mr. BOND, Mr. CLELAND, Ms. CANTWELL, Mr. BINGAMAN, and Mrs. CARNAHAN):

S. 2753. A bill to provide for a Small and Disadvantaged Business Ombudsman for Procurement in the Small Business Administration, and for other purposes; to the Committee on Small Business and Entrepreneurship.

By Ms. COLLINS:

S. 2754. A bill to establish a Presidential Commission on the United States Postal Service; to the Committee on Governmental Affairs.

By Mr. SANTORUM (for himself and Mr. SPECTER):

S. 2755. A bill to require the Secretary of the Treasury to mint coins in commemoration of the opening of the National Constitution Center in Philadelphia, Pennsylvania, scheduled for July 4, 2003; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. JEFFORDS (for himself, Mr. LEAHY, Mr. SCHUMER, and Mrs. CLINTON):

S. 2756. A bill to establish the Champlain Valley National Heritage Partnership in the States of Vermont and New York, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. BIDEN:

S. 2757. A bill to amend title XVIII of the Social Security Act to provide coverage of outpatient prescription drugs under the medicare program; to the Committee on Finance.

By Mr. DODD (for himself, Ms. SNOWE, Mr. JEFFORDS, Mr. REED, Mr. BINGAMAN, Mrs. CLINTON, Mrs. MURRAY, and Mr. EDWARDS):

S. 2758. A bill entitled ''The Child Care and Development Block Grant Amendments Act''; to the Committee on Health, Education, Labor, and Pensions.

By Mr. HOLLINGS (for himself, Mr. LOTT, and Mr. BREAUX):

S. 2759. A bill to protect the health and safety of American consumers under the Federal Food, Drug, and Cosmetic Act from seafood contaminated by certain substances; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SPECTER (for himself and Mr. HARKIN):

S.J. Res. 41. A joint resolution calling for Congress to consider and vote on a resolution for the use of force by the United States Armed Forces against Iraq before such force is deployed; to the Committee on Foreign Relations.

ADDITIONAL COSPONSORS

S. 267

At the request of Mr. AKAKA, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 267, a bill to amend the Packers and Stockyards Act of 1921, to make it unlawful for any stockyard owner, market agency, or dealer to transfer or

market nonambulatory livestock, and for other purposes.

S. 654

At the request of Mr. TORRICELLI, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 654, a bill to amend the Internal Revenue Code of 1986 to restore, increase, and make permanent the exclusion from gross income for amounts received under qualified group legal services plans.

S. 786

At the request of Mr. DURBIN, the name of the Senator from Minnesota (Mr. WELLSTONE) was added as a cosponsor of S. 786, a bill to designate certain Federal land in the State of Utah as wilderness, and for other purposes.

S. 1502

At the request of Mr. JEFFORDS, the name of the Senator from Missouri (Mrs. CARNAHAN) was added as a cosponsor of S. 1502, a bill to amend the Internal Revenue Code of 1986 to allow a refundable tax credit for health insurance costs for COBRA continuation coverage, and for other purposes.

S. 1785

At the request of Mr. CLELAND, the name of the Senator from Nevada (Mr. ENSIGN) was added as a cosponsor of S. 1785, a bill to urge the President to establish the White House Commission on National Military Appreciation Month, and for other purposes.

S. 1924

At the request of Mr. LIEBERMAN, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 1924, a bill to promote charitable giving, and for other purposes.

S. 1945

At the request of Mr. JOHNSON, the names of the Senator from South Carolina (Mr. HOLLINGS) and the Senator from Nebraska (Mr. NELSON) were added as cosponsors of S. 1945, a bill to provide for the merger of the bank and savings association deposit insurance funds, to modernize and improve the safety and fairness of the Federal deposit insurance system, and for other purposes.

S. 1961

At the request of Mr. SMITH of New Hampshire, his name was withdrawn as a cosponsor of S. 1961, a bill to improve financial and environmental sustainability of the water programs of the United States.

S. 2027

At the request of Mr. DURBIN, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 2027, a bill to implement effective measures to stop trade in conflict diamonds, and for other purposes.

S. 2053

At the request of Mr. FRIST, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 2053, a bill to amend the Public Health Service Act to improve immunization rates by increasing the distribution of vaccines and improving and clarifying the vaccine injury compensation program, and for other purposes.

S. 2085

At the request of Ms. COLLINS, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 2085, a bill to amend title XVIII of the Social Security Act to clarify the definition of homebound with respect to home health services under the medicare program.

S. 2119

At the request of Mr. GRASSLEY, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 2119, a bill to amend the Internal Revenue Code of 1986 to provide for the tax treatment of inverted corporate entities and of transactions with such entities, and for other purposes.

S. 2233

At the request of Mr. THOMAS, the name of the Senator from Arkansas (Mr. HUTCHINSON) was added as a cosponsor of S. 2233, a bill to amend title XVIII of the Social Security Act to establish a medicare subvention demonstration project for veterans.

S. 2239

At the request of Mr. SARBANES, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 2239, a bill to amend the National Housing Act to simplify the downpayment requirements for FHA mortgage insurance for single family homebuyers.

S. 2268

At the request of Mr. MILLER, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 2268, a bill to amend the Act establishing the Department of Commerce to protect manufacturers and sellers in the firearms and ammunition industry from restrictions on interstate or foreign commerce.

At the request of Mr. CRAIG, the name of the Senator from Oklahoma (Mr. NICKLES) was added as a cosponsor of S. 2268, supra.

S. 2480

At the request of Mr. LEAHY, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 2480, a bill to amend title 18, United States Code, to exempt qualified current and former law enforcement officers from state laws prohibiting the carrying of concealed handguns.

S. 2531

At the request of Ms. COLLINS, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 2531, a bill to amend the Public Health Service Act to authorize the Commissioner of Food and Drugs to conduct oversight of any entity engaged in the recovery, screening, testing, processing, storage, or distribution of human tissue or human tissue-based products.

S. 2554

At the request of Mr. SMITH of New Hampshire, the names of the Senator from Idaho (Mr. CRAIG) and the Senator from Pennsylvania (Mr. SANTORUM) were added as cosponsors of S. 2554, a bill to amend title 49, United States Code, to establish a program for Federal flight deck officers, and for other purposes.

S. 2611

At the request of Mr. REED, the name of the Senator from Montana (Mr. BAUCUS) was added as a cosponsor of S. 2611, a bill to reauthorize the Museum and Library Services Act, and for other purposes.

S. 2614

At the request of Mr. CORZINE, the name of the Senator from Minnesota (Mr. DAYTON) was added as a cosponsor of S. 2614, a bill to amend title XVIII of the Social Security Act to reduce the work hours and increase the supervision of resident physicians to ensure the safety of patients and resident physicians themselves.

S. 2674

At the request of Mr. BROWNBACK, the names of the Senator from Massachusetts (Mr. KENNEDY) and the Senator from North Carolina (Mr. HELMS) were added as cosponsors of S. 2674, a bill to improve access to health care medically underserved areas.

At the request of Mr. BINGAMAN, his name was added as a cosponsor of S. 2674, supra.

S. 2692

At the request of Mr. CORZINE, the names of the Senator from Missouri (Mrs. CARNAHAN) and the Senator from South Carolina (Mr. HOLLINGS) were added as cosponsors of S. 2692, a bill to provide additional funding for the second round of empowerment zones and enterprise communities.

S. 2712

At the request of Mr. HAGEL, the name of the Senator from North Carolina (Mr. EDWARDS) was added as a cosponsor of S. 2712, a bill to authorize economic and democratic development assistance for Afghanistan and to authorize military assistance for Afghanistan and certain other foreign countries.

S. 2721

At the request of Mr. SARBANES, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. 2721, a bill to improve the voucher rental assistance program under the United States Housing Act of 1937, and for other purposes.

S. 2734

At the request of Mr. KERRY, the names of the Senator from Georgia (Mr. CLELAND), the Senator from Missouri (Mrs. CARNAHAN) and the Senator from Wyoming (Mr. ENZI) were added as cosponsors of S. 2734, a bill to provide emergency assistance to non-farm small business concerns that have suffered economic harm from the devastating effects of drought.

S. RES. 242

At the request of Mr. THURMOND, the name of the Senator from Virginia (Mr.

WARNER) was added as a cosponsor of S. Res. 242, a resolution designating August 16, 2002, as ''National Airborne Day''.

S. RES. 266

At the request of Mr. FRIST, his name was added as a cosponsor of S. Res. 266, a resolution designating October 10, 2002, as ''Put the Brakes on Fatalities Day''.

S. RES. 293

At the request of Mr. BIDEN, the name of the Senator from Missouri (Mrs. CARNAHAN) was added as a cosponsor of S. Res. 293, a resolution designating the week of November 10 through November 16, 2002, as ''National Veterans Awareness Week'' to emphasize the need to develop educational programs regarding the contributions of veterans to the country.

AMENDMENT NO. 4305

At the request of Ms. STABENOW, the names of the Senator from North Dakota (Mr. DORGAN), the Senator from New York (Mr. SCHUMER), the Senator from Wisconsin (Mr. FEINGOLD), the Senator from New Jersey (Mr. TORRICELLI), the Senator from Missouri (Mrs. CARNAHAN), the Senator from Michigan (Mr. LEVIN), the Senator from South Dakota (Mr. JOHNSON), the Senator from Maine (Ms. SNOWE), the Senator from Vermont (Mr. JEFFORDS), the Senator from Illinois (Mr. DURBIN), the Senator from New York (Mrs. CLINTON) and the Senator from Vermont (Mr. LEAHY) were added as cosponsors of amendment No. 4305 proposed to S. 812, a bill to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. CRAPO (for himself and Mr. CONRAD):

S. 2750. A bill to improve the provision of telehealth services under the Medicare program, to provide grants for the development of telehealth networks, and for other purposes; to the Committee on Finance.

Mr. CRAPO. Mr. President, I am pleased to rise today to introduce, along with Senator CONRAD of North Dakota, legislation that would greatly enhance the use of telehealth technology to bring badly-needed health care services to rural and underserved areas throughout the country.

This bill would allow for greater reimbursement for telehealth services under Medicare and calls for a valuable investment in the development of new and more advanced telehealth networks in underserved areas. Telehealth is the future of rural health care. Access to quality health care in rural areas is at a critical stage. Today, many ill and disabled people must drive hundreds of miles, often in bad weather on dangerous roads, just to receive the most basic of health care. Access to specialists is even more prohibitive. However, by using much of the same technologies that we use to communicate with our constituents from here in Washington, we can bring quality health care, and specialty care, to their local health care provider.

I would like to thank Senator CONRAD, who has been a longtime supporter of telehealth services, for joining me in introducing this important legislation. Our bill would allow a wide variety of health care practitioners to provide telehealth services under Medicare. One of the biggest challenges for rural practitioners is obtaining the resources and infrastructure to provide technologically advanced telehealth services. Our bill would also provide valuable resources for the development of new telehealth networks in rural and underserved areas.

Technology in America is booming. We must embrace this technology as a cost-effective way to improve health care in rural and underserved areas. This legislation takes a large step in providing a modest investment toward the improvement of rural health care.

By Mr. JEFFORDS (for himself, Mr. FRIST, Mr. GREGG, Mr. BREAUX, and Mr. FEINGOLD):

S. 2752. A bill to amend title XVIII of the Social Security Act to provide for the establishment of medicare demonstration programs to improve health care quality; to the Committee on Finance.

Mr. JEFFORDS. Mr. President, I appreciate the opportunity to speak today on an issue that has been and will continue to be important and vital to the health of all Medicare beneficiaries. Medicare's origins date back to 1965; since that time little has changed in the relationship between incentives to provide care and quality of care received. The current system does not reward or provide incentives for providing quality health care. Instead, what has evolved over the last years is a perplexing data base of well documented facts concerning quality and utilization. This information is very difficult to explain but hard to ignore. Why is it that the utilization of some surgical procedures varies tremendously from one part of the country to the next? Why is it that the cost of care per beneficiary varies from location to location without clear differences in outcomes, survival, or quality? Today, after much work with numerous health systems, patient advocacy organizations, and medical quality researchers, my colleagues Senators FRIST, GREGG, BREAUX and FEINGOLD and I are pleased to announce the introduction of legislation to create Medicare demonstration projects to address these issues.

The incentives, both financial and non-financial, to provide best healthcare to Medicare beneficiaries are complex and poorly understood. These incentives have historically been rooted in the longstanding Medicare fee-for-service payment model. In an effort to better align the incentives to provide care with best practice guidelines, appropriate utilization, adherence to best medical information, and best outcomes we have written legislation to address these issues through a Medicare demonstration project. This project will implement continuous quality improvement mechanisms that are aimed at integrating primary care, referral care, support care, and outpatient services. The bill will encourage patient participation in care decisions; strive to achieve the proper allocation of health care resources; identify the appropriate use of culturally and ethnically sensitive services in health care delivery; and document the financial effects of these decisions on the medical marketplace.

As we enter an era of rapidly increasing numbers of Medicare beneficiaries, it will be increasingly important that we re-evaluate the Medicare program to insure that the quality of care received is uniformly exceptional in its delivery and quality. It is appropriate that we continue to find better ways to insure that the norms of quality health care are established and followed. It is my sincere hope that my colleges will join me in this endeavor.

Mr. FRIST. Mr. President, I rise today to introduce the Medicare Quality Improvement Act—a bill to help revitalize the Medicare Program by providing for the alignment of payment and other incentives. I want to thank Senators JEFFORDS, GREGG, and BREAUX for their work in helping craft this crucial legislation.

To meet the needs of the 21st century health care system, it is critical that payment policies be aligned to encourage and support quality improvement efforts. Even among health professionals motivated to provide the best care possible, the structure of payment and other incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions. For example, redesigning care processes to improve follow-up for chronically ill patients through electronic communication may reduce office visits and decrease revenues for a medical group under some payment schemes.

Current payment practices are complex and contradictory; and although incremental improvements are possible, more fundamental reform will be needed. In this report, ''Crossing the Quality Chasm,'' the Institute of Medicine encouraged the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality to develop a research agenda to identify, test, and evaluate options for better aligning payment methods with quality improvement goals. The demonstration project authorized by this legislation is part of that larger research agenda—to help us understand the appropriate alight of payment and other incentives and improve the quality of health care in a way that will not increase the overall costs of Medicare.

We already have identified appropriate ways to align provider incentives. Research supported by the Robert Wood Johnson Foundation has noted at least 11 different incentive models—models that can be implemented by a wide variety of organizations and applied to a range of medical groups, providers, and health plans. In many circumstances, key components of these models have been implemented in several health care markets, and the research has shown that both financial and nonfinancial incentives, such as technical assistance, are important in motiving appropriate care. However, we do not know how these incentives might apply to Medicare, and that is why this demonstration is so vital.

It has been an honor and a pleasure to work closely with my distinguished colleagues on this bill, and I look forward to continuing to work with them and others as we move forward on the debate about how to more appropriately reform Medicare.

By Mr. KERRY (for himself, Mr. BOND, Mr. CLELAND, Ms. CANTWELL, Mr. BINGAMAN, and Mrs. CARNAHAN:

S. 2753. A bill to provide for a Small and Disadvantaged Business Ombudsman for Procurement in the Small Business Administration, and for other purposes; to the Committee on Small Business and Entrepreneurship.

Mr. KERRY. Mr. President, I am pleased today to introduce a critical piece of legislation intended to help small businesses receive their fair share of the Federal procurement pie and to ensure that they are being treated fairly within the Federal procurement system. I would like to thank my cosponsors, Senators BOND, CLELAND, CANTWELL, BINGAMAN and CARNAHAN for working with me and small business groups to craft this legislation, as well as Congressman ALBERT WYNN, for his partnership on this legislation. Congressman WYNN will soon be introducing companion legislation in the House.

In my time as Chairman of the Committee on Small Business and Entrepreneurship and previously as Ranking Member, two facts regarding small business procurement have made themselves very clear, small businesses are not getting their fair share of Federal procurement and there is no one in the entire Federal Government with the sole responsibility of advocating for small businesses, governmentwide, in the procurement process and ensuring that Federal agencies and large business prime contractors treat small businesses fairly. Some individuals are responsible for portions of this job, but no one performs this role as their primary job function or has the authority to do so solely.

I felt this was a glaring oversight and looked to the current make-up of the SBA to see if it could be rectified. My solution is a new position modeled along the Small Business Administration's, SBA, regulatory ombudsman, which could focus solely on procurement matters. A new ombudsman for small business procurement, or the Small and Disadvantaged Business Ombudsman, is needed to fill this role for procurement matters, just as the SBA's National Ombudsman does for regulatory issues. By creating a parallel position, each ombudsman can focus on his or her key mission, without detracting from either regulatory or procurement issues important to the small business community.

While no legislation alone can ever solve the complex problems faced by small businesses in today's Federal procurement environment, I believe the creation of a Small and Disadvantaged Business Ombudsman at the SBA will put us firmly on the right track and address several procurement issues raised through program oversight and communication with small business owners.

For example, small businesses frequently contact my office to report problems they are having with a prime contractor or a contracting agency. Too often, these businesses are afraid to come forward and make an official complaint for fear of being blackballed and denied future contracting opportunities. The SDB Ombudsman will provide one solution for these small businesses who fear being blacklisted by allowing them to submit confidential complaints. The SDB Ombudsman will have the responsibility of tracking these complaints and trying to rectify them.

The SDB Ombudsman will also work to change the culture at Federal procuring agencies by tracking and reporting on the training of procurement personnel and working to ensure that this training not only includes the ''How to's'' of small business participation, but also includes training on why small business participation is crucial to agency success and the national economy.

Until the Federal Government, at all levels, realizes the importance of doing business with small business, small business participation in Federal procurement will continue to decline, our Nation will lose its access to a wide range of small business suppliers, and small businesses across the country will continue to lose billions of dollars in procurement opportunities year after year. Of critical importance in the legislation is the first statutory consequence of an agency failing to meet its small business goals. Under the legislation, if an agency fails to meet any small business goal, the agency would be required to submit a report and an action plan to the SDB Ombudsman detailing why the agency failed to meet its small business goal or goals, and what the agency intends to do to remedy the situation.

The SDB Ombudsman will also be responsible for tracking compliance with Section (k) of the Small Business Act, which stipulates, in part, that the Director of the Office of Small and Disadvantaged Business Utilization at each Federal agency shall report to the head or deputy head of the agency. Late last year, with the support of Ranking Member BOND, I sent a letter to 21 Federal agencies to gauge compliance with this provision. Using a very lenient standard of compliance, I have concluded that at least nine of the Federal agencies surveyed are in violation of Section (k) of the Small Business Act. This is unacceptable.

On June 19, 2002, the Committee on Small Business and Entrepreneurship help a roundtable to discuss Federal procurement policies. The roundtable, title ''Are Government Purchasing Policies Hurting Small Business?'' was attended by a wide range of small business advocates, small business owners and government officials. One of the topics discussed during the roundtable was my draft proposal, the SDB Ombudsman Act, to create a new position at the SBA to monitor Federal agency compliance with certain provisions of the Small Business Act and serve as a focal point to assist small businesses that were treated unfairly in the Federal procurement process.

During the Roundtable, I asked the participants for their recommendations on how to improve the legislation to ensure that the SDB Ombudsman serves as the most effective advocate possible for small business. The Committee record was also kept open for two weeks so that participants could submit further comments.

I have now reviewed the Committee record and further submissions and am pleased to say that the responses were very positive. Several important suggestions were made to strengthen the Office of Small and Disadvantaged Business Utilization at each Federal agency as an important corollary to the creation of the SDB Ombudsman, since the SDB Ombudsman would be relying on each OSDBU to fulfill his or her statutory responsibilities.

Many other small businesses have come to the Committee on Small Business and Entrepreneurship and requested that we strengthen the OSDBUs at each agency as well. This legislation fulfills that request by including six new provisions.

First, the legislation clarifies that OSDBU Directors shall report to the highest level at each agency. In the study I mentioned previously, too often, an agency cited a bifurcated reporting system whereby the OSDBU Director reports to the head or deputy head on small business matters, but to other, lower-ranking personnel for budgetary or personnel matters. The Small Business Act does not envision such a system. Therefore, I felt it necessary to clarify, in no uncertain terms, that the OSDBU Director must report to the head or deputy head of his or her agency only, for all matters.

Second, the legislation requires that all OSDBU Directors now be career personnel. The Director's position is one

of advocacy, which often entails challenging co-workers and political personnel, including superiors. Under current law, OSDBU Directors may be political appointees. While this has worked in some instances, I believe the small business community would be better served by career personnel with job protections.

Third, the legislation requires the OSDBU Director to be well-qualified in assisting small businesses with procurement matters. No one disputes the expertise of Federal procurement officials; however, procurement expertise does not always translate to small business procurement expertise. This provision will help ensure that small businesses are being served by those who understand their particular procurement needs.

Fourth, the legislation requires that, at major Federal agencies, the OSDBU Director have no job responsibilities outside the scope of the authorizing legislation. This provision was included because far too many agencies assign the OSDBU Director title to their procurement chief or another official with similar responsibilities, while the actual OSDBU program is run by someone else. This provision will stop this abuse.

Fifth, the legislation requires that a procurement chief not serve as the Director of the OSDBU program at a Federal agency. I firmly believe that the OSDBU Director's goal is fundamentally different from, and at times even opposed to, that of a chief procurement official who must be fair to all Federal contractors. An OSDBU Director's role is one of advocacy. He or she must take the side of small business, and no procurement chief can do this and perform both jobs fairly and effectively. While OSDBU Directors at major Federal agencies are barred from having additional responsibilities under this legislation, non-major Federal agency OSDBU Directors may. This provision will help ensure that at our non-major Federal agencies, the OSDBU Director can act fairly on behalf of small businesses.

Sixth, the legislation provides statutory authority for the OSDBU Council. Under the legislation, each OSDBU Director will have membership on the Council, which will meet at least once every two months. The Council's role is to discuss issues of importance to the OSDBUs and the small business community they serve. OSDBU Directors serving at major Federal agencies have as a part of their responsibilities an obligation, under this legislation, to attend Council meetings. This provision was included to once again prevent Federal agencies from circumventing the Small Business Act. Attendance at Council meetings will help ensure that Federal agencies are complying with the law and that OSDBU Directors are small business advocates, not simply procurement personnel with two hats.

One final note on the legislation is that the inclusion of a provision to increase the governmentwide small business prime contracting procurement goal from 23 percent to 30 percent has been retained, although it will now be phased in over three years: 26 percent in FY 2004, 28 percent in FY 2005 and 30 percent in FY 2006 and thereafter.

When I first made the suggestion that the small business procurement goal should be increased seven percentage points, my office received numerous calls, both in support of the increase and in opposition. Some even suggested raising the goal to a level of 40 percent. But, by and large, those in opposition pointed to one fact: The Federal Government has never achieved such a level of small business procurement participation. And while that is true, no one said that it was impossible. Given the disappointing achievement of the Federal Government on the current small business goal of 23 percent, I believe it is time to raise the bar.

When Congress enacted goals as part of the Small Business act, the goals were intended to be a minimum standard of achievement. For too long, the goals have been treated as a target for attainment, not a minimum level of acceptable small business participation. This too must change. Almost every year the Federal Government comes very close to hitting the small business prime contracting goal of 23 percent right on the head. Some years it does slightly better, and some years, unfortunately, it does slightly worse. However, this trend demonstrates one important principle, the government is firmly shooting for 23 percent, no more—no less.

By raising the statutory goal, it is my hope that the Federal Government will shoot for the higher target and succeed. But I ask my colleagues to look at this critically in that the goal for small business isn't so much being raised as the 77 percent of Federal procurement that now goes to large businesses, which represent only a tiny portion of all Federal contractors, is being reduced to 70 percent. So if the small business goal should increase to 30 percent, 70 percent of all Federal procurement will still be awarded to a relatively small number of all Federal contractors. Is this fair to small business? No. But it is an improvement.

I am pleased to say that my legislation is supported by groups representing primarily small businesses or small business contractors, such as the National Small Business United, NSBU, Women Impacting Public Policy, WIPP, and the Association of Small and Disadvantaged Business, as well as advocacy groups such as the Latin American Management Association, LAMA, the Minority Business Enterprise Legal Defense and Education Fund, MBELDEF, and the Veterans of Foreign Wars, VFW.

I thank them as well as the cosponsors of this legislation, Senators BOND, CLELAND, CANTWELL, BINGAMAN and CARNAHAN for their assistance, input and support, and I look forward to continuing to work with them on this and other important issues.

I ask unanimous consent that the text of the Small and Disadvantaged Business Ombudsman Act be printed in the RECORD.

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small and Disadvantaged Business Ombudsman Act''.

SEC. 2. SBA SMALL AND DISADVANTAGED BUSINESS OMBUDSMAN FOR PROCUREMENT.

Section 30 of the Small Business Act (15 U.S.C. 657) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''and'';

(B) in paragraph (2), by striking the period and adding a semicolon; and

(C) by adding at the end the following:

''(3) 'SDB Ombudsman' means the Small and Disadvantaged Business Ombudsman for Procurement, designated under subsection (e); and

''(4) 'Major Federal agency' means an agency of the United States Government that, in the previous fiscal year, entered into contracts with non-Federal entities to provide the agency with a total of not less than $200,000,000 in goods or services.''; and

(2) by adding at the end the following:

''(e) SBA SMALL AND DISADVANTAGED BUSINESS OMBUDSMAN FOR PROCUREMENT.—

''(1) APPOINTMENT.—

''(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Small and Disadvantaged Business Ombudsman Act, the Administrator shall designate a Small and Disadvantaged Business Ombudsman for Procurement (referred to in this section as the 'SDB Ombudsman').

''(B) QUALIFICATIONS.—The SDB Ombudsman shall be—

''(i) highly qualified, with experience assisting small business concerns with Federal procurement; and

''(ii) designated from among employees of the Federal Government, to the extent practicable.

''(C) LINE OF AUTHORITY.—The SDB Ombudsman shall report directly to the Administrator.

''(D) SENIOR EXECUTIVE SERVICE.—The SDB Ombudsman shall be paid at an annual rate not less than the minimum rate, nor more than the maximum rate, for the Senior Executive Service under chapter 53 of title 5, United States Code.

''(2) DUTIES.—The SDB Ombudsman shall—

''(A) work with each Federal agency with procurement authority to ensure that small business concerns are treated fairly in the procurement process;

''(B) establish a procedure for receiving comments from small business concerns and personnel of the Office of Small and Disadvantaged Business Utilization of each Federal agency regarding the activities of agencies and prime contractors that are not small business concerns on Federal procurement contracts; and

''(C) establish a procedure for addressing the concerns received under subparagraph (B).

''(3) ANNUAL REPORT.—

''(A) IN GENERAL.—No later than 1 year after the date of enactment of this subsection, and annually thereafter, the SDB Ombudsman shall provide a report to the Committee on Small Business of the House

of Representatives and the Committee on Small Business and Entrepreneurship of the Senate.

''(B) CONTENTS.—The report required under subparagraph (A) shall contain—

''(i) information from the Federal Procurement Data System pertaining to contracting and subcontracting goals of the Federal Government and each Federal agency with procurement authority;

''(ii) a copy of the report submitted to the SDB Ombudsman by each major Federal agency and an evaluation of the goal attainment plans submitted to the SDB Ombudsman pursuant to paragraph (5);

''(iii) an evaluation of the success or failure of each major Federal agency in attaining its small business procurement goals, including a ranking by agency on the attainment of such goals;

''(iv) a summary of the efforts of each major Federal agency to promote contracting opportunities for small business concerns by—

''(I) educating and training procurement officers on the importance of small business concerns to the economy and to Federal contracting; and

''(II) conducting outreach initiatives to promote prime and subcontracting opportunities for small business concerns;

''(v) an assessment of the knowledge of the procurement staff of each major Federal agency concerning programs that promote small business contracting;

''(vi) substantiated comments received from small business concerns and personnel of the Office of Small and Disadvantaged Business Utilization of each Federal agency regarding the treatment of small business concerns by Federal agencies on Federal procurement contracts;

''(vii) an analysis of the responsiveness of each Federal agency to small business concerns with respect to Federal contracting and subcontracting;

''(viii) an assessment of the compliance of each Federal agency with section 15(k) of the Small Business Act (15 U.S.C. 644(k); and

''(ix) a description of any discrimination faced by small business concerns based on their status as small business concerns or the gender or the social or economic status of their owners.

''(C) NOTICE AND COMMENT.—

''(i) IN GENERAL.—The SDB Ombudsman shall provide notice to each Federal agency identified in the report prepared under subparagraph (A) that such agency has 60 days to submit comments on the draft report to the SDB Ombudsman before the final report is submitted to Congress under subparagraph (A).

''(ii) INCLUSION OF OUTSIDE COMMENTS.—

''(I) IN GENERAL.—The final report prepared under this paragraph shall contain a section in which Federal agencies are given an opportunity to respond to the report contents with which they disagree.

''(II) NO RESPONSE.—If no response is received during the 60-day comment period from a particular agency identified in the report, the final report under this paragraph shall indicate that the agency was afforded an opportunity to comment.

''(D) CONFIDENTIALITY.—In preparing the report under this paragraph, the SDB Ombudsman shall keep confidential all information that may expose a small business concern or an employee of an Office of Small and Disadvantaged Business Utilization to possible retaliation from the agency or prime contractor identified by the small business concern, unless the small business concern or employee of the Office of Small and Disadvantaged Business Utilization consents in writing to the release of such information.

''(4) INTERAGENCY COORDINATION.—Each Federal agency, through its Office of Small and Disadvantaged Business Utilization, shall assist the SDB Ombudsman to ensure compliance with—

''(A) the Federal procurement goals established pursuant to section 15(g);

''(B) the procurement policy outlined in section 8(d), which states that small business concerns should be given the maximum practicable opportunity to participate in Federal contracts;

''(C) Federal prime contractors small business subcontracting plans negotiated under section 8(d)(4)(B);

''(D) the responsibilities outlined under section 15(k); and

''(E) any other provision of this Act.

''(5) GOAL ATTAINMENT PLAN.—If a major Federal agency fails to meet any small business procurement goal under this Act in any fiscal year, such agency shall submit a goal attainment plan to the SDB Ombudsman not later than 90 days after the end of the fiscal year in which the goal was not met, containing—

''(A) a description of the circumstances that contributed to the failure of the agency to reach its small business procurement goals; and

''(B) a detailed plan for meeting the small business procurement goals in the fiscal year immediately following the fiscal year in which the goal was not met.

''(6) EFFECT ON OTHER OFFICES.—Nothing in this section is intended to replace or diminish the activities of the Office of Small and Disadvantaged Business Utilization or any similar office in any Federal agency.

''(7) ADMINISTRATIVE RESOURCES.—To enable the SDB Ombudsman to carry out the duties required by this subsection, the Administrator shall provide the SDB Ombudsman with sufficient—

''(A) personnel;

''(B) office space; and

''(C) dedicated financial resources, which are specifically identified in the annual budget request of the Administration.''.

SEC. 3. OFFICE OF SMALL AND DISADVANTAGED BUSINESS UTILIZATION.

(a) DIRECTOR.—Section 15(k) of the Small Business Act (15 U.S.C. 644(k)) is amended—

(1) in the first sentence, by inserting ''(except for the Administration)'' after ''Federal agency'';

(2) by striking paragraph (2), and inserting the following:

''(2) be well qualified, with experience assisting small business concerns with Federal procurement, and receive basic pay at a rate not to exceed the rate of pay for grade 15 of the General Schedule, under section 5332 of title 5, United States Code;'';

(3) by striking paragraph (3) and inserting the following:

''(3) be appointed by the head of such agency, be responsible to, and report only to, the head or deputy head of such agency for policy matters, personnel matters, budgetary matters, and all other matters;'';

(4) in paragraph (9), by striking '', and'' and inserting a semicolon;

(5) in paragraph (10)—

(A) by striking ''or section 8(a) of this Act or section 2323 of title 10, United States Code. Such recommendations'' and inserting ''section 8(a), or section 2323 of title 10, United States Code, which recommendations''; and

(B) by striking the period at the end and inserting a semicolon; and

(6) by striking the undesignated matter after paragraph (10) and inserting the following:

''(11) not concurrently serve as the chief procurement officer for such agency; and

''(12) if the officer is employed by a major Federal agency (as defined in section 30)—

''(A) have no other job duties beyond those described under this subsection;

''(B) receive basic pay at a rate equal to the rate of pay for grade 15 of the General Schedule, under section 5332 of title 5, United States Code; and

''(C) attend the meetings of the Office of Small and Disadvantaged Business Utilization Council.''.

(b) OFFICE OF SMALL AND DISADVANTAGED BUSINESS UTILIZATION COUNCIL.—

(1) ESTABLISHMENT.—There is established an interagency council to be known as the ''Office of Small and Disadvantaged Business Utilization Council'' (in this subsection referred to as the ''Council'').

(2) MEMBERSHIP.—The Council shall be composed of—

(A) the Director of Small and Disadvantaged Business Utilization from each Federal agency;

(B) the Small and Disadvantaged Business Ombudsman for Procurement, as an ex officio member; and

(C) other individuals, as ex officio members, as the Council considers necessary.

(3) LEADERSHIP.—

(A) CHAIRPERSON.—The members of the Council shall elect a chairperson, who shall serve for a 1-year, renewable term.

(B) OTHER POSITIONS.—The members of the Council may elect other leadership positions, as necessary, from among its members.

(C) VOTING.—Each member of the Council, except for ex officio members, shall have voting rights on the Council.

(4) MEETINGS.—

(A) FREQUENCY.—The Council shall meet not less frequently than once every 2 months.

(B) ISSUES.—At the meetings under subparagraph (A), the Council shall discuss issues faced by each Office of Small and Disadvantaged Business Utilization, including—

(i) personnel matters;

(ii) barriers to small business participation in Federal procurement;

(iii) agency compliance with section 15(k) of the Small Business Act (15 U.S.C. 644(k)), as amended by this Act; and

(iv) any other matter that the Council considers necessary to further the mission of each Office of Small and Disadvantaged Business Utilization.

(5) FUNDING LIMITATION.—The Small Business Administration shall not provide the Council with financial assistance to carry out the provisions of this section.

SEC. 4. GOVERNMENTWIDE SMALL BUSINESS GOAL.

Section 15(g)(1) of the Small Business Act (15 U.S.C. 644(g)(1)) is amended in the second sentence, by striking ''23 percent of the total value of all prime contract awards for each fiscal year.'' and inserting ''26 percent of the total value of all prime contract awards for fiscal year 2004, not less than 28 percent of the total value of all prime contract awards for fiscal year 2005, and not less than 30 percent of the total value of all prime contract awards for fiscal year 2006 and each fiscal year thereafter.''.

By Ms. COLLINS:

S. 2754. A bill to establish a Presidential Commission on the United States Postal Service; to the Committee on Governmental Affairs.

Ms. COLLINS. Mr. President, I rise today to introduce the ''United States Postal Service Commission Act of 2002.'' This legislation will establish a Commission to examine the challenges facing the Postal Service and develop

solutions to ensure its long term viability and increased efficiency.

The Postal Service's problems have reached a near crisis level. In 2000, the Postal Service lost nearly $200 million, while in 2001, this loss ballooned to $1.68 billion. Losses are projected to be $1.35 billion this year, despite the $675 million in appropriations from Congress to cover the unanticipated costs associated with the September 11 attacks and the anthrax incidents. The Postal Service is mandated by law to break even on its operating expenses and its capital needs, both of which continue to grow.

The Postal Service is also fast approaching its $15 billion statutory borrowing limit. Given its recent history of increasing rather than paying down its debt, increasing the Postal Service's debt ceiling is not the answer. In addition, the Postal Service's long term liabilities are enormous, to the tune of nearly $6 billion for Workers Compensation claims, a staggering $32 billion in retirement costs and perhaps as much as $45 billion to cover retiree health care costs. Meanwhile, on June 30, consumers experienced a third postal rate increase in just 18 months.

How could the Postal Service have landed in such dire straits? The Postal Service's problems stem from many causes. For example, the overall growth rate of mail has been declining since 1997, and first class mail volumes actually have declined over the past four years. This is particularly significant, as first class mail accounts for 48 percent of total mail volume. In addition, revenues from first class mail cover more than two-thirds of institutional costs, such as post offices. Shortfalls must be made up by decreasing costs, increasing volumes in other categories of mail or by increasing postal rates.

Some of this declining volume can be attributed to the increasing forms of electronic communication, particularly the Internet, which has revolutionized the way we communicate and transact business. For example, while financial statements, bills and bill payments constitute about half of first class mail revenue, or about $17 billion annually, electronic bill payment is quickly becoming a major means of doing business. It is estimated that 75 percent of banks will provide online banking services by 2003. This is in addition to other competing methods of communication such as faxes and telephones. In addition, filing tax returns, receiving Social Security payments, and many other transactions are also available electronically.

The Postal Service also faces significant labor-related costs. Indeed nearly 80 percent of its expenses are related to compensation and benefits. By comparison, 56 percent of FedEx's expenses and 42 percent of UPS's expenses are related to compensation and benefits.

The need to preserve a viable Postal Service is clear. Americans rely on affordable, reliable and universal mail delivery as their primary means of communication. The Postal Service delivers more than 200 billion pieces of mail each year to nearly 140 million addresses, which accounts for more than 40 percent of the world's mail. Moreover, 1.7 million new delivery points are added each year—roughly the equivalent of adding the number of addresses in Chicago. More than seven million Americans visit post offices each day.

In States with large rural areas, such as Maine, it is vital that postal services remain in place. If the Postal Service were no longer obligated to provide universal service and deliver mail to every customer, six days a week, the affordable communication link upon which many Americans rely would be jeopardized. Most commercial enterprises would find it uneconomical, if not impossible, to deliver mail and packages to these areas at rates that the Postal Service has been offering.

In addition to providing a critical service to consumers, the Postal Service is the eleventh largest enterprise in the Nation with $66 billion in annual revenues. This is more than Microsoft, McDonald's and Coca Cola combined. While the Postal Service itself employs more than 700,000 career employees, it is also the linchpin of a $900 billion mailing industry that employs nine million Americans in fields as diverse as direct mailing, printing and paper production.

Affordable postal rates are vital to the economic health of many companies, especially magazines, catalog houses and the service providers they use. The June 2002 rate hike alone represents a ten percent increase for periodicals, and a nine percent increase for catalogs. It is estimated that the combined effect of the past three rate increases, totaling 22 percent over just 18 months, have cost the magazine industry about $400 million.

In May I met with a group of about twenty Maine businessmen and women involved in the mailing industry, who described for me the impact that rising postal rates have on their businesses. One magazine publisher told me that postage represents ten percent of her costs. I was amazed to hear that one of the catalog busineses pays more for postage a year than it pays to any one of the companies that supply the raw materials for its products. It was also startling to hear from one printer that his postage costs have doubled over the last ten years.

Most of the people I met with are small business owners, and there are millions more across the country, all grappling with the same effects of rapidly rising postage costs.

At the request of the Senate Governmental Affairs Committee and House Committee on Government Reform, the Postal Service produced a comprehensive Transformation Plan, which it presented to Congress in April. The Plan addresses general measures that the Postal Service believes it needs to take to ensure its survival, but it fails to lay out specific steps the Postal Service will take and a timeline for action. It is also unclear whether these measures will result in the cost savings necessary to ensure the long-term survival of the Postal Service.

Many attempts have been made to reform the Postal Service over the years. My colleagues in the House of Representatives have tried for nearly eight years to pass postal reform legislation, but to no avail. Stakeholders have widely diverging views on what shape postal reform should take, if any. This lack of consensus on how or whether to deal with divisive issues has led only to stalemates in Congress.

To take a fresh look at these difficult issues, I rise today to introduce legislation establishing a Presidential Postal Commission charged with examining the problems that the Postal Service faces, and developing specific recommendations and legislative proposals that Congress and the Postal Service can implement. Precedent exists for such a commission. In the late 1960s, the Kappel Commission was formed to resolve the crisis situation that the former Postal Department then found itself in, train cars of undelivered mail, strikes, and a host of other problems. The Kappel Commission's efforts laid the groundwork for the Postal Service we have today, which has functioned admirably for many years but is now in serious trouble.

Mindful of the body of work that has been done in this area by my colleagues in the House and Senate, by the General Accounting Office, by the Postal Service itself and by others, I intend that this commission have a short life of one year, during which it will carry out its study and produce legislative proposals for consideration by the Administration and the Congress.

Finally, I intend that the commission consider all relevant aspects of the Postal Service. Everything should be put on the table and evaluated. We need to ensure that the Postal Service will stand up to the challenges it is facing today and will face tomorrow.

These and many more issues must be examined in depth, if we are to preserve this vital service upon which so many Americans rely for communication and for their livelihood. The Postal Service has successfully overcome numerous difficulties over its 226-year history, and has continued to deliver the mail faithfully. Yet it has reached a critical juncture and once again, it is time for a thorough evaluation of the Postal Service's operations and requirements.

By Mr. SANTORUM (for himself and Mr. SPECTER):

S. 2755. A bill to require the Secretary of the Treasury to mint coins in commemoration of the opening of the National Constitution Center in Philadelphia, Pennsylvania scheduled for

July 4, 2003; to the Committee on Banking, Housing, and Urban Affairs.

Mr. SANTORUM. Mr. President I am pleased to introduce legislation along with my colleague Senator SPECTER to establish a one dollar silver coin that will benefit the National Constitution Center in Philadelphia, PA.

As the first national center of its kind in the country, the National Constitution Center will promote understanding of the United States Constitution and its values. The events of the past year in our nation as well as recent judicial rulings have brought increased attention to those principles and values that define and bind us as Americans. All would agree that the United States Constitution is central to defining our country, who we are, and how we live as Americans. Even as we often debate in the halls of Congress and the Supreme Court those policies and laws that best reflect the values and intent of the Constitution, we all recognize the freedoms and opportunity that this remarkable document secures for us.

The National Constitution Center has been an important project in Philadelphia with which Senator Specter and I have been involved. Construction began on September 17, 2000. When the Constitution Center is completed as expected on July 4, 2003, it will be a key feature of a revitalized Independence Mall where it will join Independence Hall and the Liberty Bell. The issuance of this coin would coincide with the opening of the Center.

I encourage all of my colleagues to support the National Constitution Center by cosponsoring this bill.

I ask unanimous consent that the text of the bill be printed in the record.

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National Constitution Center Commemorative Coin Act of 2002''.

SEC. 2. FINDINGS.

Congress finds that—

(1) a Constitutional Convention was convened in the summer of 1787 in Philadelphia, Pennsylvania for the purposes of replacing the failed Articles of Confederation as a framework for governing the 13 American colonies newly independent from Great Britain;

(2) the United States Constitution produced by the Convention would set the United States of America on a unique course of experiment in self-government that would profoundly impact the United States and the world;

(3) in its deliberations and promotion through such literary works as The Federalist Papers, the United States Constitution drew upon the successes and failures of nations and peoples dating as far back as the city-state republics of ancient Greece in forming representative governments;

(4) the first 10 amendments to the Constitution, known as the Bill of Rights, comprise the best written set of legal protections of the rights and dignity of the individual in the history of human civilization and continue to be the benchmark for nations' adherence to human rights standards;

(5) the principles of the United States Constitution have been enacted into the governing laws of numerous free countries around the globe, and are reflected in the founding documents of the United Nations;

(6) the United States Constitution created the framework for what is now the oldest representative democracy in the world;

(7) in its wisdom, the Constitutional Convention created a mechanism through which the United States Constitution can be perfected, as it has been 27 times to date, to better reflect its founding ideals, as well as to accommodate changing circumstances;

(8) the rights and freedoms secured to Americans by the United States Constitution have and continue to draw millions from around the globe to the shores of this Nation;

(9) all Americans should gain an understanding of and appreciation for the United States Constitution and the role this remarkable document plays in the freedoms and quality of life they enjoy;

(10) the National Constitution Center was established by the Constitution Heritage Act of 1988 (16 U.S.C. 407aa et seq.), which was signed into law by President Ronald Reagan on September 16, 1988, to provide for continuing interpretation of the Constitution and to establish a national center for the United States Constitution; and

(11) the National Constitution Center, located at the site of the birth of the Constitution, only steps away from the Liberty Bell and Independence Hall in the Independence National Historic Park in Philadelphia, Pennsylvania, is the only center in the world solely dedicated to promoting understanding of the Constitution and its values and ideals.

SEC. 3. COIN SPECIFICATIONS.

(a) $1 SILVER COINS.—The Secretary of the Treasury (in this Act referred to as the ''Secretary'') shall mint and issue not more than 500,000 $1 coins, which shall—

(A) weigh 26.73 grams;

(B) have a diameter of 1.500 inches; and

(C) contain 90 percent silver and 10 percent copper.

(b) LEGAL TENDER.—The coins minted under this Act shall be legal tender, as provided in section 5103 of title 31, United States Code.

SEC. 4. SOURCES OF BULLION.

The Secretary may obtain silver for minting coins under this Act from stockpiles established under the Strategic and Critical Materials Stock Piling Act, to the extent available, and from other available sources, if necessary.

SEC. 5. DESIGN OF COINS.

(a) DESIGN REQUIREMENTS.—

(1) IN GENERAL.—The design of the coins minted under this Act shall be emblematic of the National Constitution Center in Philadelphia, Pennsylvania.

(2) DESIGNATION AND INSCRIPTIONS.—On each coin minted under this Act, there shall be—

(A) a designation of the value of the coin;

(B) an inscription of the year ''2003''; and

(C) inscriptions of the words ''Liberty'', ''In God We Trust'', ''United States of America'', and ''E Pluribus Unum''.

(b) DESIGN SELECTION.—The design for the coins minted under this Act shall be—

(1) selected by the Secretary, after consultation with the Constitution Center Coin Advisory Committee; and

(2) reviewed by the Citizens Commemorative Coin Advisory Committee.

SEC. 6. ISSUANCE OF COINS.

(a) QUALITY OF COINS.—Coins minted under this Act shall be issued in uncirculated and proof qualities.

(b) MINT FACILITY.—Only 1 facility of the United States Mint may be used to mint coins under this Act.

(c) PERIOD FOR ISSUANCE.—The Secretary may issue coins minted under this Act beginning on January 1, 2003, and ending when the quantity of coins issued under this Act reaches the limit under section 3(a).

SEC. 7. SALE OF COINS.

(a) SALE PRICE.—The coins minted under this Act shall be sold by the Secretary at a price equal to the sum of—

(1) the face value of the coins;

(2) the surcharge provided in subsection (d) with respect to such coins; and

(3) the cost of designing and issuing the coins (including labor, materials, dies, use of machinery, overhead expenses, marketing, and shipping).

(b) BULK SALES.—The Secretary shall make bulk sales of the coins issued under this Act at a reasonable discount.

(c) PREPAID ORDERS.—

(1) IN GENERAL.—The Secretary shall accept prepaid orders for the coins minted under this Act before the issuance of such coins.

(2) DISCOUNT.—Sale prices with respect to prepaid orders under paragraph (1) shall be at a reasonable discount.

(d) SURCHARGES.—All sales of coins issued under this Act shall include a surcharge established by the Secretary, in an amount equal to not more than $10 per coin.

SEC. 8. DISTRIBUTION OF SURCHARGES.

(a) IN GENERAL.—Subject to section 5134(f) of title 31, United States Code, the proceeds from the surcharges received by the Secretary from the sale of coins minted under this Act shall be paid promptly by the Secretary to the National Constitution Center.

(b) USE OF PROCEEDS.—The proceeds received by the National Constitution Center under subsection (a) shall be used by the Center to promote a greater understanding of the Constitution and its values and ideals.

(c) AUDITS.—The Comptroller General of the United States shall have the right to examine such books, records, documents, and other data of the National Constitution Center as may be related to the expenditures of amounts paid under subsection (a).

SEC. 8. FINANCIAL ASSURANCES.

(a) NO NET COST TO THE GOVERNMENT.—The Secretary shall take such actions as may be necessary to ensure that minting and issuing coins under this Act will not result in any net cost to the United States Government.

(b) PAYMENT FOR COINS.—A coin shall not be issued under this Act, unless the Secretary has received—

(1) full payment for the coin;

(2) security satisfactory to the Secretary to indemnify the United States for full payment; or

(3) a guarantee of full payment satisfactory to the Secretary from a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration.

By Mr. JEFFORDS (for himself, Mr. LEAHY, Mr. SCHUMER, and Mrs. CLINTON):

S. 2756. A bill to establish the Champlain Valley National Heritage Partnership in the States of Vermont and New York, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. JEFFORDS. Mr. President, I am very pleased to introduce the Champlain Valley National Heritage Act of 2002. I am joined by Senator LEAHY and

Senators SCHUMER and CLINTON of New York. This bill will establish a National Heritage Partnership within the Champlain Valley. Passage of this bill will culminate a process to enhance the incredible cultural resources of the Champlain Valley.

The Champlain Valley of Vermont and New York has one of the richest and most intact collections of historic resources in the United States. Fort Ticonderoga still stands where it has for centuries, at the scene of numerous battles critical to the birth of our Nation. Revolutionary gunboats have recently been found fully intact on the bottom of Lake Champlain. Our cemeteries are the permanent resting place for great explorers, soldiers and sailors. The United States and Canada would not exist today but for events that occurred in this region.

We in Vermont and New York take great pride in our history. We preserve it, honor it and show it off to visitors from around the world. These visitors are also very important to our economy. Tourism is among the most important industries in this region and has much potential for growth.

The Champlain Valley Heritage Partnership will bring together more than one hundred local groups working to preserve and promote our heritage. Up to $2 million a year will be made available from the National Park Service though the Lake Champlain Basin Program to support local efforts to preserve and interpret our heritage and present it to the world. Most of the funding will be given to small communities to help preserve their heritage and develop economic opportunities.

This project has taken many years for me to bring to the point of introducing legislation. This has been time well spent working at the grass-roots level to develop a framework to direct federal resources to where it will do the most good. I am confident that we have found the best model. This will be a true partnership that supports each member but does not impose any new Federal requirements.

The Champlain Valley National Heritage Partnership will preserve our historic resources, interpret and teach about the events that shaped our Nation and will be an engine for economic growth. I am hopeful that this bill soon become law.

Mr. LEAHY. Mr. President, I am very pleased to join with my Senate colleagues from Vermont and New York as we introduce the Lake Champlain Heritage Act of 2002. With this legislation, we will take an important step in recognizing the importance of the Lake Champlain Valley in the history of America.

I want to thank Senator JEFFORDS and his staff for all the work they have put into this effort. I know that many hours have gone into the research, discussion and editing to get where we are today. I also want to thank Senators CLINTON and SCHUMER who are our valuable New York partners in all things related to Lake Champlain.

Over the July 4th recess, I was able to participate in the Lake Champlain Maritime Museum's opening of a new exhibit featuring artifacts recovered from the 1776 Revolutionary War Battle of Valcour. It was just 1 year ago that Senator CLINTON and I were at the site of the Battle to take part in the recovery and beginning of the conservation process of those artifacts.

The Valcour Bay Research Project followed the 1997 discovery of the missing American gunboat from the Battle. I bring this up because our purpose today as we introduce this legislation underscores to the rest of our Nation a message we Vermonters and New Yorkers have long proclaimed: the role of Lake Champlain in the cause of American independence cannot be overlooked.

The evidence of the struggle for this strategic waterway from the days of Native American excursions, through the colonial rivalry between Britain and France, our War of Independence, until the end of the War of 1812, constantly surrounds those of us who make our homes in this Valley.

This act is intended to advance the cultural heritage goals of ''Opportunities for Action,'' the comprehensive plan developed under the Lake Champlain Special Designation Act by the Lake Champlain Basin Program with broad public input and support as well as with the involvement of local, State and Federal Governments.

We envision activities such as locally planned and managed heritage networks and programs, a management strategy for the Lake's underwater cultural resources and strengthening the links between cultural resources and economic development. This legislation will also help provide assistance as the 400th anniversary of Samuel De Champlain's arrival in the Valley is commemorated in 2009.

Today, we are taking a significant step in helping all Americans better appreciate the full history of the Lake Champlain Valley which holds such an extensive collection of historic sites and artifacts.

As Vermonters and New Yorkers the stewards of Lake Champlain, we have a serious responsibility to conserve this evidence for future generations. We believe that what we do here, how we manage the cultural heritage of the Valley, can contribute to the growing debate on how present generations can live and prosper on the same ground that we conserve as our natural and cultural heritage.

Our Vermont and New York Champlain Valley communities share this heritage and have helped us develop a vision to enhance the conservation, interpretation and enjoyment of our shared history and to make it more readily available to residents and visitors alike. We can help revitalize local economies and promote heritage tourism as we improve the stewardship of the Valley's cultural legacy by making additional resources available to communities and organizations through the Lake Champlain Basin Program.

I think it is most fitting that we have come here together to introduce this long-awaited bill, reasserting our partnership for Lake Champlain: Vermont and New York engaged in a cooperative effort to conserve, interpret, and honor our common heritage.

By Mr. BIDEN:

S. 2757. A bill to amend title XVIII of the Social Security Act to provide coverage of outpatient prescription drugs under the medicare program; to the Committee on Finance.

Mr. BIDEN. Mr. President, today I am introducing a bill to add outpatient prescription drug coverage as a new and integral benefit under Part B of Medicare. Under this bill, like the rest of the services under Part B, Medicare will pick up 80 percent of the cost of prescription drugs. This would be the case until a beneficiary hits a $4000 annual out-of-pocket limit, at which point the government picks up 100 percent of drug costs. Moreover, beneficiaries will not have to pay increased monthly premiums or annual deductibles as a result of this new drug benefit.

Now, we have been discussing prescription drug coverage for seniors in this chamber for many years, and there have been numerous proposals brought forward. Some might ask, why do you feel the need to propose your own prescription drug plan; what is wrong with the many previous proposals.

Well, to my way of thinking, we have lost our focus on this issue. In developing a drug plan, we have concentrated too much on such things as budget allotments, philosophy of government, desires of committee chairs, election politics, and other related issues, while ignoring the one thing that really counts: what do the citizens of this country, the ones who are supposed to use this plan, really want? All of these prescription drug plans will be voluntary, and yet unless a plan is attractive enough to ensure the participation of close to 100 percent of those eligible, it probably won't work from an economic point of view. Those of us who were around in 1988 for the debates about catastrophic health care remember with great clarity the consequences of passing a health-related bill that the citizens don't want.

Frankly, I have some doubts about whether any of the prescription drug proposals to date provide what the citizens in Delaware or elsewhere really want. And I think I have a pretty good idea of what people want in a prescription drug plan, at least people in my home state of Delaware. I live in Delaware, and I commute back and forth on AMTRAK every day between Delaware and Washington DC. I have been a Senator for 30 years and people in Delaware know me well. They have no reluctance about walking up to me at the local diner, on the train, or at the drugstore, to give me a piece of their

minds. And here is what Delawareans want in a prescription drug bill.

They want something simple and easily understandable. They don't want a plan with a lot of fine print, exclusions, complicated payment formulas, gaps in coverage, lengthy paragraphs filled with whereases and wherefores. They don't want to be in a state of constant anxiety because they really don't know what they have signed up for and what they are covered for. They don't want to have to spend hours on the phone listening to music while waiting for an insurance company clerk to answer the phone and try to explain what the benefits are. They don't want to spend a whole day filling out paperwork to try to get reimbursed for their expenses when they could just as well be playing with their grandchildren. They don't want to be caught in the middle of a fight between their drug insurance plan and their Medicare over who is going to pay for what.

They want a plan that provides meaningful and substantial financial help towards the cost of their medications. For most people I talk to, a cut in prescription drug costs from $5000 per year down to $4700 per year is not very helpful; they are still faced with choosing between paying for medications and paying for rent. With the increasing costs of prescription drugs these days, this is a criterion that is just as important to the middle class as it is to those with low incomes.

They want a plan that is stable, reliable, and predictable. They don't want to sign up with an insurance company and then have the company pull out of the state the following year. They don't want the specifics of their benefits to be changing every year. They want to know what they are getting.

They want a guarantee that a plan will be available to them. They don't want a guarantee that a plan will be available only if an insurance company decides it will offer a plan or if an insurance company decides they are a good risk.

They want a plan that is uniform, not one whose benefits change drastically if they happen to move a few miles. Delaware is a small state, and people who live or work in Delaware move back and forth across state lines with great frequency.

My prescription drug bill is focused on what consumers want, and it fulfills all of these requirements. People are already very familiar with Medicare Part B, so the addition of a prescription drug benefit will not add any confusion. People know that Medicare is stable, reliable, predictable, and the same all over the country. People know that Medicare Part B covers a substantial 80 percent of their medical expense. We know that people like Medicare Part B, since 94 percent of those eligible have voluntarily signed up for it. The addition of a new prescription drug benefit to Part B, without any change in monthly premiums or deductibles, is almost certain to increase the voluntary participation rate close to 100 percent.

Can we afford such a bill? Absolutely. It's just a matter of priorities and choices. And these choices simply reflect our values. My values tell me that providing life-saving prescription drugs to the seniors and disabled is a higher priority than, say, making permanent a tax cut for the well-to-do that they probably don't need and have not really requested.

Many of my colleagues in the Senate, and a large number of their staff, have been working enormously hard to develop a Medicare prescription drug bill that satisfies everybody's concerns. However, I am reminded of the statement by the noted British engineer Sir Alec Issigonis, who commented that ''A camel is a horse designed by committee''. If the public is expecting a horse, we better not end up with a camel.

Our current situation here in Congress brings to mind a story related by a local TV weatherman here in Washington, DC. This weatherman works in a very high tech underground office with fancy color radars, computers, split-second communications devices, and state of the art graphics. Yet before each broadcast, the weatherman goes upstairs and looks out the window to make sure it is not raining. I would ask my colleagues, as they work through their cost estimates, economic projections, and so forth in developing a prescription drug plan, to walk upstairs and look out the window. Policy makers must not work in protective isolation, in a vacuum; they need a strong dose of reality to inform their deliberations.

I believe that my bill provides the kind of prescription drug plan that Medicare beneficiaries in Delaware, and around the country, really want. I encourage my colleagues to keep the wants of their constituents foremost as they move to craft a vitally-needed prescription drug bill for Medicare beneficiaries.

By Mr. DODD (for himself, Ms. SNOWER, Mr. JEFFORDS, Mr. REED, Mr. BINGAMAN, Mrs. CLINTON, Mrs. MURRAY, and Mr. EDWARDS):

S. 2758. A bill entitled ''The Child Care and Development Block Grant Amendments Act''; to the Committee on Health, Education, Labor, and Pensions.

Mr. DODD. Mr. President, I am pleased to join with my colleagues Senator SNOWE, Senator JEFFORDS, Senator REED, Senator BINGAMAN, Senator CLINTON, Senator MURRAY, and Senator EDWARDS today in introducing the new Access to High Quality Child Care Act.

On April 11, I introduced, S. 2117, which represented a bipartisan partnership with the Senate Finance Committee and Senate Health, Education, Labor, and Pensions, HELP, Committee to both improve the quality of child care and expand the availability of child care. The bill that we are introducing today further strengthens and improves that legislation.

Compared to S. 2117, the new legislation we are introducing today: further strengthens the coordination among agencies and outreach about the availability of child care assistance, so that the child care agency and TANF agency coordinate in providing information to eligible parents about the availability of child care assistance; includes a new section to improve parent access to the process of obtaining child care subsidies; strengthens accountability for the use of quality funds by requiring States to set State child care quality goals, set quantifiable measures for each goal; and requires States to describe their progress in meeting each goal in an annual report; strengthens provisions to improve the quality and availability of child care for infants and toddlers, child care for disabled children, and child care for children who need care during nontraditional hours; allows States to operate an At Home Infant Care program to improve the quality of care for infants, currently successful in Montana and Minnesota; consolidates the general quality setaside and the child care workforce development setaside under S. 2117 into one 10 percent quality setaside to be used by States to improve the quality of care that children receive, regardless of setting; consolidates data collection under current law to make data collection and reporting requirements easier for States while retaining useful information for policymakers; deletes the section on school readiness incentive grants under S. 2117, instead, replacing these grants with the text of S. 2566, the Early Care and Education Act authorized separately under Title III of this new legislation; shifts the text of the Child Care Centers in Federal Facilities Act and the Technical and Financial Assistance Grants Act under S. 2117 to Title II of the new bill as separate authorizations; adds the text of the Book Stamps Act to Title II as a separate authorization; and, authorizes $1 billion in FY2003 and such sums as necessary in the out years 2004–2007.

In short, the Access to High Quality Child Care Act is about putting ''Development'' back into the Child Care and Development Block Grant.

The fact is that 78 percent of school-age parents are working today; 65 percent of parents with children under 6 are working today; and, over half of mothers with infants are in the workforce today.

That means about 14 million children, including 6 million infants and toddlers, under the age of 5 are in some type of child care arrangement. Many of them are in child care every week for many hours.

While their parents work, children are being cared for in a variety of settings. Some of them are very good, but sadly, some of them are not. What we know is that 46 percent of kindergarten

teachers report that half or more of their students enter kindergarten not ready to learn.

This new legislation that we are introducing today further strengthens our efforts to improve the quality of care to promote school readiness while expanding child care assistance to more working poor families.

We filed this legislation yesterday in the HELP Committee and will proceed to markup next Wednesday, July 24th. I urge my colleagues to join us in supporting this legislation that so many working families with children need.

I ask unanimous consent that summary of the legislation be printed in the RECORD.

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

THE 2002 ACCESS ACT—THE ACCESS TO HIGH QUALITY CHILD CARE ACT BRIEF SUMMARY

Background: The Access to High Quality Child Care is about putting ''Development'' back into the Child Care and Development Block Grant. About 14 million children, including 6 million infants and toddlers, under the age of 5 are in some type of child care arrangement. Many of them are in child care every week for many hours. The fact is that 78% of school-age parents are working today; 65% of parents with children under 6 are working today; and, over half of mothers with infants are in the workforce today. While these parents work, their children are being cared for in a variety of settings—some of which are very good, but sadly, some of them are not. What we know is that 46% of kindergarten teachers report that half or more of their students enter kindergarten not ready to learn. This reauthorization bill is geared toward improving the quality of care to promote school readiness while expanding child care assistance to more working poor families.

Key Provisions: The Child Care and Development Block Grant is designed to give parents maximum choice among child care providers. The bill retains parental choice, but provides states with a number of ways to help child care providers improve the quality of care that they provide. The 2002 Access Act will: Strengthen the coordination among agencies and outreach about the availability of child care assistance; Promote greater coordination among federal, state, and local care and early childhood development programs, including the transition from early care programs to elementary school; Set aside 10% of CCDBG funds to improve the quality of child care for any of the following activities—initiatives to improve recruitment, education, and retention of child care staff; initiatives to improve the quality and availability of care for infants and toddlers, children with disabilities, or care during nontraditional hours; resource and referral services; training and technical assistance; grants or loans to improve provider compliance with state or local law; support for states to monitor compliance or other activities deemed by the state to improve the quality of care, including the provision of emergency child care.

Improve the accountability of the use of quality funds by requiring states to set quality improvement goals that are measurable to ensure that states are making progress in improving the quality of child care. Set aside 5% of CCDBG funds to help states increase the reimbursement rate for child care providers to ensure that parents have real choices among quality providers. Under current law, CCDBG payment rates are supposed to be sufficient ''to ensure equal access for eligible children to comparable child care services in the state or substate area that are provided to children whose parents are not eligible to receive assistance''. But, current low state reimbursement rates do not offer parents comparable care for their children.

Allow states to operate an at-home infant care program to promote the quality of care for infants.

The children of working parents need quality child care if they are to enter school ready to learn. Yet, 30 states require no training in early childhood development before a teacher walks into a child care classroom. 42 states require no training in early childhood development before a family day care provider opens its home to unrelated children. The 2002 Access Act will: Require states to set training standards, just as they are required to do now for health and safety under current law. Such training would go beyond CPR and first aid to include training in the social, emotional, physical, and cognitive development of children.

Exempt relatives from the training requirements, but through the quality funding in CCDBG states could partner with colleges and R&Rs to provide training to relatives and informal caregivers on a voluntary basis. Initial evaluations in Connecticut of such efforts show that relatives and informal caregivers are voluntarily participating and are feeling better about themselves and their interactions with the children have improved.

Reduce administrative barriers and improve coordination among agencies so that low income working parents can more easily access the process for obtaining and retaining child care assistance.

SEPARATE AUTHORIZATIONS FOR QUALITY CHILD CARE INITIATIVES

Separate authorizations include the following measures: the Child Care Centers in Federal Facilities Act, the Technical and Financial Assistance Grants Act, the Book Stamps Act, and the Early Care & Education Act.

By Mr. HOLLINGS (for himself, Mr. LOTT, and Mr. BREAUX):

S. 2759. A bill to protect the health and safety of American consumers under the Federal Food, Drug, and Cosmetic Act from seafood contaminated by certain substances; to the Committee on Health, Education, Labor, and Pensions.

Mr. HOLLINGS. Mr. President, I rise today as Chairman of the Commerce, Science and Transportation Committee to introduce the Seafood Safety Enforcement Act of 2002. I am pleased to be joined by the Republican minority leader, Senator TRENT LOTT, and by Senator JOHN BREAUX, both distinguished members of the Commerce Committee. This Act would ensure that imports of seafood into the United States are meeting the same food safety standards imposed on seafood that originates from the United States.

Shrimp and other seafood harvested and processed in the United States is some of the best quality seafood in the world. I know how hard the shrimpers in my State of South Carolina work to bring good, wholesome products to our tables. To preserve the quality of seafood, the United States has established rigorous food standards to protect the health and well-being of American consumers. As part of that approach, we have banned the use of certain harmful substances in food-producing animals due to the extreme hazards they pose to human health. While these standards also apply to imported foods that cross our borders, these protections cannot be enforced without adequate inspection and testing.

Unfortunately, not all countries are applying the same rigorous standards that the United States demands for our consumers. In the last few months, one of the banned substances, namely the antibiotic chloramphenicol, was detected in shrimp and other food product imported from several countries to the United States, the European Union and Canada. Shockingly these substances have not been detected by the inspectors for the federal Food and Drug Administration, FDA, the agency responsible for protecting U.S. consumers from adulterated food imports. Rather, these substances were detected in the United States by independent testing done by State authorities in Louisiana.

While these products are prohibited by law, FDA testing has never detected such substances in food imports. We were alarmed to discover that FDA currently tests only 1 to 2 percent of all food imports for compliance with food safety standards. This failure to detect such substances may be due not only to inadequate frequency of testing, but also may be attributed to inadequate testing methods employed by the FDA. While the testing protocol used in Europe and Canada can detect such substances to 0.3 parts per billion ppb, FDA until very recently used a technique that only measures up to 3 ppb, and now is using a test that only detects to 1 ppb.

It is vital that we close this inspection gap at our borders and ensure the safety of our food supply, while not placing unreasonable burdens on the men and women who are tasked with this huge inspection job. This bill would ensure that U.S. consumers are protected from serious health risks associated with harmful substances, while allowing the continued flow of imports that are shown to be free of these harmful substances. It would require FDA to ensure that imports suspected of containing such substances are demonstrated to meet food safety standards. Such demonstration would be made by the importer or exporter, and subject to FDA approval.

Due to the health threats posed by such substances in our food supply, and the national interest of having a uniform inspection and testing standard, federal action is appropriate. This bill provides the safety and security we seek, while not placing unreasonable burdens on our federal food safety inspection system.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2759

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Seafood Safety Enforcement Act''.

SEC. 2. FINDINGS.

(1) Chloramphenicol, a potent antibiotic, can cause severe toxic effects in humans, including hypo-aplastic anemia, which is usually irreversible and fatal. The drug is administered to humans only in life-threatening situations when less toxic drugs are not effective.

(2) Because of these human health impacts, chloramphenicol and similar drugs are not approved for use in food-producing animals in the United States. However, other countries have been found to use these drugs in the aquaculture of shrimp and other seafood, including Thailand, Vietnam, and China.

(3) The majority of shrimp consumed by the United States is imported. The nation imports 400,000 metric tons of shrimp annually, and the percentage of shrimp imports rises each year. Thailand and Vietnam are the top two exporters of shrimp to the United States, and China is the fifth largest exporter of shrimp to the United States.

(4) Upon detection of chloramphenicol in certain shipments of seafood from China and other nations, in 2002 the European Union and Canada severely restricted imports of shrimp and other food from these nations.

(5) The United States Food and Drug Administration inspects only 2 percent of all seafood imports into the United States and utilizes a testing procedure that cannot detect the presence of chloramphenicol below 1 part per billion. The European Union and Canada use testing protocols that can detect such substances to 0.3 parts per billion.

(6) While Food and Drug Administration import testing did not detect chloramphenicol in shrimp imported from these nations in 2002, independent testing performed by the state of Louisiana detected chloramphenicol at a level of over 2 parts per billion in crawfish imported from China.

(7) Imports of seafood from nations that utilize substances banned in the United States pose potential threats to United States consumers. Denial of entry to contaminated shrimp and other products to the European Union and Canada will likely redirect imports to the United States of contaminated products turned away from these countries.

(8) Immediate and focused actions must be taken by the Federal government to improve enforcement of food import restrictions of seafood imports in order to protect United States consumers and ensure safety of the food supply.

SEC. 3. CONTAMINATED SEAFOOD.

Section 801 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381) is amended by—

(1) striking all of the text in the third sentence of subsection (a) after ''section 505,'' and inserting ''or (4) such article is seafood that appears to bear or contain one or more substances listed in section 530.41(a) of title 21, Code of Federal Regulations, or (5) such article is seafood originating from an exporter or country that the Secretary has identified in guidance as a likely source of articles subject to refusal of admission under clause (4) of this sentence, then such article shall be refused admission, except as provided in subsection (c) of this section and, with respect to articles subject to clause (5) of this sentence, except as provided in subsection (b) of this section.'';

(2) redesignating subsections (b) through (n) as subsections (c) through (o), respectively; and

(3) inserting after subsection (a) the following:

''(b)(1) Notwithstanding clause (5) of the third sentence in subsection (a) of this section, the Secretary may permit individual shipments of seafood originating in a country or from an exporter listed in guidance to be admitted into the United States if evidence acceptable to the Secretary is presented that the seafood in that shipment does not bear or contain a substance listed in section 530.41(a) of title 21, Code of Federal Regulations.

''(2) The Secretary may remove a country or exporter listed in guidance under clause (5) of the third sentence of subsection (a) of this section only if the country or exporter has shown to the satisfaction of the Secretary that each substance at issue is no longer sold for use in, being used in, or being used in a manner that could contaminate food-producing animals in the country at issue.''.

SEC. 4. GUIDANCE FOR REFUSING ENTRY OF SEAFOOD FROM A COUNTRY OR EXPORTER.

(a) ISSUANCE OF GUIDANCE.—Upon a determination by the Secretary of Health and Human Services that, based on information acceptable to the Secretary, an exporter or country appears to be a source of articles subject to refusal under section 801(a)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381(a)(4)), the Secretary shall issue guidance described in section 801(a)(5) of that Act.

(b) DETERMINATION CRITERIA.—In making the determination described in subsection (a), or any determination under section 801(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381(a)), the Secretary may consider—

(A) the detection of substances described in section 801(a)(4) of that Act by the Secretary;

(B) the detection of such substances by a person commissioned to carry out examinations and investigations under section 702(a) of that Act;

(C) findings from an inspection under section 704 of that Act;

(D) the detection by other importing countries of such substances in shipments of seafood that originate from such country or exporter; and

(E) other evidence or information as determined by the Secretary.

(c) ANNUAL REPORT.—The Secretary shall provide a report within 30 days after the end of each fiscal year to the Senate Committee on Health, Education, Labor, and Pensions and the House of Representatives Committee on Energy and Commerce setting forth the names of all countries and exporters for which the guidance described in subsection (a) was issued during that fiscal year.

(d) RULE OF CONSTRUCTION.—Nothing in this Act, and no amendment made by this Act, shall be construed to limit the existing authority of the Secretary of Health and Human Services or the Secretary of the Treasury to consider any information or to refuse admission of any article under section 801(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381(a)).

SEC. 5. ISSUANCE OF TOLERANCES.

If, after the date of enactment of this Act, the Secretary of Health and Human Services intends to issue a tolerance under section 512(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360b(b)) for any of the substances listed in section 530.41(a) of title 21, Code of Federal Regulations, then the Secretary shall notify the Senate Committee on Health, Education, Labor, and Pensions and the House of Representatives Committee on Energy and Commerce before issuing that tolerance. The Secretary shall include in the notification a draft of any changes in Federal statute law that may be necessary.

SEC. 6. CONFORMING AMENDMENTS.

Section 801 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381), as amended by subsection (a), is amended by—

(1) striking ''subsection (b)'' in subsection (d), as redesignated by section 2(2) of this Act, and inserting ''subsection (c)'';

(2) striking ''subsection (e)'' in paragraph (1) of subsection (g), as redesignated by section 2(2) of this Act, and inserting ''subsection (f)'';

(3) striking ''section 801(a)'' in paragraph (1)(A)(i) of subsection (h), as redesignated by section 2(2) of this Act, and inserting ''subsection (a) of this section'';

(4) striking ''section 801(a)'' in paragraph (1)(A)(ii) of subsection (h), as redesignated by section 2(2) of this Act, and inserting ''subsection (a) of this section'';

(5) striking ''section 801(d)(1);'' in paragraph (1)(A)(iii) of subsection (h), as redesignated by section 2(2) of this Act, and inserting ''subsection (e)(1) of this section;''.

(6) striking ''Subsection (b)'' in paragraph (2) of subsection (k), as redesignated by section 2(2) of this Act, and inserting ''Subsection (c)'';

(7) striking ''Subsection (b)'' in paragraph (1) of subsection (l), as redesignated by section 2(2) of this Act, and inserting ''Subsection (c)'';

(8) striking ''Subsection (b)'' in subsection (m), as redesignated by section 2(2) of this Act, and inserting ''Subsection (c)''; and

(9) striking ''Subsection (b)'' in paragraph (2)(B)(i) of subsection (n), as redesignated by section 2(2) of this Act, and inserting ''Subsection (c)''.

By Mr. SPECTER (for himself and Mr. HARKIN):

S.J. Res. 41. A joint resolution calling for Congress to consider and vote on a resolution for the use of force by the United States Armed Forces against Iraq before such force is deployed; to the Committee on Foreign Relations.

Mr. SPECTER. Mr. President, I sought recognition to introduce a joint resolution on behalf of Senator HARKIN and myself calling upon the Congress to consider, vote on, and enact a joint resolution authorizing the use of force by the U.S. Armed Forces against Iraq before such force is used.

This resolution takes no position as to whether the use of force should be authorized or it should not be authorized, but goes to the essential authority of the Congress under the Constitution to declare war.

The President's powers as Commander in Chief are reserved for an emergency where Congress does not have an opportunity to deliberate and decide. It is obvious that concerning the current situation with Iraq, there is ample time for a resolution of the issue by the Congress.

There have been repeated statements by the administration relating to military action against Saddam Hussein. It is known that Saddam has weapons of mass destruction, such as chemicals which he used against the Kurds, and there exists evidence of biological

weapons that he possesses. The best thinking is Saddam does not now have nuclear bombs but is trying to acquire them.

The President of the United States, in his State of the Union speech, identified Iraq, along with Iran and North Korea, as the ''axis of evil.'' Secretary of State Powell in congressional testimony then testified that the United States was not going to go to war against either Iran or North Korea, raising the inference that war against Iraq by negative implication was a distinct possibility.

There have been repeated requests for regime change by the administration. In lieu of the limited time, I will not enumerate them, although they are set forth in some detail in my prepared statement.

On February 13, 2002, I spoke on the floor calling for hearings by the Senate Foreign Relations Committee and/or the Senate Armed Services Committee, and by letters dated February 14, 2002, and March 12, 2002, wrote to the respective chairmen of those committees. I am glad to note that Senator BIDEN, chairman of the Foreign Relations Committee, has called for a September hearing on the Iraq issue.

The power of the Congress on the declaration of war has been eroded very materially, with the President taking unilateral action in Korea, Vietnam, Grenada, Lebanon, Panama, Somalia, and Kosovo. But in a situation where there is ample time for the Congress to deliberate and decide, the Congress should assert its constitutional authority.

Among the many issues regarding the separation of powers, none is more important than this basic power to declare war and the separate power which the President has as Commander in Chief which sometimes conflict, but not in the situation such as the one at hand where we have time to deliberate and decide.

Earlier this month, I conducted some 19 town meetings across my State of Pennsylvania and found a great deal of citizen concern. People are unaware of the details and would like to know more.

In my February 13, 2002 floor speech, I enumerated a number of issues which are worth repeating. First, hearings would identify with greater precision what Saddam has by way of weapons of mass destruction.

Secondly, we would get into the details as to what Saddam and Iraq have done by way of thwarting the United Nations from conducting inspections. Earlier this year, I met with Secretary General Kofi Annan to get a firsthand briefing and to press the U.N. to do everything it could to get those inspections.

Another issue which I think needs to be subjected to analysis and hearings and national debate is what the cost would be of toppling Saddam, including the cost in casualties.

Fourth, what will happen after a regime change? What will happen if, as and when Saddam goes?

There is also the critical issue as to what we may expect from Saddam by way of reprisal or by way of anticipatory action. We know that Saddam Hussein is ruthless. We have seen him use chemicals against his own people, the Kurds. We have his statement just yesterday on the 24th anniversary of the July revolution when Saddam came into power. It is a belligerent, bellicose statement.

I had an opportunity to meet with Saddam Hussein in January of 1990 at a meeting with Senator RICHARD SHELBY. There is no doubt in my mind, from that contact—a meeting of about an hour and a quarter—that we are dealing with someone who has a mindset and a determination, having invaded Kuwait, having acted against the Kurds, that should give us every reason to be concerned about what he may do in light of the administration's repeated statements about a regime change; a concern if there is action by the United States against Iraq that there may be retaliation against Israel or others in the Mideast.

Consideration by the Congress also would be very helpful in addressing the concerns which the international community has expressed on the unilateralism of President Bush and President Bush's administration. We have had instances of that: the International Criminal Court, Kyoto, the U.N.-Bosnia peacekeeping force, and others which I have enumerated in greater detail in the written statement which I will include at the conclusion of these remarks.

If there are Members of the Senate and House who come forward and support the President—people in this body with extensive experience in the field over many years, respected international reputations—I think that would give credence to a position that the President may wish to take and would allay some of the concerns internationally on unilateralism, and perhaps persuade some of our allies that this is the right course of conduct.

In considering what to do about Saddam, we have the example fresh in our mind of al-Qaeda and Osama bin Laden. We have learned that 20/20 hindsight always being very good that we should have acted against bin Laden before September 11. We had ample warning and ample cause to do so. Bin Laden was under indictment for killing Americans in Mogadishu in 1993. Bin Laden was under indictment for the East Africa Embassy bombings in 1998. We knew he was involved in the U.S.S. *Cole* terrorism. He had made pronouncements about a worldwide jihad. The United States and the United Nations made demands on the Taliban to turn over bin Laden, which were refused. So we had a right under international law to proceed against bin Laden.

There is obviously great concern about Saddam Hussein or what the future may hold if he goes unchecked. But these are all complicated issues. There ought to be full hearings. The American people ought to be informed. We have learned from the bitter experience of Vietnam what happens when there is military action where the American people are not supportive and the Congress is not supportive.

Obviously, in a representative democracy, the matter first comes to the Congress. There is the precedent of President George H.W. Bush in 1991, when the Congress authorized a resolution for the use of force. I know the Presiding Officer remembers it well, as do I. It was a historic debate, and has been so characterized by the media and other commentators. President Bush, in 1990, had originally said he did not need congressional authorization. Then Senator HARKIN took the floor on January 3, 1991, during a swearing-in ceremony, and procedurally the course that then followed, without going into great detail now, was that we had the debate on January 10, 11, and 12 and voted 52 to 47 in this body authorizing the use of force to repel Iraq from Kuwait. So that precedent is with us.

There is no doubt that Congress is reluctant to step into the breach and to take a position. I urged in 1998 that the Congress authorize the use of force before President Clinton moved in with the missile attacks against Iraq in December of 1998. My written statement goes into detail as to what I have done on this issue going back to 1983, when I conducted a debate with Senator Charles Percy on the question of Korea and Vietnam being a war, and the questioning of Justice Souter in 1990 on whether Korea was a war. There has been a reluctance on the part of Congress to step forward. If we do nothing and it all works out, everything is fine, the Congress is happy. If the President acts unilaterally and is wrong, he gets the blame and we do not get the blame.

I believe we have a responsibility to step forward. We have a responsibility institutionally under the Constitution to declare war, and we have a responsibility to acquaint the American people as to what is involved, and I think a responsibility to have this debate, to tell our European allies what our reasons are for what we may do.

If there is to be military action against Saddam and Iraq, there is no doubt it would be much stronger with a congressional resolution, which implicitly carries the support of the American people. I think the hearings which I have called for and the debate on the resolution will do a great deal to inform the American people and the people of the world as to what we are up to, and whatever justification it is we have.

I understand that my distinguished colleague, Senator HARKIN, will be a cosponsor of this resolution.

Repeated statements from the administration carry the strong suggestion that President Bush intends to take military action to change the regime of Saddam Hussein in Iraq. There

are good reasons to be concerned about Saddam Hussein's developing weapons of mass destruction. Iraq's exclusion of UN inspectors raises the inference he has something to hide.

On February 13, 2002, in a Senate floor statement, I urged that the Senate Armed Services and/or Senate Foreign Relations Committee hold hearings as much as possible in public with some necessarily in closed sessions, to determine:

(1) The specifics on Iraq's weapons of mass destruction;

(2) Precisely what happened on the United Nations efforts to conduct inspections in Iraq and Iraq's refusals;

(3) What type of a military action would be necessary to topple Saddam, including estimates of U.S. casualties;

(4) What is anticipated in a change in regime in Iraq including Saddam's prospective replacement.

CONGRESSIONAL RECORD, S730–731, February 13, 2002.

On April 4, 2002, I met with United Nations Secretary General Kofi Annan urging the UN to press Iraq to submit to wide-open, including surprise inspections, to determine the facts on Iraq's possession and efforts to create weapons of mass destruction. Meetings between UN officials and Iraqi representatives on May 1 and 3, 2002 produced no results. Subsequent meetings between UN officials and Iraqi representatives in early July produced no results.

A ranking U.S. intelligence official advised that wide-open and surprise inspections in Iraq could provide reasonable assurances as to what Iraq has by way of possessing and/or developing weapons of mass destruction.

Presidents have acted unilaterally in the past half century in initiating military actions in Korea, Vietnam, Grenada, Lebanon, Panama, Somalia and Kosovo. In some of those situations where there was not time for the Congress to deliberate and decide on a declaration of war or an authorization for the use of force, it was appropriate for the President to utilize his authority as Commander-in-Chief in an emergency. There is now ample time for the Congress to hold hearings, deliberate and take whatever action Congress deems appropriate regarding Iraq.

There is a need for the American public to understand the issues involved in the use of military force against Iraq. There has been some public discussion, but relatively little. Congressional hearings would stimulate a national dialogue on the nation's op-ed pages, radio and television talk shows and in town halls across the country. I am glad to see that Senator JOSEPH R. BIDEN, Chairman of the Foreign Relations Committee, has announced his committee will hold hearings on Iraq in September.

In 19 town meetings, which I conducted across the Commonwealth of Pennsylvania this month, I heard considerable public concern and confusion over the President's intentions as to Iraq. Public support, reflected through the elected members of the House and Senate, is indispensable to successfully carry out an extensive military action. The United States learned a better lesson in Vietnam that a war cannot be successfully fought without public and congressional support.

Consideration by the Congress on these key issues would provide a basis for international understanding of our position and perhaps even support in some quarters. There is a world view that President Bush too often acts unilaterally on critical international issues such as the International Criminal Court, the UN/Bosnia peacekeeping force, the Kyoto Protocol, ABM Treaty withdrawal, and the Biological Weapons Convention. If congressional consideration was followed by the authorization for the use of force supported by thoughtful and experienced members of the House and Senate, the international community might well be reassured that the U.S. military action was not the decision of just one man, even though he is the President of the United States.

There is solid precedent for President George W. Bush to request congressional authority for the use of force against Iraq, just as President George H.W. Bush did in January, 1991. On December 21, 1990, and as late as January 9, 1991, President Bush was quoted as saying a congressional authorization was not necessary. See Weekly Compilation of Presidential Documents, January 14, 1991. Vol. 27, No. 2, pp. 24–25. Many Senators, including Claiborne Pell of Rhode Island, RICHARD LUGAR of Indiana, TOM HARKIN of Iowa, EDWARD M. KENNEDY of Massachusetts, JOSEPH R. BIDEN, Jr. of Delaware, Brock Adams of Washington and I sought to force debate on a resolution that would require congressional authorization for the use of force against Iraq. CONGRESSIONAL RECORD, S 48, January 4, 1991; CONGRESSIONAL RECORD, S119–120, January 10, 1991; see also New York Times, October 18, 1990, page A1, ''Senators Demand Role in Approving Any Move on Iraq;'' Washington Post, January 4, 1991, page A19, ''Canceling Recess, Lawmakers Prepare to Debate War Powers.''

On January 3, 1991, the date that Senators who were elected and re-elected the previous November took the oath of office, Senator Harkin successfully sought Senate debate and a vote on a use-of-force resolution. Senate Majority Leader George Mitchell scheduled Senate floor action for consideration of a resolution for the use of force on January 10, 1991. Following a Senate debate which was characterized as ''historical'' by the Washington Post, the Senate authorized the use of force against Iraq by a vote of 52 to 47. CONGRESSIONAL RECORD, S1018–1019, January 12, 1991. Similarly, the House of Representatives passed such a resolution by a vote of 250 to 183. CONGRESSIONAL RECORD, H1139–1140, January 12, 1991.

With the repeated public commentary on the President's plans to use force against Iraq, there has been public concern about what Saddam Hussein might do in anticipation or retaliation. Saddam is well known for his ruthlessness and his disdain for life by use of chemicals against his own people, the Kurds. Saddam is widely reported to have stockpiles of biological weapons. In a struggle for his own survival, why should we expect Saddam Hussein to refrain from using every weapon at his disposal against an announced attacker? A lengthy article in the New York Times on July 6, 2002 concerning U.S. plans for widespread inoculation for smallpox carried the implicit suggestion of a concern for a bioterrorism attack.

Consideration by Congress on a resolution for the use of force against Saddam would not impact on any potential element of surprise because there is no element of surprise left. The news media has been full of notice to Saddam of potential U.S. plans such as: The New York Times February 16, 2002, edition which quoted Vice President CHENEY as saying, ''The President is determined to press on and stop Iraq . . . from continuing to develop weapons of mass destruction'' and intends to use ''the means at our disposal—including military, diplomatic and intelligence to address these concerns'';

The Los Angeles Times on May 5, 2002, reported that the defense Intelligence Agency has produced an operational support study on Iraq including maps and data on geography, roads, refineries, communication facilities, security organizations and military deployments;

The Washington Post reported on May 24, 2002, General Tommy R. Franks, Commander of the U.S. Central Command, has briefed the President concerning troop levels necessary to invade Iraq and oust Saddam Hussein;

The New York Times on July 5, 2002, reported on an American military document calling for air, land and sea based forces to attack Iraq and topple Saddam Hussein;

The New York Times on July 9, 2002, quoted President Bush as saying on Iraq: ''It's the stated policy of this government to have regime change and it hasn't changed. And we'll use all tools at our disposal to do so.''

In considering a pre-emptive strike against Iraq, we should consider—not that it is determinative—the consequences of not acting against al-Qaeda and Osama bin Laden before September 11, 2001. We had reason in that situation to anticipate a terrorist attack and we had rights under international law to move against bin Laden and al-Qaeda in a pre-emptive strike before September 11, 2001.

Prior to September 11, Osama bin Laden was under U.S. indictment for killing Americans in Mogadishu in 1993. He was further under U.S. indictment for the attacks against American embassies in 1998. He was known to have been involved in the terrorist attack of the USS *Cole*. Osama bin Laden

had spoken repeatedly and publicly about his intention to carry out a worldwide Jihad against the United States.

When the Taliban in control in Afghanistan refused to turn over bin Laden to the United States after demands by the United States and the United Nations, the United States had rights under international law to use military force against al-Qaeda and bin Laden.

With congressional hearings as a start, the American people should be informed about Iraq's threat and all our efforts to deal with this threat short of use of military force. We should do our utmost to organize an international coalition against Iraq, which President George Bush did in 1991, specifying as much of the evidence as possible in public congressional hearings in order to create American and worldwide public support for appropriate action. Such public hearings would be supplemented by classified information given to the leaders of the prospective coalition.

Article I, Section 8 of the United States Constitution provides that ''Congress has the authority to declare war.'' Article 2 Section 2 of the United States Constitution provides that the President ''shall be commander in chief of the army and navy of the United States. . . .''

In the past half century, there has been a consistent and considerable erosion of Congress' constitutional authority to declare war with a concomitant expansion of the President's powers as Commander-in-Chief. My concerns about the erosion of congressional authority to declare war first arose in 1951 when I was called to active duty in the United States Air Force after having received in R.O.T.C. commission as a second lieutenant upon graduation from the University of Pennsylvania. I was glad to serve state-side from July 29, 1951 to July 31, 1953 as a special agent in the Office of Special Investigations, noting that President Truman had acted on his authority as Commander-in-Chief to order a ''police action'' without congressional authorization.

Early in my Senate career, I participated extensively in floor debate on the War Powers Resolution concerning U.S. military action in Lebanon. On September 27, 1983, I questioned Senator Charles H. Percy, Chairman of the Foreign Relations Committee, as to whether Korea and Vietnam were wars. Senator Percy stated that both Korea and Vietnam were wars even though undeclared. CONGRESSIONAL RECORD, S. 12995, September 27, 1983.

In 1983, I prepared a legal document for a declaratory judgment action to take to the Supreme Court of the United States on the issue of the constitutionality of the War Powers Act and seeking a judicial determination of the respective authority of the President as Commander-in-Chief and the Congress to declare war. It was my thought that if the Congress and the President asked the Court to take jurisdiction and decide this issue, the Court might do so although even with such a joint request, the Supreme Court might be unwilling to be involved in the so-called ''political thicket''. The Reagan Administration was unwilling to join in such a request and congressional leaders were reluctant to do so although no final determination was made since the issue was rendered moot by the Reagan Administration's declination. Understandably, the parties preferred to leave the issue ambiguous with a resolution on a case-by-case basis in the political process without a finite judicial determination.

I pursued my inquiries by questioning Supreme Court nominees as to whether Korea was a war. In confirmation hearings for Justice David Souter on September 14, 1990, I questioned him as to whether Korea was a war, whether the Presidents exceeded their constitutional authority in military action in Korea and Vietnam and whether the War Powers Act was unconstitutional in violating presidential powers as Commander-in-Chief. Justice Souter declined to express an opinion stating, in effect, that there was no law to guide him in answering these questions. See Hearings Before the Committee on the Judiciary, United States Senate, 101st Cong., 2nd Sess., on the Nomination of David H. Souter to be Associate of the Supreme Court of the United States.

In the Fall of 1990 and in early January 1991, I joined other senators in successfully taking the position that the President needed congressional authorization for the use of military force against Iraq and the enforcement of UN Security Council Resolution 678. CONGRESSIONAL RECORD, S. 405–490, January 10, 1991.

I took up this question again on September 13, 1994, taking the position that the President did not have the constitutional authority to order an invasion of Haiti without prior congressional authorization. CONGRESSIONAL RECORD, S. 12760, September 13, 1994.

On June 5, 1995, I introduced S. Res. 128, which stated it was the sense of the Senate that no U.S. military personnel should be introduced into combat or potential combat situations in Bosnia without clearly defined objectives and sufficient resources to achieve those objectives. CONGRESSIONAL RECORD, S. 7703, June 5, 1995. That resolution noted that there was ample time for Congress to deliberate and decide that matter, stating that such a decision was a matter for the Congress and that there should be no further erosion of that authority by the Executive Branch.

On November 1, 1995, noting the military action in Somalia without congressional authority and the military action in Haiti without congressional authority, I urge the President to follow the precedent of the Gulf war and seek congressional approval for incursions into Bosnia since there was ample opportunity for Congress to consider and decide the issue. CONGRESSIONAL RECORD, S. 31102, November 1, 1995.

On September 17, 1996, I spoke on the Senate floor on the use of force with missile strikes against Iraq on September 3, 1996, noting that this was another example where the President did not seek congressional authorization or even consultation in advance of that military action. CONGRESSIONAL RECORD, S. 10624–10625, September 17, 1996.

When there was speculation about additional military action against Iraq in early 1998, I spoke on the Senate floor on February 12, 1998, noting that an air attack or a missile attack constituted acts of war which required congressional authority. CONGRESSIONAL RECORD, S. 791–792, February 12, 1998. The President then ordered missile strikes against Iraq in December 1998 without seeking congressional authority.

On February 23, 1999, during Senate debate on the President's use of force in Kosovo, I noted my concern that air strikes constituted acts of war which required authorization by Congress. CONGRESSIONAL RECORD, S. 1771–1773, February 23, 1999. I again noted the continuing erosion of constitutional authority and the need for Congress to debate, deliberate and decide these issues when there was ample time to do so. I noted the tendency on the part of Congress to sit back and avoid such tough decisions. If things go wrong, there is always the President to blame. If things go right, we have not impeded Presidential action.

On March 23, 1999, the Senate voted 58 to 41 to authorize air strikes in Kosovo after the President's request for such congressional action. CONGRESSIONAL RECORD, S. 3118, March 23, 1999. I voted in favor of air strikes even though I had concerns about the President's reliance on the ''humanitarian catastrophe'' which was a departure from recognized U.S. policy to use force where there was a vital U.S. national security interest. The House deadlocked 213 to 213 on the same vote to authorize force. CONGRESSIONAL RECORD, H. 2451–2452, April 28, 1999.

On May 24, 1999, I proposed an amendment to S. 1059—the Department of Defense Authorization bill—calling on the President to ''seek approval from Congress prior to the introduction of ground troops from the United States Armed Forces in connection with the present operations against the Federal Republic of Yugoslavia or funding for that operation will not be authorized.'' CONGRESSIONAL RECORD, S. 5809–5811, May 25, 1999.

While supporting air strikes proposed by the President against the former Yugloslavia, I opposed any open-ended authorization, such as S.J. Res. 20, which would have ''authorized [the President] to use all necessary force and other means in concert with

United States allies to accomplish the United States and North Atlantic Treaty Organization objectives in the Federal Republic of Yugoslavia, Serbia and Montenegro''. I thought the broad wording of that resolution constituted a blank check which was unwise. Instead, the President should seek specific congressional authority after specifying the objectives and the means for accomplishing those objectives.

There is an understandable reluctance on the part of Members of the House and Senate to challenge a President, especially a popular President, on his actions as Commander-in-Chief to protect U.S. national interests. The constitutional issues on separation of powers and the respective authority of the Congress vis-a-vis the President are obviously important. Of even greater importance, however, is the value of a united front with the President backed by congressional authorization and American public opinion on an issue where most, if not virtually all, of the international community is in opposition.

If the Congress sits back and does nothing and the President is right, then there is public approval. If the President turns out to be wrong, then it is his responsibility without blame being attached to the Congress. There is an added element that the President may, and probably does, know more than the Congress. Hearings, in closed session, could address that discrepancy in knowledge.

The current issue of Iraq is another chapter, albeit a very important chapter, in the ongoing effort to define congressional and Presidential authority on the critical constitutional doctrine of separation of powers. In the present case, there is ample time for Congress to deliberate and decide. With the stakes so high, Congress should assert its constitutional authority to make this critical decision.

AMENDMENTS SUBMITTED & PROPOSED

SA 4307. Mr. NELSON of Florida submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table.

SA 4308. Mr. TORRICELLI (for himself, Mr. LEAHY, and Mr. JEFFORDS) submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4309. Mr. GRAHAM (for himself, Mr. MILLER, Mr. KENNEDY, and Mr. CORZINE) proposed an amendment to the bill S. 812, supra.

SA 4310. Mr. HATCH (for Mr. GRASSLEY (for himself, Ms. SNOWE, Mr. JEFFORDS, Mr. BREAUX, Mr. HATCH, Ms. COLLINS, Ms. LANDRIEU, Mr. HUTCHINSON, and Mr. DOMENICI)) proposed an amendment to the bill S. 812, supra.

SA 4311. Mr. REID (for Mr. WYDEN (for himself and Mr. ALLEN)) proposed an amendment to the bill S. 2037, to mobilize technology and science experts to respond quickly to the threats posed by terrorist attacks and other emergencies, by providing for the establishment of a national emergency technology guard, a technology reliability advisory board, and a center for evaluating antiterrorism and disaster response technology within the National Institute of Standards and Technology.

TEXT OF AMENDMENTS

SA 4304. Mr. SMITH of New Hampshire (for himself, Mr. ALLARD, Mr. GRASSLEY, Mr. HATCH, Mr. BURNS, Mr. CRAIG, Mr. CRAPO, and Mr. SANTORUM) submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. MEDICARE PAYMENT FOR OUTPATIENT PRESCRIPTION DRUGS UNDER THE RX OPTION.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

''PART E—VOLUNTARY MEDICARE PRESCRIPTION DRUG COVERAGE

''MEDICARE PRESCRIPTION DRUG PLAN

''SEC. 1860AA. (a) IN GENERAL.—Each Medicare Prescription Drug Plan eligible individual may elect coverage (beginning on January 1, 2003) under this part in lieu of any other prescription drug coverage program under this title by enrolling in the Rx Option in order to receive coverage for outpatient prescription drugs as described in section 1860BB and to pay a combined deductible under section 1860CC.

''(b) MEDICARE PRESCRIPTION DRUG PLAN ELIGIBLE INDIVIDUAL DEFINED.—In this part, the term 'Medicare Prescription Drug Plan eligible individual' means an individual who is—

''(1) eligible for benefits under part A and enrolled under part B;

''(2) not enrolled in a Medicare+Choice plan under part C; and

''(3) not eligible for medical assistance for outpatient prescription drugs under title XIX.

''RX OPTION

''SEC. 1860BB. (a) ENROLLMENT IN THE RX OPTION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall establish a process for the enrollment of Medicare Prescription Drug Plan eligible individuals under the Rx Option that is based upon the process for enrollment in Medicare+Choice plans under part C of this title.

''(2) EXCEPTIONS.—

''(A) 2-YEAR OBLIGATION.—Except as provided in subparagraph (B), a Medicare Prescription Drug Plan eligible individual who elects the Rx Option shall be subject to the provisions of this part for a minimum period of 2 years, beginning with the first full month during which the individual is eligible for benefits under the Rx Option.

''(B) FREE LOOK PERIOD.—An individual who elects the Rx Option may disenroll from such Option no later than the last day of the first full month following the month in which such election was made.

''(3) ENROLLMENT IN MEDICARE SUPPLEMENTAL POLICIES.—An individual enrolled in the Rx Option may be enrolled only in a medicare supplemental policy subject to the special rules described in section 1882(v).

''(b) OUTPATIENT PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—Beginning in 2002, under the Rx Option, after the enrollee has met the combined deductible under section 1860C, the Secretary shall provide a benefit for outpatient prescription drugs through private entities under section 1860D equal to 50 percent of the lesser of—

''(A) the cost of outpatient prescription drugs for such year; or

''(B) $5000.

''(2) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year beginning after 2002, the dollar amount in paragraph (1)(B) shall be increased by an amount equal to—

''(A) such dollar amount; multiplied by

''(B) the percentage (if any) by which—

''(i) the prescription drug component of the Consumer Price Index for all urban consumers (all items city average) for the 12-month period ending with August of the preceding year; exceeds

''(ii) such prescription drug component of the Consumer Price Index for the 12-month period ending with August 2001.

''(3) ROUNDING.—If any increase determined under paragraph (2) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''COMBINED DEDUCTIBLE

''SEC. 1860CC. (a) IN GENERAL.—Notwithstanding any provision of this title and beginning in 2002, a beneficiary electing the Rx Option shall be subject to a combined deductible that shall apply in lieu of the deductibles applied under sections 1813(a)(1) and 1833(b).

''(b) AMOUNT.—

''(1) IN GENERAL.—For purposes of subsection (a), the combined deductible is equal to $675.

''(2) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year after 2002, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(A) such dollar amount; multiplied by

''(B) the percentage (if any) by which—

''(i) the medical component of the Consumer Price Index for all urban consumers (all items city average) for the 12-month period ending with August of the preceding year; exceeds

''(ii) such medical component of the Consumer Price Index for the 12-month period ending with August 2001.

''(3) ROUNDING.—If any increase determined under paragraph (2) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(c) APPLICATION.—In applying the combined deductible described in subsection (a) such deductible shall apply to each expense incurred on a calendar year basis for each item or service covered under this title, and each expense paid on a calendar year basis for such an item or service shall be credited against such deductible.

''PARTNERSHIPS WITH PRIVATE ENTITIES TO OFFER THE RX OPTION

''SEC. 1860DD. (a) PARTNERSHIPS.—

''(1) IN GENERAL.—The Secretary shall contract with private entities for the provision of outpatient prescription drug benefits under the Rx Option.

''(2) PRIVATE ENTITIES.—The private entities described in paragraph (1) shall include insurers (including issuers of medicare supplemental policies under section 1882), pharmaceutical benefit managers, chain pharmacies, groups of independent pharmacies, and other private entities that the Secretary determines are appropriate.

''(3) AREAS.—The Secretary may award a contract to a private entity under this section on a local, regional, or national basis.

''(4) DRUG BENEFITS ONLY THROUGH PRIVATE ENTITIES.—Outpatient prescription drug benefits under the Rx Option shall be offered only through a contract with a private entity under this section.

''(b) SECRETARY REQUIRED TO CONTRACT WITH ANY WILLING QUALIFIED PRIVATE ENTITY.—The Secretary may not exclude a private entity from receiving a contract to provide outpatient prescription drug benefits under the Rx Option if the private entity meets all of the requirements established by the Secretary for providing such benefits.

''ELIGIBILITY FOR CATASTROPHIC COVERAGE

''SEC. 1860EE. Noting in this part shall be construed to prohibit an individual who elects coverage under the Rx Option from obtaining catastrophic coverage under any other program under this title.''.

(b) CONFORMING MEDIGAP CHANGES.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) SPECIAL RULES FOR MEDICARE PRESCRIPTION DRUG PLAN ENROLLEES.—

''(1) REVISION OF BENEFIT PACKAGES.—

''(A) IN GENERAL.—Notwithstanding subsection (p), the benefit packages established under such subsection (including the 2 plans described in paragraph (11)(A) of such subsection) shall be revised (in the manner described in subsection (p)(1)(E)) so that each of the benefit packages classified as 'A' through 'J' remain exactly the same, except that each benefit package shall include special rules that apply only to individuals enrolled in the Rx Option under section 1860B as follows:

''(i) COMBINED DEDUCTIBLE.—Each benefit package shall require the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in an amount equal to the amount of the combined deductible under section 1860C(b) before the policy begins payment of any benefits.

''(ii) PRESCRIPTION DRUG COVERAGE.—In the case of a benefit package classified as 'H', 'I', and 'J', such policy may not provide coverage for outpatient prescription drugs that duplicates the coverage for outpatient prescription drugs provided under the Rx Option under section 1860B(b).

''(B) ADJUSTED PREMIUM.—In the case of an individual enrolled in the Rx Option, the premium for the policy in which the individual is enrolled may be appropriately adjusted to reflect the special rules applicable to such individual under subparagraph (A).

''(2) RENEWABILITY AND CONTINUITY OF COVERAGE.—The revisions of benefit packages under paragraph (1) shall not affect—

''(A) the renewal of medicare supplemental policies under this section that are in existence on the effective date of such revisions; or

''(B) the continuity of coverage under such policies.''.

SA 4307. Mr. NELSON of Florida submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON PAYMENTS TO PROVIDERS UNDER A FEDERAL HEALTH CARE PROGRAM.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

''SEC. 1128G. LIMITATION ON PAYMENTS TO PROVIDERS UNDER A FEDERAL HEALTH CARE PROGRAM.

''(a) IN GENERAL.—No Federal funds shall be used to provide payments under a Federal health care program to any physician (as defined in section 1861(r)), practitioner (as described in section 1842(b)(18)(C)), or other individual who charges a membership fee or any other extraneous or incidental fee to a patient, or requires a patient to purchase an item or service, as a prerequisite for the provision of an item or service to the patient.

''(b) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this section, the term 'Federal health care program' has the meaning given that term under section 1128B(f) except that, for purposes of this section, such term includes the health insurance program under chapter 89 of title 5, United States Code.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to payments made on or after the date of enactment of this Act.

SA 4308. Mr. TORRICELLI (for himself, Mr. LEAHY, and Mr. JEFFORDS) submitted an amendment intended to be proposed by him to the bill S. 812. to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—GIFT AND REBATE DISCLOSURE

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Gift and Rebate Disclosure Act of 2002''.

SEC. ___02. DISCLOSURE BY PRESCRIPTION DRUG MANUFACTURERS, PACKERS, AND DISTRIBUTORS OF CERTAIN GIFTS.

Section 503 of the Federal Food, Drug, and Cosmetics Act (21 U.S.C. 353) is amended by adding at the end the following:

''(h)(1) Each manufacturer, packer, or distributor of a drug subject to subsection (b)(1) shall disclose to the Commissioner—

''(A) not later than June 30, 2004, and each June 30 thereafter, the value, nature, and purpose of any—

''(i) gift provided during the preceding calendar year to any covered health entity by the manufacturer, packer, or distributor, or a representative thereof, in connection with detailing, promotional, or other marketing activities; and

''(ii) cash rebate, discount, or any other financial consideration provided during the preceding calendar year to any pharmaceutical benefit manager by the manufacturer, packer, or distributor, or a representative thereof, in connection with detailing, promotional, or other marketing activities; and

''(B) not later than the date that is 6 months after the date of enactment of this subsection and each June 30 thereafter, the name and address of the individual responsible for the compliance of the manufacturer, packer, or distributor with the provisions of this subsection.

''(2) Subject to paragraph (3), the Commissioner shall make all information disclosed to the Commissioner under paragraph (1) publicly available, including by posting such information on the Internet.

''(3) The Commissioner shall keep confidential any information disclosed to or otherwise obtained by the Commissioner under this subsection that relates to a trade secret referred to in section 1905 of title 18, United States Code. The Commissioner shall provide an opportunity in the disclosure form required under paragraph (4) for a manufacturer, packer, or distributor to identify any such information.

''(4) Each disclosure under this subsection shall be made in such form and manner as the Commissioner may require.

''(5) Each manufacturer, packer, and distributor described in paragraph (1) shall be subject to a civil monetary penalty of not more than $10,000 for each violation of this subsection. Each unlawful failure to disclose shall constitute a separate violation. The provisions of paragraphs (3), (4), and (5) of section 303(g) shall apply to such a violation in the same manner as such provisions apply to a violation of a requirement of this Act that relates to devices.

''(6) For purposes of this subsection:

''(A) The term 'covered health entity' includes any physician, pharmaceutical benefit manager, hospital, nursing home, pharmacist, health benefit plan administrator, or any other entity authorized to prescribe or dispense drugs that are subject to subsection (b)(1), in the District of Columbia or any State, commonwealth, possession, or territory of the United States.

''(B) The term 'gift' includes any gift, fee, payment, subsidy, or other economic benefit with a value of $50 or more, except that such term excludes the following:

''(i) Free samples of drugs subject to subsection (b)(1) intended to be distributed to patients.

''(ii) The payment of reasonable compensation and reimbursement of expenses in connection with any clinical trial conducted in connection with a valid scientific study designed to answer specific questions about drugs, devices, new therapies, or new ways of using known treatments, or in connection with a clinical trial involving the compassionate use of an experimental drug or device as permitted under regulations promulgated by the Food and Drug Administration.

''(iii) Any scholarship or other support for medical students, residents, or fellows selected by a national, regional, or specialty medical or other professional association to attend a significant educational, scientific, or policy-making conference of the association.''.

SEC. ___03. DISALLOWANCE OF DEDUCTION FOR PHYSICIAN GIFT EXPENSES OF PRESCRIPTION DRUG MANUFACTURERS.

(a) GENERAL RULE.—Part IX of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items not deductible) is amended by adding at the end the following new section:

''SEC. 280I. PHYSICIAN GIFT EXPENSES OF PRESCRIPTION DRUG MANUFACTURERS.

''(a) GENERAL RULE.—No deduction shall be allowed under this chapter for any physician gift expense paid or incurred by any prescription drug manufacturer.

''(b) PHYSICIAN GIFT EXPENSE.—For purposes of this section, the term 'physician gift expense' means any gift provided directly or indirectly to or for the benefit of a physician, including gifts of meals, sponsored teachings, symposia, and travel, but not including product samples.

''(c) PRESCRIPTION DRUG MANUFACTURER.—For purposes of this section, the term 'prescription drug manufacturer' means—

''(1) any person engaged in the trade or business of manufacturing or producing any prescription drug, and

''(2) any person who is a member of an affiliated group which includes a person described in paragraph (1).

For purposes of the preceding sentence, the term 'affiliated group' means any affiliated group as defined in section 1504 (determined without regard to paragraphs (3) and (4) of 1504(b)).''

(b) CLERICAL AMENDMENT.—The table of sections for part IX of subchapter B of chapter 1 of such Code is amended by adding at the end thereof the following new item:

''Sec. 280I. Physician gift expenses of prescription drug manufacturers.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred after December 31, 2001.

SA 4309. Mr. GRAHAM (for himself, Mr. MILLER, Mr. KENNEDY and Mr. CORZINE) proposed an amendment to the bill S. 812. to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; as follows:

At the end, add the following:

TITLE II—MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

SEC. 201. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the ''Medicare Outpatient Prescription Drug Act of 2002''.

(b) TABLE OF CONTENTS.—The table of contents of this title is as follows:

Sec. 201. Short title; table of contents.
Sec. 202. Medicare outpatient prescription drug benefit program.

''PART D—OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

''Sec. 1860. Definitions.
''Sec. 1860A. Establishment of outpatient prescription drug benefit program.
''Sec. 1860B. Enrollment under program.
''Sec. 1860C. Enrollment in a plan.
''Sec. 1860D. Providing information to beneficiaries.
''Sec. 1860E. Premiums.
''Sec. 1860F. Outpatient prescription drug benefits.
''Sec. 1860G. Entities eligible to provide outpatient drug benefit.
''Sec. 1860H. Minimum standards for eligible entities.
''Sec. 1860I. Payments.
''Sec. 1860J. Employer incentive program for employment-based retiree drug coverage.
''Sec. 1860K. Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.
''Sec. 1860L. Medicare Prescription Drug Advisory Committee.''.
Sec. 203. Part D benefits under Medicare+Choice plans.
Sec. 204. Additional assistance for low-income beneficiaries.
Sec. 205. Medigap revisions.
Sec. 206. Comprehensive immunosuppressive drug coverage for transplant patients under part B.
Sec. 207. HHS study and report on uniform pharmacy benefit cards.
Sec. 208. GAO study and biennial reports on competition and savings.
Sec. 209. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).

SEC. 202. MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM.

(a) ESTABLISHMENT.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

''PART D—OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

''DEFINITIONS

''SEC. 1860. In this part:

''(1) COVERED OUTPATIENT DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered outpatient drug' means any of the following products:

''(i) A drug which may be dispensed only upon prescription, and—

''(I) which is approved for safety and effectiveness as a prescription drug under section 505 of the Federal Food, Drug, and Cosmetic Act;

''(II)(aa) which was commercially used or sold in the United States before the date of enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

''(III)(aa) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

''(ii) A biological product which—

''(I) may only be dispensed upon prescription;

''(II) is licensed under section 351 of the Public Health Service Act; and

''(III) is produced at an establishment licensed under such section to produce such product.

''(iii) Insulin approved under appropriate Federal law, including needles and syringes for the administration of such insulin.

''(iv) A prescribed drug or biological product that would meet the requirements of clause (i) or (ii) except that it is available over-the-counter in addition to being available upon prescription.

''(B) EXCLUSION.—The term 'covered outpatient drug' does not include any product—

''(i) except as provided in subparagraph (A)(iv), which may be distributed to individuals without a prescription;

''(ii) for which payment is available under part A or B or would be available under part B but for the application of a deductible under such part (unless payment for such product is not available because benefits under part A or B have been exhausted), determined, except as provided in subparagraph (C), without regard to whether the beneficiary involved is entitled to benefits under part A or enrolled under part B; or

''(iii) except for agents used to promote smoking cessation and agents used for the treatment of obesity, for which coverage may be excluded or restricted under section 1927(d)(2).

''(C) CLARIFICATION REGARDING IMMUNOSUPPRESSIVE DRUGS.—In the case of a beneficiary who is not eligible for any coverage under part B of drugs described in section 1861(s)(2)(J) because of the requirements under such section (and would not be so eligible if the individual were enrolled under such part), the term 'covered outpatient drug' shall include such drugs if the drugs would otherwise be described in subparagraph (A).

''(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual that is entitled to benefits under part A or enrolled under part B.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any entity that the Secretary determines to be appropriate to provide eligible beneficiaries with covered outpatient drugs under a plan under this part, including—

''(A) a pharmacy benefit management company;

''(B) a retail pharmacy delivery system;

''(C) a health plan or insurer;

''(D) a State (through mechanisms established under a State plan under title XIX);

''(E) any other entity approved by the Secretary; or

''(F) any combination of the entities described in subparagraphs (A) through (E) if the Secretary determines that such combination—

''(i) increases the scope or efficiency of the provision of benefits under this part; and

''(ii) is not anticompetitive.

''(4) MEDICARE+CHOICE ORGANIZATION; MEDICARE+CHOICE PLAN.—The terms 'Medicare+Choice organization' and 'Medicare+Choice plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to Medicare+Choice organizations).

''(5) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860K) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''ESTABLISHMENT OF OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

''SEC. 1860A. (a) PROVISION OF BENEFIT.—

''(1) IN GENERAL.—Beginning in 2005, the Secretary shall provide for and administer an outpatient prescription drug benefit program under which each eligible beneficiary enrolled under this part shall be provided with coverage of covered outpatient drugs as follows:

''(A) MEDICARE+CHOICE PLAN.—If the eligible beneficiary is eligible to enroll in a Medicare+Choice plan, the beneficiary—

''(i) may enroll in such a plan; and

''(ii) if so enrolled, shall obtain coverage of covered outpatient drugs through such plan.

''(B) MEDICARE PRESCRIPTION DRUG PLAN.—If the eligible beneficiary is not enrolled in a Medicare+Choice plan, the beneficiary shall obtain coverage of covered outpatient drugs through enrollment in a plan offered by an eligible entity with a contract under this part.

''(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program established under this part.

''(3) SCOPE OF BENEFITS.—The program established under this part shall provide for coverage of all therapeutic classes of covered outpatient drugs.

''(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860B(b)(1)(F)), such beneficiary—

''(1) may continue to receive such coverage and not enroll under this part; and

''(2) pursuant to section 1860B(b)(1)(C), is permitted to subsequently enroll under this part without any penalty and obtain coverage of covered outpatient drugs in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

''(c) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

''ENROLLMENT UNDER PROGRAM

''SEC. 1860B. (a) ESTABLISHMENT OF PROCESS.—

''(1) PROCESS SIMILAR TO ENROLLMENT UNDER PART B.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

''(2) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive covered outpatient drugs under this title.

''(b) SPECIAL ENROLLMENT PROCEDURES.—

''(1) LATE ENROLLMENT PENALTY.—

''(A) INCREASE IN PREMIUM.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in paragraph (2), the Secretary shall establish procedures for increasing the amount of the monthly part D premium under section 1860E(a) applicable to such beneficiary by an amount that the Secretary determines is actuarily sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

''(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account—

''(i) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

''(ii) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

''(C) PERIODS NOT TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

''(ii) APPLICATION.—This subparagraph shall only apply with respect to a coverage period the enrollment for which occurs before the end of the 60-day period that begins on the first day of the month which includes—

''(I) in the case of a beneficiary with coverage described in clause (ii) of subparagraph (F), the date on which the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of the coverage provided under the program under this part; or

''(II) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of subparagraph (F), the date on which the beneficiary loses eligibility for such coverage.

''(D) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly part D premium under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

''(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary's 'continuous period of eligibility' is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

''(ii) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate 'continuous period of eligibility' with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

''(F) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

''(i) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934 and through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part.

''(ii) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined in section 1860J(e)(3)), but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part.

''(iii) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part.

''(iv) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part.

''(2) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—

''(A) IN GENERAL.—The Secretary shall establish an applicable period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may enroll under this part without the application of the late enrollment procedures established under paragraph (1)(A).

''(B) OPEN ENROLLMENT PERIOD TO BEGIN PRIOR TO JANUARY 1, 2005.—The Secretary shall ensure that eligible beneficiaries are permitted to enroll under this part prior to January 1, 2005, in order to ensure that coverage under this part is effective as of such date.

''(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES WHO INVOLUNTARILY LOSE CREDITABLE PRESCRIPTION DRUG COVERAGE.—The Secretary shall establish a special open enrollment period for an eligible beneficiary that loses creditable prescription drug coverage.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) OPEN AND SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to paragraph (2) or (3) of subsection (b) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(3) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2005.

''(d) TERMINATION.—

''(1) IN GENERAL.—The causes of termination specified in section 1838 shall apply to this part in the same manner as such causes apply to part B.

''(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—

''(A) IN GENERAL.—In addition to the causes of termination specified in paragraph (1), the Secretary shall terminate an individual's coverage under this part if the individual is no longer enrolled in either part A or B.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if later) under part B.

''(3) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Secretary shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Secretary under section 1860C(a)(1)).

''ENROLLMENT IN A PLAN

''SEC. 1860C. (a) PROCESS.—

''(1) ESTABLISHMENT.—

''(A) ELECTION.—

''(i) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization—

''(I) shall make an annual election to enroll in any plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides; and

''(II) may make an annual election to change the election under this clause.

''(ii) DEFAULT ENROLLMENT.—Such process shall include for the default enrollment in such a plan in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of such a plan.

''(B) RULES.—In establishing the process under subparagraph (A), the Secretary shall—

''(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a Medicare+Choice plan under section 1851, including—

''(I) the establishment of special election periods under subsection (e)(4) of such section; and

''(II) the application of the guaranteed issue and renewal provisions of subsection (g) of such section (other than paragraph (3)(C)(i), relating to default enrollment); and

''(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

''(2) FIRST ENROLLMENT PERIOD FOR PLAN ENROLLMENT.—The process developed under paragraph (1) shall—

''(A) ensure that eligible beneficiaries who choose to enroll under this part are permitted to enroll with an eligible entity prior to January 1, 2005, in order to ensure that coverage under this part is effective as of such date; and

''(B) be coordinated with the open enrollment period under section 1860B(b)(2)(A).

''(b) MEDICARE+CHOICE ENROLLEES.—

''(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization shall receive coverage of covered outpatient drugs under this part through such plan.

''(2) RULES.—Enrollment in a Medicare+Choice plan is subject to the rules for enrollment in such a plan under section 1851.

''PROVIDING INFORMATION TO BENEFICIARIES

''SEC. 1860D. (a) ACTIVITIES.—

''(1) IN GENERAL.—The Secretary shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

''(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 30 days prior to the open enrollment period described in section 1860B(b)(2)(A).

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The activities described in subsection (a) shall—

''(A) be similar to the activities performed by the Secretary under section 1851(d);

''(B) be coordinated with the activities performed by the Secretary under such section and under section 1804; and

''(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

''(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

''(A) BENEFITS.—The benefits provided under the plan, including the prices beneficiaries will be charged for covered outpatient drugs, any preferred pharmacy networks used by the eligible entity under the plan, and the formularies and appeals processes under the plan.

''(B) QUALITY AND PERFORMANCE.—To the extent available, the quality and performance of the eligible entity offering the plan.

''(C) BENEFICIARY COST-SHARING.—The cost-sharing required of eligible beneficiaries under the plan.

''(D) CONSUMER SATISFACTION SURVEYS.—To the extent available, the results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan.

''(E) ADDITIONAL INFORMATION.—Such additional information as the Secretary may prescribe.

''(3) INFORMATION STANDARDS.—The Secretary shall develop standards to ensure that the information provided to eligible beneficiaries under this part is complete, accurate, and uniform.

''(c) USE OF MEDICARE CONSUMER COALITIONS TO PROVIDE INFORMATION.—

''(1) IN GENERAL.—The Secretary may contract with Medicare Consumer Coalitions to conduct the informational activities under—

''(A) this section;

''(B) section 1851(d); and

''(C) section 1804.

''(2) SELECTION OF COALITIONS.—If the Secretary determines the use of Medicare Consumer Coalitions to be appropriate, the Secretary shall—

''(A) develop and disseminate, in such areas as the Secretary determines appropriate, a request for proposals for Medicare Consumer Coalitions to contract with the Secretary in order to conduct any of the informational activities described in paragraph (1); and

''(B) select a proposal of a Medicare Consumer Coalition to conduct the informational activities in each such area, with a preference for broad participation by organizations with experience in providing information to beneficiaries under this title.

''(3) PAYMENT TO MEDICARE CONSUMER COALITIONS.—The Secretary shall make payments to Medicare Consumer Coalitions contracting under this subsection in such amounts and in such manner as the Secretary determines appropriate.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary to contract with Medicare Consumer Coalitions under this section.

''(5) MEDICARE CONSUMER COALITION DEFINED.—In this subsection, the term 'Medicare Consumer Coalition' means an entity that is a nonprofit organization operated under the direction of a board of directors that is primarily composed of beneficiaries under this title.

''PREMIUMS

''SEC. 1860E. (a) ANNUAL ESTABLISHMENT OF MONTHLY PART D PREMIUM RATES.—

''(1) IN GENERAL.—The Secretary shall, during September of each year (beginning in 2004), determine and promulgate a monthly part D premium rate for the succeeding year.

''(2) AMOUNT.—The Secretary shall determine the monthly part D premium rate for the succeeding year as follows:

''(A) PREMIUM FOR 2005.—The monthly part D premium rate for 2005 shall be $25.

''(B) INFLATION ADJUSTMENT OF PREMIUM FOR 2006 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—Subject to clause (ii), in the case of any calendar year beginning after 2005, the monthly part D premium rate for the year shall be the amount described in subparagraph (A) increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the percentage (if any) by which the amount of the average annual per capita aggregate expenditures payable from the Prescription Drug Account for the year (as estimated under section 1860J(c)(2)(C)) exceeds the amount of such expenditures in 2005.

''(ii) ROUNDING.—If the monthly part D premium rate determined under clause (i) is not a multiple of $1, such rate shall be rounded to the nearest multiple of $1.

''(b) COLLECTION OF PART D PREMIUM.—The monthly part D premium applicable to an eligible beneficiary under this part (after application of any increase under section 1860B(b)(1)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''OUTPATIENT PRESCRIPTION DRUG BENEFITS

''SEC. 1860F. (a) REQUIREMENT.—A plan offered by an eligible entity under this part shall provide eligible beneficiaries enrolled in such plan with—

''(1) coverage of covered outpatient drugs—

''(A) without the application of any deductible; and

''(B) with the cost-sharing described in subsection (b); and

''(2) access to negotiated prices for such drugs under subsection (c).

''(b) COST-SHARING.—

''(1) COPAYMENT STRUCTURE FOR DRUGS INCLUDED IN THE FORMULARY.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, in the case of a covered outpatient drug that is dispensed in a year to an eligible beneficiary and that is included in the formulary established by the eligible entity (pursuant to section 1860H(c)) for the plan, the beneficiary shall be responsible for a copayment for the drug in an amount equal to the following:

''(i) GENERIC DRUGS.—In the case of a generic covered outpatient drug, $10 for each prescription (as defined in subparagraph (D)) of such drug.

''(ii) PREFERRED BRAND NAME DRUGS.—In the case of a preferred brand name covered outpatient drug (including a drug treated as a preferred brand name drug under subparagraph (C)), $40 for each prescription (as so defined) of such drug.

''(B) REDUCTION BY ELIGIBLE ENTITY.—An eligible entity offering a plan under this part may reduce the applicable copayment amount that an eligible beneficiary enrolled in the plan is subject to under subparagraph (A) if the Secretary determines that such reduction—

''(i) is tied to the performance requirements described in section 1860I(b)(1)(C); and

''(ii) will not result in an increase in the expenditures made from the Prescription Drug Account.

''(C) TREATMENT OF MEDICALLY NECESSARY NONFORMULARY DRUGS.—The eligible entity shall treat a nonformulary drug as a preferred brand name drug under subparagraph (A)(ii) if such nonformulary drug is determined (pursuant to subparagraph (D) or (E) of section 1860H(a)(4)) to be medically necessary.

''(D) PRESCRIPTION DEFINED.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of subparagraph (A), the term 'prescription' means—

''(I) a 30-day supply for a maintenance drug; and

''(II) a supply necessary for the length of the course that is typical of current practice for a nonmaintenance drug.

''(ii) SPECIAL RULE FOR MAIL ORDER DRUGS.—In the case of drugs obtained by mail order, the term 'prescription' may be for a supply that is longer than the period specified in clause (i) or (ii) (as the case may be) if the Secretary determines that the longer supply will not result in an increase in the expenditures made from the Prescription Drug Account.

''(2) BENEFICIARY RESPONSIBLE FOR NEGOTIATED PRICE OF NONFORMULARY DRUGS.—In the case of a covered outpatient drug that is dispensed to an eligible beneficiary and that is not included in the formulary established by the eligible entity (pursuant to section 1860H(c)) for the plan (and not treated a preferred brand name drug under paragraph (1)(C)), the beneficiary shall be responsible for the negotiated price for the drug (as reported to the Secretary pursuant to section 1860H(a)(6)(A)).

''(3) COST-SHARING MAY NOT EXCEED NEGOTIATED PRICE.—

''(A) IN GENERAL.—If the amount of cost-sharing for a covered outpatient drug that

would otherwise be required under this subsection (but for this paragraph) is greater than the applicable amount, then the amount of such cost-sharing shall be reduced to an amount equal to such applicable amount.

''(B) APPLICABLE AMOUNT DEFINED.—For purposes of subparagraph (A), the term 'applicable amount' means an amount equal to—

''(i) in the case of a drug included in the formulary (generic drugs and preferred brand name drugs, including a drug treated as a preferred brand name drug under paragraph (1)(C)), the negotiated price for the drug (as reported to the Secretary pursuant to section 1860H(a)(6)(A)) less $5; and

''(ii) in the case of a nonformulary drug, the negotiated price for the drug (as so reported).

''(4) NO COST-SHARING ONCE EXPENSES EQUAL ANNUAL OUT-OF-POCKET LIMIT.—

''(A) IN GENERAL.—An eligible entity offering a plan under this part shall provide coverage of covered outpatient drugs without any cost-sharing if the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—Subject to paragraph (5), for purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph is equal to $4,000.

''(C) APPLICATION.—In applying subparagraph (A)—

''(i) incurred costs shall only include costs incurred for the cost-sharing described in this subsection; but

''(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

''(5) INFLATION ADJUSTMENT FOR COPAYMENT AMOUNTS AND ANNUAL OUT-OF-POCKET LIMIT FOR 2006 AND SUBSEQUENT YEARS.—

''(A) IN GENERAL.—For any year after 2005—

''(i) the copayment amounts described in clauses (i) and (ii) of paragraph (1)(A) are equal to the copayment amounts determined under such paragraph (or this paragraph) for the previous year—

''(I) increased by the annual percentage increase described in subparagraph (B); and

''(II) further adjusted to reflect relative changes in the composition of drug spending among the copayment structure under paragraph (1) to ensure that the percentage of drug spending that beneficiaries enrolled under this part are required to pay in the year is the same (as estimated by the Secretary) as the percentage required in the previous year; and

''(ii) the annual out-of-pocket limit specified in paragraph (4)(B) is equal to the annual out-of-pocket limit determined under such paragraph (or this paragraph) for the previous year increased by the annual percentage increase described in subparagraph (C).

''(B) ANNUAL PERCENTAGE INCREASE SPECIFIED IN SUBPARAGRAPH (B).—The annual percentage increase specified in this subparagraph for a year is equal to the annual percentage increase in the prices of covered outpatient drugs (including both price inflation and price changes due to changes in therapeutic mix), as determined by the Secretary for the 12-month period ending in July of the previous year.

''(C) ANNUAL PERCENTAGE INCREASE SPECIFIED IN SUBPARAGRAPH (C).—The annual percentage increase specified in this subparagraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year.

''(D) ROUNDING.—If any amount determined under subparagraph (A) is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(c) ACCESS TO NEGOTIATED PRICES.—

''(1) ACCESS.—Under a plan offered by an eligible entity with a contract under this part, the eligible entity offering such plan shall provide eligible beneficiaries enrolled in such plan with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that only partial benefits may be payable under the coverage with respect to such drugs because of the application of the cost-sharing under subsection (b).

''(2) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated under a plan under this part with respect to covered outpatient drugs, under a Medicare+Choice plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860J(e)(3)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''ENTITIES ELIGIBLE TO PROVIDE OUTPATIENT DRUG BENEFIT

''SEC. 1860G. (a) ESTABLISHMENT OF PANELS OF PLANS AVAILABLE IN AN AREA.—

''(1) IN GENERAL.—The Secretary shall establish procedures under which the Secretary—

''(A) accepts bids submitted by eligible entities for the plans which such entities intend to offer in an area established under subsection (b); and

''(B) awards contracts to such entities to provide such plans to eligible beneficiaries in the area.

''(2) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into contracts under this part.

''(b) AREA FOR CONTRACTS.—

''(1) REGIONAL BASIS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to paragraph (2), the contract entered into between the Secretary and an eligible entity with respect to a plan shall require the eligible entity to provide coverage of covered outpatient drugs under the plan in a region determined by the Secretary under paragraph (2).

''(B) PARTIAL REGIONAL BASIS.—

''(i) IN GENERAL.—If determined appropriate by the Secretary, the Secretary may permit the coverage described in subparagraph (A) to be provided in a partial region determined appropriate by the Secretary.

''(ii) REQUIREMENTS.—If the Secretary permits coverage pursuant to clause (i), the Secretary shall ensure that the partial region in which coverage is provided is—

''(I) at least the size of the commercial service area of the eligible entity for that area; and

''(II) not smaller than a State.

''(2) DETERMINATION.—

''(A) IN GENERAL.—In determining regions for contracts under this part, the Secretary shall—

''(i) take into account the number of eligible beneficiaries in an area in order to encourage participation by eligible entities; and

''(ii) ensure that there are at least 10 different regions in the United States.

''(B) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of coverage areas under this part shall not be subject to administrative or judicial review.

''(c) SUBMISSION OF BIDS.—

''(1) SUBMISSION.—

''(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity desiring to offer a plan under this part in an area shall submit a bid with respect to such plan to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(B) BID THAT COVERS MULTIPLE AREAS.—The Secretary shall permit an eligible entity to submit a single bid for multiple areas if the bid is applicable to all such areas.

''(2) REQUIRED INFORMATION.—The bids described in paragraph (1) shall include—

''(A) a proposal for the estimated prices of covered outpatient drugs and the projected annual increases in such prices, including differentials between formulary and nonformulary prices, if applicable;

''(B) a statement regarding the amount that the entity will charge the Secretary for managing, administering, and delivering the benefits under the contract;

''(C) a statement regarding whether the entity will reduce the applicable cost-sharing amount pursuant to section 1860F(b)(1)(B) and if so, the amount of such reduction and how such reduction is tied to the performance requirements described in section 1860I(b)(1)(C);

''(D) a detailed description of the performance requirements for which the payments to the entity will be subject to risk pursuant to section 1860I(b)(1)(C);

''(E) a detailed description of access to pharmacy services provided under the plan;

''(F) with respect to the formulary used by the entity, a detailed description of the procedures and standards the entity will use for—

''(i) adding new drugs to a therapeutic class within the formulary; and

''(ii) determining when and how often the formulary should be modified;

''(G) a detailed description of any ownership or shared financial interests with other entities involved in the delivery of the benefit as proposed under the plan;

''(H) a detailed description of the entity's estimated marketing and advertising expenditures related to enrolling eligible beneficiaries under the plan and retaining such enrollment; and

''(I) such other information that the Secretary determines is necessary in order to carry out this part, including information relating to the bidding process under this part.

''(d) ACCESS TO BENEFITS IN CERTAIN AREAS.—

''(1) AREAS NOT COVERED BY CONTRACTS.—The Secretary shall develop procedures for the provision of covered outpatient drugs under this part to each eligible beneficiary enrolled under this part that resides in an area that is not covered by any contract under this part.

''(2) BENEFICIARIES RESIDING IN DIFFERENT LOCATIONS.—The Secretary shall develop procedures to ensure that each eligible beneficiary enrolled under this part that resides in different areas in a year is provided the benefits under this part throughout the entire year.

''(e) AWARDING OF CONTRACTS.—

''(1) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this part and the goal of containing costs under this title, award in a competitive manner at least 2 contracts to offer a plan in an area, unless only 1 bidding entity (and the

plan offered by the entity) meets the minimum standards specified under this part and by the Secretary.

''(2) DETERMINATION.—In determining which of the eligible entities that submitted bids that meet the minimum standards specified under this part and by the Secretary to award a contract, the Secretary shall consider the comparative merits of each bid, as determined on the basis of the past performance of the entity and other relevant factors, with respect to—

''(A) how well the entity (and the plan offered by the entity) meet such minimum standards;

''(B) the amount that the entity will charge the Secretary for managing, administering, and delivering the benefits under the contract;

''(C) the performance requirements for which the payments to the entity will be subject to risk pursuant to section 1860I(b)(1)(C);

''(D) the proposed negotiated prices of covered outpatient drugs and annual increases in such prices;

''(E) the factors described in section 1860D(b)(2);

''(F) prior experience of the entity in managing, administering, and delivering a prescription drug benefit program;

''(G) effectiveness of the entity and plan in containing costs through pricing incentives and utilization management; and

''(H) such other factors as the Secretary deems necessary to evaluate the merits of each bid.

''(3) EXCEPTION TO CONFLICT OF INTEREST RULES.—In awarding contracts under this part, the Secretary may waive conflict of interest laws generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(A) is not inconsistent with the—

''(i) purposes of the programs under this title; or

''(ii) best interests of beneficiaries enrolled under this part; and

''(B) permits a sufficient level of competition for such contracts, promotes efficiency of benefits administration, or otherwise serves the objectives of the program under this part.

''(4) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of the Secretary to award or not award a contract to an eligible entity with respect to a plan under this part shall not be subject to administrative or judicial review.

''(f) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

''(g) DURATION OF CONTRACTS.—Each contract awarded under this part shall be for a term of at least 2 years but not more than 5 years, as determined by the Secretary.

''MINIMUM STANDARDS FOR ELIGIBLE ENTITIES

''SEC. 1860H. (a) IN GENERAL.—The Secretary shall not award a contract to an eligible entity under this part unless the Secretary finds that the eligible entity agrees to comply with such terms and conditions as the Secretary shall specify, including the following:

''(1) QUALITY AND FINANCIAL STANDARDS.—The eligible entity meets the quality and financial standards specified by the Secretary.

''(2) PROCEDURES TO ENSURE PROPER UTILIZATION, COMPLIANCE, AND AVOIDANCE OF ADVERSE DRUG REACTIONS.—

''(A) IN GENERAL.—The eligible entity has in place drug utilization review procedures to ensure—

''(i) the appropriate utilization by eligible beneficiaries enrolled in the plan covered by the contract of the benefits to be provided under the plan;

''(ii) the avoidance of adverse drug reactions among such beneficiaries, including problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse and misuse; and

''(iii) the reasonable application of peer-reviewed medical literature pertaining to improvements in pharmaceutical safety and appropriate use of drugs.

''(B) AUTHORITY TO USE CERTAIN COMPENDIA AND LITERATURE.—The eligible entity may use the compendia and literature referred to in clauses (i) and (ii), respectively, of section 1927(g)(1)(B) as a source for the utilization review under subparagraph (A).

''(3) ELECTRONIC PRESCRIPTION PROGRAM.—

''(A) IN GENERAL.—The eligible entity has in place, for years beginning with 2006, an electronic prescription drug program that includes at least the following components, consistent with national standards established under subparagraph (B):

''(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions are only received electronically, except in emergency cases and other exceptional circumstances recognized by the Secretary.

''(ii) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides, upon transmittal of a prescription by a prescribing health care professional, for transmittal by the pharmacist to the professional of information that includes—

''(I) information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for that patient;

''(II) cost-effective alternatives (if any) for the use of the drug prescribed; and

''(III) information on the drugs included in the applicable formulary.

To the extent feasible, such program shall permit the prescribing health care professional to provide (and be provided) related information on an interactive, real-time basis.

''(B) STANDARDS.—

''(i) DEVELOPMENT.—The Secretary shall provide for the development of national standards relating to the electronic prescription drug program described in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

''(ii) ADVISORY TASK FORCE.—In developing such standards, the Secretary shall establish a task force that includes representatives of physicians, hospitals, pharmacists, and technology experts and representatives of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Secretary on such standards, including recommendations relating to the following:

''(I) The range of available computerized prescribing software and hardware and their costs to develop and implement.

''(II) The extent to which such systems reduce medication errors and can be readily implemented by physicians and hospitals.

''(III) Efforts to develop a common software platform for computerized prescribing.

''(IV) The cost of implementing such systems in the range of hospital and physician office settings, including hardware, software, and training costs.

''(V) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

''(iii) DEADLINES.—

''(I) The Secretary shall constitute the task force under clause (ii) by not later than April 1, 2003.

''(II) Such task force shall submit recommendations to Secretary by not later than January 1, 2004.

''(III) The Secretary shall develop and promulgate the national standards referred to in clause (ii) by not later than January 1, 2005.

''(C) WAIVER OF APPLICATION FOR CERTAIN RURAL PROVIDERS.—If the Secretary determines that it is unduly burdensome on providers in rural areas to comply with the requirements under this paragraph, the Secretary may waive such requirements for such providers.

''(D) REFERENCE TO AVAILABILITY OF GRANT FUNDS.—Grant funds are authorized under section 399O of the Public Health Service Act to provide assistance to health care providers in implementing electronic prescription drug programs.

''(4) PATIENT PROTECTIONS.—

''(A) ACCESS.—

''(i) IN GENERAL.—The eligible entity ensures that the covered outpatient drugs are accessible and convenient to eligible beneficiaries enrolled in the plan covered by the contract, including by offering the services 24 hours a day and 7 days a week for emergencies.

''(ii) AGREEMENTS WITH PHARMACIES.—The eligible entity shall enter into a participation agreement with any pharmacy that meets the requirements of subsection (d) to dispense covered prescription drugs to eligible beneficiaries under this part. Such agreements shall include the payment of a reasonable dispensing fee for covered outpatient drugs dispensed to a beneficiary under the agreement.

''(iii) PREFERRED PHARMACY NETWORKS.—If the eligible entity utilizes a preferred pharmacy network, the network complies with the standards under subsection (e).

''(B) ENSURING THAT BENEFICIARIES ARE NOT OVERCHARGED.—The eligible entity has procedures in place to ensure that each pharmacy with a participation agreement under this part with the entity complies with the requirements under subsection (d)(1)(C) (relating to adherence to negotiated prices).

''(C) CONTINUITY OF CARE.—

''(i) IN GENERAL.—The eligible entity ensures that, in the case of an eligible beneficiary who loses coverage under this part with such entity under circumstances that would permit a special election period (as established by the Secretary under section 1860C(a)(1)), the entity will continue to provide coverage under this part to such beneficiary until the beneficiary enrolls and receives such coverage with another eligible entity under this part or, if eligible, with a Medicare+Choice organization.

''(ii) LIMITED PERIOD.—In no event shall an eligible entity be required to provide the extended coverage required under clause (i) beyond the date which is 30 days after the coverage with such entity would have terminated but for this subparagraph.

''(D) PROCEDURES REGARDING THE DETERMINATION OF DRUGS THAT ARE MEDICALLY NECESSARY.—

''(i) IN GENERAL.—The eligible entity has in place procedures on a case-by-case basis to treat a nonformulary drug as a preferred brand name drug under this part if the nonformulary drug is determined—

''(I) to be not as effective for the enrollee in preventing or slowing the deterioration of, or improving or maintaining, the health of the enrollee; or

''(II) to have a significant adverse effect on the enrollee.

''(ii) REQUIREMENT.—The procedures under clause (i) shall require that determinations under such clause are based on professional medical judgment, the medical condition of the enrollee, and other medical evidence.

''(E) PROCEDURES REGARDING APPEAL RIGHTS WITH RESPECT TO DENIALS OF CARE.—The eligible entity has in place procedures to ensure—

''(i) a timely internal review for resolution of denials of coverage (in whole or in part and including those regarding the coverage of nonformulary drugs as preferred brand name drugs) in accordance with the medical exigencies of the case and a timely resolution of complaints, by enrollees in the plan, or by providers, pharmacists, and other individuals acting on behalf of each such enrollee (with the enrollee's consent) in accordance with requirements (as established by the Secretary) that are comparable to such requirements for Medicare+Choice organizations under part C (and are not less favorable to the enrollee than such requirements under such part as in effect on the date of enactment of the Medicare Outpatient Prescription Drug Act of 2002);

''(ii) that the entity complies in a timely manner with requirements established by the Secretary that (I) provide for an external review by an independent entity selected by the Secretary of denials of coverage described in clause (i) not resolved in the favor of the beneficiary (or other complainant) under the process described in such clause, and (II) are comparable to the external review requirements established for Medicare+Choice organizations under part C (and are not less favorable to the enrollee than such requirements under such part as in effect on the date of enactment of the Medicare Outpatient Prescription Drug Act of 2002); and

''(iii) that enrollees are provided with information regarding the appeals procedures under this part at the time of enrollment with the entity and upon request thereafter.

''(F) PROCEDURES REGARDING PATIENT CONFIDENTIALITY.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in the plan that is covered by the contract, the entity has in place procedures to—

''(i) safeguard the privacy of any individually identifiable beneficiary information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033);

''(ii) maintain such records and information in a manner that is accurate and timely;

''(iii) ensure timely access by such beneficiaries to such records and information; and

''(iv) otherwise comply with applicable laws relating to patient confidentiality.

''(G) PROCEDURES REGARDING TRANSFER OF MEDICAL RECORDS.—

''(i) IN GENERAL.—The eligible entity has in place procedures for the timely transfer of records and information described in subparagraph (F) (with respect to a beneficiary who loses coverage under this part with the entity and enrolls with another entity (including a Medicare+Choice organization) under this part) to such other entity.

''(ii) PATIENT CONFIDENTIALITY.—The procedures described in clause (i) shall comply with the patient confidentiality procedures described in subparagraph (F).

''(H) PROCEDURES REGARDING MEDICAL ERRORS.—The eligible entity has in place procedures for—

''(i) working with the Secretary to deter medical errors related to the provision of covered outpatient drugs; and

''(ii) ensuring that pharmacies with a contract with the entity have in place procedures to deter medical errors related to the provision of covered outpatient drugs.

''(5) PROCEDURES TO CONTROL FRAUD, ABUSE, AND WASTE.—

''(A) IN GENERAL.—The eligible entity has in place procedures to control fraud, abuse, and waste.

''(B) APPLICABILITY OF FRAUD AND ABUSE PROVISIONS.—The provisions of section 1128 through 1128C (relating to fraud and abuse) apply to eligible entities with contracts under this part.

''(6) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—The eligible entity provides the Secretary with reports containing information regarding the following:

''(i) The negotiated prices that the eligible entity is paying for covered outpatient drugs.

''(ii) The prices that eligible beneficiaries enrolled in the plan that is covered by the contract will be charged for covered outpatient drugs.

''(iii) The management costs of providing such benefits.

''(iv) Utilization of such benefits.

''(v) Marketing and advertising expenditures related to enrolling and retaining eligible beneficiaries.

''(B) TIMEFRAME FOR SUBMITTING REPORTS.—

''(i) IN GENERAL.—The eligible entity shall submit a report described in subparagraph (A) to the Secretary within 3 months after the end of each 12-month period in which the eligible entity has a contract under this part. Such report shall contain information concerning the benefits provided during such 12-month period.

''(ii) LAST YEAR OF CONTRACT.—In the case of the last year of a contract under this part, the Secretary may require that a report described in subparagraph (A) be submitted 3 months prior to the end of the contract. Such report shall contain information concerning the benefits provided between the period covered by the most recent report under this subparagraph and the date that a report is submitted under this clause.

''(C) CONFIDENTIALITY OF INFORMATION.—

''(i) IN GENERAL.—Notwithstanding any other provision of law and subject to clause (ii), information disclosed by an eligible entity pursuant to subparagraph (A) (except for information described in clause (ii) of such subparagraph) is confidential and shall only be used by the Secretary for the purposes of, and to the extent necessary, to carry out this part.

''(ii) UTILIZATION DATA.—Subject to patient confidentiality laws, the Secretary shall make information disclosed by an eligible entity pursuant to subparagraph (A)(iv) (regarding utilization data) available for research purposes. The Secretary may charge a reasonable fee for making such information available.

''(7) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The eligible entity complies with the requirements described in section 1860G(f).

''(8) RECORDS AND AUDITS.—The eligible entity maintains adequate records related to the administration of the benefits under this part and affords the Secretary access to such records for auditing purposes.

''(b) SPECIAL RULES REGARDING COST-EFFECTIVE PROVISION OF BENEFITS.—

''(1) IN GENERAL.—In providing the benefits under a contract under this part, an eligible entity shall—

''(A) employ mechanisms to provide the benefits economically, such as through the use of—

''(i) alternative methods of distribution;

''(ii) preferred pharmacy networks (pursuant to subsection (e)); and

''(iii) generic drug substitution;

''(B) use mechanisms to encourage eligible beneficiaries to select cost-effective drugs or less costly means of receiving drugs, such as through the use of—

''(i) pharmacy incentive programs;

''(ii) therapeutic interchange programs; and

''(iii) disease management programs;

''(C) encourage pharmacy providers to—

''(i) inform beneficiaries of the differentials in price between generic and brand name drug equivalents; and

''(ii) provide medication therapy management programs in order to enhance beneficiaries' understanding of the appropriate use of medications and to reduce the risk of potential adverse events associated with medications; and

''(D) develop and implement a formulary in accordance with subsection (c).

''(2) RESTRICTION.—If an eligible entity uses alternative methods of distribution pursuant to paragraph (1)(A)(i), the entity may not require that a beneficiary use such methods in order to obtain covered outpatient drugs.

''(c) REQUIREMENTS FOR FORMULARIES.—

''(1) STANDARDS.—

''(A) IN GENERAL.—The formulary developed and implemented by the eligible entity shall comply with standards established by the Secretary in consultation with the Medicare Prescription Drug Advisory Committee established under section 1860L.

''(B) NO NATIONAL FORMULARY OR REQUIREMENT TO EXCLUDE SPECIFIC DRUGS.—

''(i) SECRETARY MAY NOT ESTABLISH A NATIONAL FORMULARY.—The Secretary may not establish a national formulary.

''(ii) NO REQUIREMENT TO EXCLUDE SPECIFIC DRUGS.—The standards established by the Secretary pursuant to subparagraph (A) may not require that an eligible entity exclude a specific covered outpatient drug from the formulary developed and implemented by the entity.

''(2) REQUIREMENTS FOR STANDARDS.—The standards established under paragraph (1) shall require that the eligible entity—

''(A) use a pharmacy and therapeutic committee (that meets the standards for a pharmacy and therapeutic committee established by the Secretary in consultation with such Medicare Prescription Drug Advisory Committee) to develop and implement the formulary;

''(B) include—

''(i) all generic covered outpatient drugs in the formulary; and

''(ii) at least 1 but no more than 2 (unless the Secretary determines that such limitation is determined to be clinically inappropriate for a given therapeutic class) brand name covered outpatient drugs from each therapeutic class (as defined by the Secretary in consultation with such Medicare Prescription Drug Advisory Committee) as a preferred brand name drug in the formulary;

''(C) develop procedures for the modification of the formulary, including for the addition of new drugs to an existing therapeutic class;

''(D) pursuant to section 1860F(b)(1)(C), provide for coverage of nonformulary drugs at the preferred brand name drug rate when determined under subparagraph (D) or (E) of subsection (a)(3) to be medically necessary;

''(E) disclose to current and prospective beneficiaries and to providers in the service area the nature of the formulary restrictions, including information regarding the drugs included in the formulary and any difference in the cost-sharing for—

''(i) drugs included in the formulary; and

''(ii) for drugs not included in the formulary; and

''(F) provide a reasonable amount of notice to beneficiaries enrolled in the plan that is covered by the contract under this part of any change in the formulary.

''(3) CONSTRUCTION.—Nothing in this part shall be construed as precluding an eligible entity from—

''(A) educating prescribing providers, pharmacists, and beneficiaries about the medical and cost benefits of drugs included in the formulary (including generic drugs); or

''(B) requesting prescribing providers to consider a drug included in the formulary prior to dispensing of a drug not so included, as long as such a request does not unduly delay the provision of the drug.

''(d) TERMS OF PARTICIPATION AGREEMENT WITH PHARMACIES.—

''(1) IN GENERAL.—A participation agreement between an eligible entity and a pharmacy under this part (pursuant to subsection (a)(3)(A)(ii)) shall include the following terms and conditions:

''(A) APPLICABLE REQUIREMENTS.—The pharmacy shall meet (and throughout the contract period continue to meet) all applicable Federal requirements and State and local licensing requirements.

''(B) ACCESS AND QUALITY STANDARDS.—The pharmacy shall comply with such standards as the Secretary (and the eligible entity) shall establish concerning the quality of, and enrolled beneficiaries' access to, pharmacy services under this part. Such standards shall require the pharmacy—

''(i) not to refuse to dispense covered outpatient drugs to any eligible beneficiary enrolled under this part;

''(ii) to keep patient records (including records on expenses) for all covered outpatient drugs dispensed to such enrolled beneficiaries;

''(iii) to submit information (in a manner specified by the Secretary to be necessary to administer this part) on all purchases of such drugs dispensed to such enrolled beneficiaries; and

''(iv) to comply with periodic audits to assure compliance with the requirements of this part and the accuracy of information submitted.

''(C) ENSURING THAT BENEFICIARIES ARE NOT OVERCHARGED.—

''(i) ADHERENCE TO NEGOTIATED PRICES.—The total charge for each covered outpatient drug dispensed by the pharmacy to a beneficiary enrolled in the plan, without regard to whether the individual is financially responsible for any or all of such charge, shall not exceed the negotiated price for the drug (as reported to the Secretary pursuant to subsection (a)(5)(A)).

''(ii) ADHERENCE TO BENEFICIARY OBLIGATION.—The pharmacy may not charge (or collect from) such beneficiary an amount that exceed's the cost-sharing that the beneficiary is responsible for under this part (as determined under section 1860F(b) using the negotiated price of the drug).

''(D) ADDITIONAL REQUIREMENTS.—The pharmacy shall meet such additional contract requirements as the eligible entity specifies under this section.

''(2) APPLICABILITY OF FRAUD AND ABUSE PROVISIONS.—The provisions of section 1128 through 1128C (relating to fraud and abuse) apply to pharmacies participating in the program under this part.

''(e) PREFERRED PHARMACY NETWORKS.—

''(1) IN GENERAL.—If an eligible entity uses a preferred pharmacy network to deliver benefits under this part, such network shall meet minimum access standards established by the Secretary.

''(2) STANDARDS.—In establishing standards under paragraph (1), the Secretary shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''PAYMENTS

''SEC. 1860I. (a) PROCEDURES FOR PAYMENTS TO ELIGIBLE ENTITIES.—The Secretary shall establish procedures for making payments to each eligible entity with a contract under this part for the management, administration, and delivery of the benefits under this part.

''(b) REQUIREMENTS FOR PROCEDURES.—

''(1) IN GENERAL.—The procedures established under subsection (a) shall provide for the following:

''(A) MANAGEMENT PAYMENT.—Payment for the management, administration, and delivery of the benefits under this part.

''(B) REIMBURSEMENT FOR NEGOTIATED COSTS OF DRUGS PROVIDED.—Payments for the negotiated costs of covered outpatient drugs provided to eligible beneficiaries enrolled under this part and in a plan offered by the eligible entity, reduced by any applicable cost-sharing under section 1860F(b).

''(C) RISK REQUIREMENT TO ENSURE PURSUIT OF PERFORMANCE REQUIREMENTS.—An adjustment of a percentage (as determined under paragraph (2)) of the payments made to an entity under subparagraph (A) to ensure that the entity, in managing, administering, and delivering the benefits under this part, pursues performance requirements established by the Secretary, including the following:

''(i) CONTROL OF MEDICARE AND BENEFICIARY COSTS.—The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and in the plan offered by the entity, as measured by generic substitution rates, price discounts, and other factors determined appropriate by the Secretary that do not reduce the access of such beneficiaries to medically necessary covered outpatient drugs.

''(ii) QUALITY CLINICAL CARE.—The entity provides such beneficiaries with quality clinical care, as measured by such factors as—

''(I) the level of adverse drug reactions and medical errors among such beneficiaries; and

''(II) providing specific clinical suggestions to improve health and patient and prescriber education as appropriate.

''(iii) QUALITY SERVICE.—The entity provides such beneficiaries with quality services, as measured by such factors as sustained pharmacy network access, timeliness and accuracy of service delivery in claims processing and card production, pharmacy and member service support access, response time in mail delivery service, and timely action with regard to appeals and current beneficiary service surveys.

''(2) PERCENTAGE OF PAYMENT TIED TO RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the percentage (which may be up to 100 percent) of the payments made to an entity under subparagraph (A) that will be tied to the performance requirements described in paragraph (1)(C).

''(B) LIMITATION ON RISK TO ENSURE PROGRAM STABILITY.—In order to provide for program stability, the Secretary may not establish a percentage to be adjusted under this subsection at a level that jeopardizes the ability of an eligible entity to administer and deliver the benefits under this part or administer and deliver such benefits in a quality manner.

''(3) RISK ADJUSTMENT OF PAYMENTS BASED ON ENROLLEES IN PLAN.—To the extent that an eligible entity is at risk under this subsection, the procedures established under subsection (a) may include a methodology for risk adjusting the payments made to such entity based on the differences in actuarial risk of different enrollees being served if the Secretary determines such adjustments to be necessary and appropriate.

''(4) PASS-THROUGH OF REBATES, DISCOUNTS, AND PRICE CONCESSIONS OBTAINED BY THE ELIGIBLE ENTITY.—The Secretary shall establish procedures for reducing the amount of payments to an eligible entity under subsection (a) to take into account any rebates, discounts, or price concessions obtained by the entity from manufacturers of covered outpatient drugs, unless the Secretary determines that such procedures are not in the best interests of the medicare program or eligible beneficiaries.

''(c) PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS.—For provisions related to payments to Medicare+Choice organizations for the administration and delivery of benefits under this part to eligible beneficiaries enrolled in a Medicare+Choice plan offered by the organization, see section 1853(c)(8).

''(d) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE

''SEC. 1860J. (a) PROGRAM AUTHORITY.—The Secretary is authorized to develop and implement a program under this section to be known as the 'Employer Incentive Program' that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription drug benefits to retired individuals by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

''(b) SPONSOR REQUIREMENTS.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified retiree prescription drug plan (as defined in subsection (e)(3)), a sponsor shall meet the following requirements:

''(1) ASSURANCES.—The sponsor shall—

''(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered by the sponsor is a qualified retiree prescription drug plan, and will remain such a plan for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Secretary and covered retirees—

''(i) at least 120 days before terminating its plan; and

''(ii) immediately upon determining that the actuarial value of the prescription drug benefit under the plan falls below the actuarial value of the outpatient prescription drug benefit under this part.

''(2) BENEFICIARY INFORMATION.—The sponsor shall report to the Secretary, for each calendar quarter for which it seeks an incentive payment under this section, the names and social security numbers of all retirees (and their spouses and dependents) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

''(3) AUDITS.—The sponsor and the employment-based retiree health coverage plan seeking incentive payments under this section shall agree to maintain, and to afford the Secretary access to, such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of incentive payments made, and such other matters as may be appropriate.

''(4) OTHER REQUIREMENTS.—The sponsor shall provide such other information, and

comply with such other requirements, as the Secretary may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENTS.—

''(1) IN GENERAL.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made by the Secretary on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate employment-based health plan) of an incentive payment, in the amount determined in paragraph (2), for each retired individual (or spouse or dependent) who—

''(A) was covered under the sponsor's qualified retiree prescription drug plan during such quarter; and

''(B) was eligible for, but was not enrolled in, the outpatient prescription drug benefit program under this part.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment for a quarter shall be, for each individual described in paragraph (1), ⅔ of the sum of the monthly Government contribution amounts (computed under subparagraph (B)) for each of the 3 months in the quarter.

''(B) COMPUTATION OF MONTHLY GOVERNMENT CONTRIBUTION AMOUNT.—For purposes of subparagraph (A), the monthly Government contribution amount for a month in a year is equal to the amount by which—

''(i) 1/12 of the amount estimated under subparagraph (C) for the year involved; exceeds

''(ii) the monthly Part D premium under section 1860E(a) (determined without regard to any increase under section 1860B(b)(1)) for the month involved.

''(C) ESTIMATE OF AVERAGE ANNUAL PER CAPITA AGGREGATE EXPENDITURES.—

''(i) IN GENERAL.—The Secretary shall for each year after 2004 estimate for that year an amount equal to average annual per capita aggregate expenditures payable from the Prescription Drug Account for that year.

''(ii) TIMEFRAME FOR ESTIMATION.—The Secretary shall make the estimate described in clause (i) for a year before the beginning of that year.

''(3) PAYMENT DATE.—The payment under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

''(d) CIVIL MONEY PENALTIES.—A sponsor, health plan, or other entity that the Secretary determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an amount up to 3 times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

''(e) DEFINITIONS.—In this section:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage, whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation, of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(2) EMPLOYER.—The term 'employer' has the meaning given the term in section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of 2 or more employees).

''(3) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription drugs with an actuarial value (as defined by the Secretary) to each retired beneficiary that equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part; and

''(B) does not deny, limit, or condition the coverage or provision of prescription drug benefits for retired individuals based on age or any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(4) SPONSOR.—The term 'sponsor' has the meaning given the term 'plan sponsor' in section 3(16)(B) of the Employer Retirement Income Security Act of 1974.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, such sums as may be necessary to carry out the program under this section.

''PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860K. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

''(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the account as provided in this part.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including payments to eligible entities under section 1860I, payments to Medicare+Choice organizations under section 1853(c)(8), and payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—

''(1) IN GENERAL.—Subject to paragraph (2), there are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part in the year exceed the premiums collected under section 1860E(b) for the year.

''(2) LIMITATION.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), no obligations shall be incurred, no amounts shall be appropriated, and no amounts expended, for expenses incurred for providing coverage of covered outpatient drugs after December 31, 2010.

''(B) EXPENSES FOR COVERAGE PRIOR TO 2011.—The Secretary shall make payments on or after January 1, 2011, for expenses incurred to the extent such expenses were incurred for providing coverage of covered outpatient drugs prior to such date.

''(C) LEGISLATION ENACTED THAT PROVIDES SAVINGS.—Amounts shall continue to be appropriated, and the Secretary shall continue to incur obligations and expend amounts, for expenses incurred for providing coverage of covered outpatient drugs after December 31, 2010, if legislation is enacted prior to January 1, 2011, which states that savings have been achieved equal to or greater than the difference between the full cost of the Medicare Outpatient Prescription Drug Act of 2002 over the period beginning October 1, 2004, and ending September 30, 2012, and the full cost of such Act over such period if this paragraph had not been included in such Act.

''MEDICARE PRESCRIPTION DRUG ADVISORY COMMITTEE

''SEC. 1860L. (a) ESTABLISHMENT OF COMMITTEE.—There is established a Medicare Prescription Drug Advisory Committee (in this section referred to as the 'Committee').

''(b) FUNCTIONS OF COMMITTEE.—On and after January 1, 2004, the Committee shall advise the Secretary on policies related to—

''(1) the development of guidelines for the implementation and administration of the outpatient prescription drug benefit program under this part; and

''(2) the development of—

''(A) standards for a pharmacy and therapeutics committee required of eligible entities under section 1860H(c)(2)(A);

''(B) standards required under subparagraphs (D) and (E) of section 1860H(a)(4) for determining if a drug is medically necessary;

''(C) standards for—

''(i) establishing therapeutic classes;

''(ii) adding new therapeutic classes to a formulary; and

''(iii) defining maintenance and nonmaintenance drugs and determining the length of the course that is typical of current practice for nonmaintenance drugs for purposes of applying section 1860F(b)(1);

''(D) procedures to evaluate the bids submitted by eligible entities under this part; and

''(E) procedures to ensure that eligible entities with a contract under this part are in compliance with the requirements under this part.

''(c) STRUCTURE AND MEMBERSHIP OF THE COMMITTEE.—

''(1) STRUCTURE.—The Committee shall be composed of 19 members who shall be appointed by the Secretary.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The members of the Committee shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, attainments, and understanding of pharmaceutical cost control and quality enhancement, exceptionally qualified to perform the duties of members of the Committee.

''(B) SPECIFIC MEMBERS.—Of the members appointed under paragraph (1)—

''(i) five shall be chosen to represent physicians, 2 of whom shall be geriatricians;

''(ii) two shall be chosen to represent nurse practitioners;

''(iii) four shall be chosen to represent pharmacists;

''(iv) one shall be chosen to represent the Centers for Medicare & Medicaid Services;

''(v) four shall be chosen to represent actuaries, pharmacoeconomists, researchers, and other appropriate experts;

''(vi) one shall be chosen to represent emerging drug technologies;

''(vii) one shall be closed to represent the Food and Drug Administration; and

''(viii) one shall be chosen to represent individuals enrolled under this part.

''(d) TERMS OF APPOINTMENT.—Each member of the Committee shall serve for a term

determined appropriate by the Secretary. The terms of service of the members initially appointed shall begin on March 1, 2003.

''(e) CHAIRPERSON.—The Secretary shall designate a member of the Committee as Chairperson. The term as Chairperson shall be for a 1-year period.

''(f) COMMITTEE PERSONNEL MATTERS.—

''(1) MEMBERS.—

''(A) COMPENSATION.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee. All members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

''(B) TRAVEL EXPENSES.—The members of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Committee.

''(2) STAFF.—The Committee may appoint such personnel as the Committee considers appropriate.

''(g) OPERATION OF THE COMMITTEE.—

''(1) MEETINGS.—The Committee shall meet at the call of the Chairperson (after consultation with the other members of the Committee) not less often than quarterly to consider a specific agenda of issues, as determined by the Chairperson after such consultation.

''(2) QUORUM.—Ten members of the Committee shall constitute a quorum for purposes of conducting business.

''(h) FEDERAL ADVISORY COMMITTEE ACT.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

''(i) TRANSFER OF PERSONNEL, RESOURCES, AND ASSETS.—For purposes of carrying out its duties, the Secretary and the Committee may provide for the transfer to the Committee of such civil service personnel in the employ of the Department of Health and Human Services (including the Centers for Medicare & Medicaid Services), and such resources and assets of the Department used in carrying out this title, as the Committee requires.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.''.

(b) EXCLUSIONS FROM COVERAGE.—

(1) APPLICATION TO PART D.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(2) PRESCRIPTION DRUGS NOT EXCLUDED FROM COVERAGE IF REASONABLE AND NECESSARY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(A) in subparagraph (H), by striking ''and'' at the end;

(B) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(J) in the case of prescription drugs covered under part D, which are not reasonable and necessary to prevent or slow the deterioration of, or improve or maintain, the health of eligible beneficiaries;''.

(c) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking ''and'' before ''such amounts''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860K'';

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),'';

(3) in subsection (h), by inserting after ''1840(d)'' the following: ''and section 1860E(b) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)''; and

(4) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', section 1860E(b) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),''.

(d) CONFORMING REFERENCES TO PREVIOUS PART D.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this title.

SEC. 203. PART D BENEFITS UNDER MEDICARE+CHOICE PLANS.

(a) ELIGIBILITY, ELECTION, AND ENROLLMENT.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)(A), by striking ''parts A and B'' and inserting ''parts A, B, and D''; and

(2) in subsection (i)(1), by striking ''parts A and B'' and inserting ''parts A, B, and D''.

(b) VOLUNTARY BENEFICIARY ENROLLMENT FOR DRUG COVERAGE.—Section 1852(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under that part)'' after ''parts A and B''.

(c) ACCESS TO SERVICES.—Section 1852(d)(1) of the Social Security Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(1) in subparagraph (D), by striking ''and'' at the end;

(2) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) in the case of covered outpatient drugs (as defined in section 1860(1)) provided to individuals enrolled under part D, the organization complies with the access requirements applicable under part D.''.

(d) PAYMENTS TO ORGANIZATIONS FOR PART D BENEFITS.—

(1) IN GENERAL.—Section 1853(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended—

(A) by inserting ''determined separately for the benefits under parts A and B and under part D (for individuals enrolled under that part)'' after ''as calculated under subsection (c)'';

(B) by striking ''that area, adjusted for such risk factors'' and inserting ''that area. In the case of payment for the benefits under parts A and B, such payment shall be adjusted for such risk factors as''; and

(C) by inserting before the last sentence the following: ''In the case of the payments under subsection (c)(8) for the provision of coverage of covered outpatient drugs to individuals enrolled under part D, such payment shall be adjusted for the risk factors of each enrollee as the Secretary determines to be feasible and appropriate to ensure actuarial equivalence.''.

(2) AMOUNT.—Section 1853(c) of the Social Security Act (42 U.S.C. 1395w–23(c)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''for benefits under parts A and B'' after ''capitation rate''; and

(B) by adding at the end the following new paragraph:

''(8) CAPITATION RATE FOR PART D BENEFITS.—

''(A) IN GENERAL.—In the case of a Medicare+Choice plan that provides coverage of covered outpatient drugs to an individual enrolled under part D, the capitation rate for such coverage shall be the amount described in subparagraph (B). Such payments shall be made in the same manner and at the same time as the payments to the Medicare+Choice organization offering the plan for benefits under parts A and B are otherwise made, but such payments shall be payable from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(B) AMOUNT.—The amount described in this paragraph is an amount equal to 1/12 of the average annual per capita aggregate expenditures payable from the Prescription Drug Account for the year (as estimated under section 1860J(c)(2)(C)).''.

(e) LIMITATION ON ENROLLEE LIABILITY.—Section 1854(e) of the Social Security Act (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR PART D BENEFITS.—With respect to outpatient prescription drug benefits under part D, a Medicare+Choice organization may not require that an enrollee pay any deductible or pay a cost-sharing amount that exceeds the amount of cost-sharing applicable for such benefits for an eligible beneficiary under part D.''.

(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—Section 1854(f)(1) of the Social Security Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new sentence: ''Such determination shall be made separately for the benefits under parts A and B and for prescription drug benefits under part D.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services provided under a Medicare+Choice plan on or after January 1, 2005.

SEC. 204. ADDITIONAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) INCLUSION IN MEDICARE COST-SHARING.—Section 1905(p)(3) of the Social Security Act (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and'' at the end; and

(C) by adding at the end the following new clause:

''(iii) premiums under section 1860E(a).''; and

(2) in subparagraph (B), by inserting ''and cost-sharing described in section 1860F(b)'' after ''section 1813''.

(b) EXPANSION OF MEDICAL ASSISTANCE.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(1) in clause (iii)—

(A) by striking ''section 1905(p)(3)(A)(ii)'' and inserting ''clauses (ii) and (iii) of section

1905(p)(3)(A) and for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII),''; and

(B) by striking ''and'' at the end;

(2) by redesignating clause (iv) as clause (vi); and

(3) by inserting after clause (iii) the following new clauses:

''(iv) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds 120 percent but does not exceed 135 percent of such official poverty line for a family of the size involved;

''(v) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) on a linear sliding scale based on the income of such individuals for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds 135 percent but does not exceed 150 percent of such official poverty line for a family of the size involved; and''.

(c) NONAPPLICABILITY OF RESOURCE REQUIREMENTS TO MEDICARE PART D COST-SHARING.—Section 1905(p)(1) of the Social Security Act (42 U.S.C. 1396d(p)(1)) is amended by adding at the end the following flush sentence:

''In determining if an individual is a qualified medicare beneficiary under this paragraph, subparagraph (C) shall not be applied for purposes of providing the individual with medicare cost-sharing described in section 1905(p)(3)(A)(iii) or for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII).''.

(d) NONAPPLICABILITY OF PAYMENT DIFFERENTIAL REQUIREMENTS TO MEDICARE PART D COST-SHARING.—Section 1902(n)(2) of the Social Security Act (42 U.S.C. 1396a(n)(2)) is amended by adding at the end the following new sentence: ''The preceding sentence shall not apply to the cost-sharing described in section 1860F(b).''.

(e) 100 PERCENT FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) by striking ''and'' before ''(4)''; and

(2) by inserting before the period at the end the following: '', and (5) the Federal medical assistance percentage shall be 100 percent with respect to medical assistance provided under clauses (iv) and (v) of section 1902(a)(10)(E)''.

(f) TREATMENT OF TERRITORIES.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

''(3) Notwithstanding the preceding provisions of this subsection, with respect to fiscal year 2005 and any fiscal year thereafter, the amount otherwise determined under this subsection (and subsection (f)) for the fiscal year for a Commonwealth or territory shall be increased by the ratio (as estimated by the Secretary) of—

''(A) the aggregate amount of payments made to the 50 States and the District of Columbia for the fiscal year under title XIX that are attributable to making medical assistance available for individuals described in clauses (i), (iii), (iv), and (v) of section 1902(a)(10)(E) for payment of medicare cost-sharing described in section 1905(p)(3)(A)(iii) and for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII); to

''(B) the aggregate amount of total payments made to such States and District for the fiscal year under such title.''.

(g) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(1) by striking ''and'' at the end of subclause (III);

(2) by striking the period at the end of subclause (IV) and inserting ''; and''; and

(3) by adding at the end the following new subclause:

''(V) any prices charged which are negotiated under a plan under part D of title XVIII with respect to covered outpatient drugs, under a Medicare+Choice plan under part C of such title with respect to such drugs, or by a qualified retiree prescription drug plan (as defined in section 1860J(e)(3)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860(2).''.

(h) CONFORMING AMENDMENTS.—Section 1933 of the Social Security Act (42 U.S.C. 1396u–3) is amended—

(1) in subsection (a), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(vi)'';

(2) in subsection (c)(2)(A)—

(A) in clause (i), by striking ''section 1902(a)(10)(E)(iv)(I)'' and inserting ''section 1902(a)(10)(E)(vi)(I)''; and

(B) in clause (ii), by striking ''section 1902(a)(10)(E)(iv)(II)'' and inserting ''section 1902(a)(10)(E)(vi)(II)'';

(3) in subsection (d), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(vi)''; and

(4) in subsection (e), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(vi)''.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply for medical assistance provided under section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) on and after January 1, 2005.

SEC. 205. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) MODERNIZED BENEFIT PACKAGES FOR MEDICARE SUPPLEMENTAL POLICIES.—

''(1) REVISION OF BENEFIT PACKAGES.—

''(A) IN GENERAL.—Notwithstanding subsection (p), the benefit packages classified as 'H', 'I', and 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) shall be revised so that—

''(i) the coverage of outpatient prescription drugs available under such benefit packages is replaced with coverage of outpatient prescription drugs that complements but does not duplicate the coverage of outpatient prescription drugs that is otherwise available under this title;

''(ii) the revised benefit packages provide a range of coverage options for outpatient prescription drugs for beneficiaries, but do not provide coverage for more than 90 percent of the cost-sharing amount applicable to an individual under section 1860F(b);

''(iii) uniform language and definitions are used with respect to such revised benefits;

''(iv) uniform format is used in the policy with respect to such revised benefits;

''(v) such revised standards meet any additional requirements imposed by the amendments made by the Medicare Outpatient Prescription Drug Act of 2002; and

''(vi) except as revised under the preceding clauses or as provided under subsection (p)(1)(E), the benefit packages are identical to the benefit packages that were available on the date of enactment of the Medicare Outpatient Prescription Drug Act of 2002.

''(B) MANNER OF REVISION.—The benefit packages revised under this section shall be revised in the manner described in subparagraph (E) of subsection (p)(1), except that for purposes of subparagraph (C) of such subsection, the standards established under this subsection shall take effect not later than January 1, 2005.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'G' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

''(3) GUARANTEED ISSUANCE AND RENEWAL OF REVISED POLICIES.—The provisions of subsections (q) and (s), including provisions of subsection (s)(3) (relating to special enrollment periods in cases of termination or disenrollment), shall apply to medicare supplemental policies revised under this subsection in the same manner as such provisions apply to medicare supplemental policies issued under the standards established under subsection (p).

''(4) OPPORTUNITY OF CURRENT POLICYHOLDERS TO PURCHASE REVISED POLICIES.—

''(A) IN GENERAL.—No medicare supplemental policy of an issuer with a benefit package that is revised under paragraph (1) shall be deemed to meet the standards in subsection (c) unless the issuer—

''(i) provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860B(b)(2)(A), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer (at the most recent available address of that individual) of the offer described in clause (ii) and of the fact that such individual will no longer be covered under such policy as of January 1, 2005; and

''(ii) offers the policyholder or certificate holder under the terms described in subparagraph (B), during at least the period established under section 1860B(b)(2)(A), a medicare supplemental policy with the benefit package that the Secretary determines is most comparable to the policy in which the individual is enrolled with coverage effective as of the date on which the individual is first entitled to benefits under part D.

''(B) TERMS OF OFFER DESCRIBED.—The terms described in this subparagraph are terms which do not—

''(i) deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (A)(ii) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition; or

''(iii) impose an exclusion of benefits based on a preexisting condition under such policy.

''(5) ELIMINATION OF OBSOLETE POLICIES WITH NO GRANDFATHERING.—No person may sell, issue, or renew a medicare supplemental policy with a benefit package that is classified as 'H', 'I', or 'J' (or with a benefit package classified as 'J' with a high deductible feature) that has not been revised under this subsection on or after January 1, 2005.

''(6) PENALTIES.—Each penalty under this section shall apply with respect to policies revised under this subsection as if such policies were issued under the standards established under subsection (p), including the

penalties under subsections (a), (d), (p)(8), (p)(9), (q)(5), (r)(6)(A), (s)(4), and (t)(2)(D).''.

SEC. 206. COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS UNDER PART B.

(a) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)), as amended by section 113(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–473), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking '', to an individual who receives'' and all that follows before the semicolon at the end and inserting ''to an individual who has received an organ transplant''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs furnished on or after the date of enactment of this Act.

SEC. 207. HHS STUDY AND REPORT ON UNIFORM PHARMACY BENEFIT CARDS.

(a) STUDIES.—The Secretary of Health and Human Services shall conduct a study to determine the feasibility and advisability of establishing a uniform format for pharmacy benefit cards provided to beneficiaries by eligible entities under the outpatient prescription drug benefit program under part D of title XVIII of the Social Security Act (as added by section 202).

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the results of the study conducted under subsection (a) together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

SEC. 208. GAO STUDY AND BIENNIAL REPORTS ON COMPETITION AND SAVINGS.

(a) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study and analysis of the outpatient prescription drug benefit program under part D of title XVIII of the Social Security Act (as added by section 202), including an analysis of—

(1) the extent to which the competitive bidding process under such program fosters maximum competition and efficiency; and

(2) the savings to the medicare program resulting from such outpatient prescription drug benefit program, including the reduction in the number or length of hospital visits.

(b) INITIAL REPORT ON COMPETITIVE BIDDING PROCESS.—Not later than 9 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the results of the portion of the study conducted pursuant to subsection (a)(1).

(c) BIENNIAL REPORTS.—Not later than January 1, 2006, and biennially thereafter, the Comptroller General of the United States shall submit to Congress a report on the results of the study conducted under subsection (a) together with such recommendations for legislation and administrative action as the Comptroller General determines appropriate.

SEC. 209. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) of the Social Security Act (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking ''17'' and inserting ''19''; and

(B) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription drug benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2004.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) of the Social Security Act (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) PRESCRIPTION MEDICINE BENEFIT PROGRAM.—Specifically, the Commission shall review, with respect to the outpatient prescription drug benefit program under part D, the impact of such program on—

''(i) the pharmaceutical market, including costs and pricing of pharmaceuticals, beneficiary access to such pharmaceuticals, and trends in research and development;

''(ii) franchise, independent, and rural pharmacies; and

''(iii) beneficiary access to outpatient prescription drugs, including an assessment of out-of-pocket spending, generic and brand name drug utilization, and pharmacists' services.''.

SA 4310. Mr. HATCH (for Mr. GRASSLEY (for himself, Ms. SNOWE, Mr. JEFFORDS, Mr. BREAUX, Mr. HATCH, Ms. COLLINS, Ms. LANDRIEU, Mr. HUTCHINSON, and Mr. DOMENICI)) proposed an amendment to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; as follows:

At the end, add the following:

DIVISION ____—21ST CENTURY MEDICARE ACT

SEC. 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''21st Century Medicare Act''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term ''BIPA'' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA; table of contents.

TITLE I—MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

Sec. 101. Medicare voluntary prescription drug delivery program.

''PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''Sec. 1860D. Definitions; treatment of references to provisions in Medicare+Choice program.

''Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

''Sec. 1860D–1. Establishment of voluntary prescription drug delivery program.

''Sec. 1860D–2. Enrollment under program.

''Sec. 1860D–3. Election of a Medicare Prescription Drug plan.

''Sec. 1860D–4. Providing information to beneficiaries.

''Sec. 1860D–5. Beneficiary protections.

''Sec. 1860D–6. Prescription drug benefits.

''Sec. 1860D–7. Requirements for entities offering Medicare Prescription Drug plans; establishment of standards.

''Subpart 2—Prescription Drug Delivery System

''Sec. 1860D–10. Establishment of service areas.

''Sec. 1860D–11. Publication of risk adjusters.

''Sec. 1860D–12. Submission of bids for proposed Medicare Prescription Drug plans.

''Sec. 1860D–13. Approval of proposed Medicare Prescription Drug plans.

''Sec. 1860D–14. Computation of monthly standard coverage premiums.

''Sec. 1860D–15. Computation of monthly national average premium.

''Sec. 1860D–16. Payments to eligible entities offering Medicare Prescription Drug plans.

''Sec. 1860D–17. Computation of beneficiary obligation.

''Sec. 1860D–18. Collection of beneficiary obligation.

''Sec. 1860D–19. Premium and cost-sharing subsidies for low-income individuals.

''Sec. 1860D–20. Reinsurance payments for qualified prescription drug coverage.

''Subpart 3—Medicare Competitive Agency; Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund

''Sec. 1860D–25. Establishment of Medicare Competitive Agency.

''Sec. 1860D–26. Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.''.

Sec. 102. Study and report on permitting part B only individuals to enroll in medicare voluntary prescription drug delivery program.

Sec. 103. Additional requirements for annual financial report and oversight on medicare program.

Sec. 104. Reference to medigap provisions.

Sec. 105. Medicaid amendments.

Sec. 106. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).

Sec. 107. Miscellaneous administrative provisions.

TITLE II—OPTION FOR ENHANCED MEDICARE BENEFITS

Sec. 201. Option for enhanced medicare benefits.

''PART E—ENHANCED MEDICARE BENEFITS

''Sec. 1860E–1. Entitlement to elect to receive enhanced medicare benefits.

''Sec. 1860E–2. Scope of enhanced medicare benefits.

''Sec. 1860E–3. Payment of benefits.

''Sec. 1860E–4. Eligible beneficiaries; election of enhanced medicare benefits; termination of election.

''Sec. 1860E–5. Premium adjustments; late election penalty.''.
Sec. 202. Rules relating to medigap policies that provide prescription drug coverage; establishment of enhanced medicare fee-for-service medigap policies.
TITLE III—MEDICARE+CHOICE COMPETITION
Sec. 301. Annual calculation of benchmark amounts based on floor rates and local fee-for-service rates.
Sec. 302. Application of comprehensive risk adjustment methodology.
Sec. 303. Annual announcement of benchmark amounts and other payment factors.
Sec. 304. Submission of bids by Medicare+Choice organizations.
Sec. 305. Adjustment of plan bids; comparison of adjusted bid to benchmark; payment amount.
Sec. 306. Determination of premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums.
Sec. 307. Eligibility, election, and enrollment in competitive Medicare+Choice plans.
Sec. 308. Benefits and beneficiary protections under competitive Medicare+Choice plans.
Sec. 309. Payments to Medicare+Choice organizations for enhanced medicare benefits under part E based on risk-adjusted bids.
Sec. 310. Separate payments to Medicare+Choice organizations for part D benefits.
Sec. 311. Administration by the Medicare Competitive Agency.
Sec. 312. Continued calculation of annual Medicare+Choice capitation rates.
Sec. 313. Five-year extension of medicare cost contracts.
Sec. 314. Effective date.

TITLE I—MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

SEC. 101. MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part F and by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN MEDICARE+CHOICE PROGRAM

''SEC. 1860D. (a) DEFINITIONS.—In this part:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Medicare Competitive Agency as established under section 1860D–25.

''(2) COVERED DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered drug' means—

''(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2); or

''(ii) a biological product or insulin described in subparagraph (B) or (C) of such section;

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—The term 'covered drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B (or under part E for an eligible beneficiary who elects to receive enhanced medicare benefits under that part), but shall be so considered if such payment is not available because benefits under part A or B (or part E, as applicable) have been exhausted.

''(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual that is entitled to benefits under part A and enrolled under part B.

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any risk-bearing entity that the Administrator determines to be appropriate to provide eligible beneficiaries with the benefits under a Medicare Prescription Drug plan, including—

''(A) a pharmaceutical benefit management company;

''(B) a wholesale or retail pharmacist delivery system;

''(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

''(D) another entity; or

''(E) any combination of the entities described in subparagraphs (A) through (D).

''(5) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the limit as established under section 1860D–6(c)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

''(6) MEDICARE+CHOICE ORGANIZATION; MEDICARE+CHOICE PLAN.—The terms 'Medicare+Choice organization' and 'Medicare+Choice plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to Medicare+Choice organizations).

''(7) MEDICARE PRESCRIPTION DRUG PLAN.—The term 'Medicare Prescription Drug plan' means prescription drug coverage that is offered under a policy, contract, or plan—

''(A) by an eligible entity pursuant to, and in accordance with, a contract between the Administrator and the entity under section 1860D–7(b); and

''(B) that has been approved under section 1860D–13.

''(8) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860D–26) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(9) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' means the coverage described in section 1860D–6(a)(1).

''(10) STANDARD COVERAGE.—The term 'standard coverage' means the coverage described in section 1860D–6(c).

''(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a Medicare Prescription Drug plan and an eligible entity, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a Medicare+Choice plan included a reference to a Medicare Prescription Drug plan;

''(2) any reference to a provider-sponsored organization included a reference to an eligible entity;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–7(b); and

''(4) any reference to part C included a reference to this part.

''Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

''ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''SEC. 1860D–1. (a) PROVISION OF BENEFIT.—

''(1) IN GENERAL.—The Administrator shall provide for and administer a voluntary prescription drug delivery program under which each eligible beneficiary enrolled under this part shall be provided with access to qualified prescription drug coverage as follows:

''(A) MEDICARE+CHOICE PLAN.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization shall receive coverage of benefits under this part through such plan if such plan provides qualified prescription drug coverage.

''(B) MEDICARE PRESCRIPTION DRUG PLAN.—An eligible beneficiary who is enrolled under this part but is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides.

''(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

''(3) SCOPE OF BENEFITS.—The program established under this part shall provide for coverage of all therapeutic classes of covered drugs.

''(4) PROGRAM TO BEGIN IN 2005.—The Administrator shall establish the program under this part in a manner so that benefits are first provided for months beginning with January 2005.

''(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860D–2(b)(1)(F)), such beneficiary—

''(1) may continue to receive such coverage and not enroll under this part; and

''(2) pursuant to section 1860D–2(b)(1)(C), is permitted to subsequently enroll under this part without any penalty and obtain access to qualified prescription drug coverage in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

''(c) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

''ENROLLMENT UNDER PROGRAM

''SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLLMENT PROCESS.—

''(1) PROCESS SIMILAR TO PART B ENROLLMENT.—The Administrator shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

''(2) CONDITION OF ENROLLMENT.—An eligible beneficiary must be enrolled under this part in order to be eligible to receive access to qualified prescription drug coverage.

''(b) SPECIAL ENROLLMENT PROCEDURES.—

''(1) LATE ENROLLMENT PENALTY.—

''(A) INCREASE IN PREMIUM.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in paragraph (2), the Administrator shall establish procedures for increasing the amount of the monthly beneficiary obligation under section 1860D–17 applicable to

such beneficiary by an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

''(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account—

''(i) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

''(ii) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

''(C) PERIODS NOT TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clauses (ii) and (iii), there shall not be taken into account months for which the eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

''(ii) BENEFICIARY MUST INVOLUNTARILY LOSE COVERAGE.—Clause (i) shall only apply with respect to coverage—

''(I) in the case of coverage described in clause (ii) of subparagraph (F), if the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of standard coverage (as determined under section 1860D–6(f));

''(II) in the case of coverage described in clause (i), (iii), or (iv) of subparagraph (F), if the beneficiary loses eligibility for such coverage; or

''(III) in the case of a beneficiary with coverage described in clause (v) of subparagraph (F), if the issuer of the policy terminates coverage under the policy.

''(iii) PARTIAL CREDIT FOR CERTAIN MEDIGAP COVERAGE.—In the case of a beneficiary that had creditable prescription drug coverage described in subparagraph (F)(v) that does not provide coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)), the Administrator shall determine a percentage of the period in which the beneficiary had such creditable prescription drug coverage that will be taken into account under subparagraph (B) (and not considered to be such creditable prescription drug coverage under clause (i)).

''(D) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly beneficiary obligation under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

''(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary's 'continuous period of eligibility' is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

''(ii) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate 'continuous period of eligibility' with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

''(F) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

''(i) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)).

''(ii) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)), but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)).

''(iii) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)).

''(iv) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)).

''(v) PRESCRIPTION DRUG COVERAGE UNDER MEDIGAP POLICIES.—Subject to subparagraph (C)(iii), coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)).

''(2) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—In the case of an individual who is an eligible beneficiary as of January 1, 2005, the Administrator shall establish procedures under which such beneficiary may enroll under this part during the open enrollment period without the application of the late enrollment procedures established under paragraph (1)(A). For purposes of the preceding sentence, the open enrollment period shall be the 7-month period that begins on April 1, 2004, and ends on November 30, 2004.

''(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES WHO INVOLUNTARILY LOSE CREDITABLE PRESCRIPTION DRUG COVERAGE.—

''(A) ESTABLISHMENT.—The Administrator shall establish a special open enrollment period (as described in subparagraph (B)) for an eligible beneficiary that loses creditable prescription drug coverage.

''(B) SPECIAL OPEN ENROLLMENT PERIOD.—The special open enrollment period described in this subparagraph is the 63-day period that begins—

''(i) in the case of a beneficiary with coverage described in clause (ii) of paragraph (1)(F), the date on which the plan terminates, ceases to provide, or substantially reduces (as defined by the Administrator) the value of the prescription drug coverage under such plan;

''(ii) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of paragraph (1)(F), the date on which the beneficiary loses eligibility for such coverage; or

''(iii) in the case of a beneficiary with coverage described in clause (v) of paragraph (1)(F), the date on which the issuer of the policy terminates coverage under the policy.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) OPEN AND SPECIAL ENROLLMENT.—

''(A) OPEN ENROLLMENT.—An eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(2) shall be entitled to the benefits under this part beginning on January 1, 2005.

''(B) SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(3) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(3) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2005.

''(d) TERMINATION.—

''(1) IN GENERAL.—The causes of termination specified in section 1838 shall apply to this part in the same manner as such causes apply to part B.

''(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A OR B.—

''(A) IN GENERAL.—In addition to the causes of termination specified in paragraph (1), the Administrator shall terminate an individual's coverage under this part if the individual is no longer enrolled in both parts A and B.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if earlier) under part B.

''(3) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Administrator shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a Medicare Prescription Drug plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Administrator under section 1860D–3(a)(1)).

''ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

''SEC. 1860D–3. (a) IN GENERAL.—

''(1) PROCESS.—

''(A) ELECTION.—

''(i) IN GENERAL.—The Administrator shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization that provides qualified prescription drug coverage—

''(I) shall make an election to enroll in any Medicare Prescription Drug plan that is offered by an eligible entity and that serves the geographic area in which the beneficiary resides; and

''(II) may make an annual election to change the election under this clause.

''(ii) CLARIFICATION REGARDING ENROLLMENT.—The process established under clause (i) shall include, in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of a Medicare Prescription Drug plan in an area, for the enrollment in the Medicare Prescription Drug plan with the lowest monthly premium that is available in the area.

''(B) REQUIREMENTS FOR PROCESS.—In establishing the process under subparagraph (A), the Administrator shall—

''(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a Medicare+Choice plan under section 1851, including—

''(I) the establishment of special election periods under subsection (e)(4) of such section; and

''(II) the application of the guaranteed issue and renewal provisions of section 1851(g) (other than clause (i) and the second sentence of clause (ii) of paragraph (3)(C), relating to default enrollment); and

''(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

''(2) FIRST ENROLLMENT PERIOD FOR PLAN ENROLLMENT.—The process developed under paragraph (1) shall ensure that eligible beneficiaries who enroll under this part during the open enrollment period under section 1860D–2(b)(2) are permitted to elect an eligible entity prior to January 1, 2005, in order to ensure that coverage under this part is effective as of such date.

''(b) ENROLLMENT IN A MEDICARE+CHOICE PLAN.—

''(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization that provides qualified prescription drug coverage shall receive access to such coverage under this part through such plan.

''(2) RULES.—Enrollment in a Medicare+Choice plan is subject to the rules for enrollment in such plan under section 1851.

''PROVIDING INFORMATION TO BENEFICIARIES

''SEC. 1860D–4. (a) ACTIVITIES.—

''(1) IN GENERAL.—The Administrator shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

''(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—The activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 30 days prior to the first enrollment period described in section 1860D–3(a)(2).

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The activities described in subsection (a) shall—

''(A) be similar to the activities performed by the Administrator under section 1851(d);

''(B) be coordinated with the activities performed by—

''(i) the Administrator under such section; and

''(ii) the Secretary under section 1804; and

''(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

''(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

''(A) BENEFITS.—The benefits provided under the plan and the formularies and appeals processes under the plan.

''(B) QUALITY AND PERFORMANCE.—To the extent available, the quality and performance of the eligible entity offering the plan.

''(C) BENEFICIARY COST-SHARING.—The cost-sharing required of eligible beneficiaries under the plan.

''(D) CONSUMER SATISFACTION SURVEYS.—To the extent available, the results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan.

''(E) ADDITIONAL INFORMATION.—Such additional information as the Administrator may prescribe.

''BENEFICIARY PROTECTIONS

''SEC. 1860D–5. (a) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan shall disclose, in a clear, accurate, and standardized form to each enrollee at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

''(A) Access to covered drugs, including access through pharmacy networks.

''(B) How any formulary used by the entity functions.

''(C) Copayments, coinsurance, and deductible requirements.

''(D) Grievance and appeals procedures.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll in a Medicare Prescription Drug plan, the eligible entity offering such plan shall provide the information described in section 1852(c)(2) to such individual.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—An eligible entity offering a Medicare Prescription Drug plan shall have a mechanism for providing specific information to enrollees upon request, including information on the coverage of specific drugs and changes in its formulary on a timely basis.

''(4) CLAIMS INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket limit for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(5) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

''(b) ACCESS TO COVERED DRUGS.—

''(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Drug plan shall issue such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860D–6(e) for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Drug plan.

''(2) ASSURING PHARMACY ACCESS.—

''(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D–7(f) that ensure such convenient access. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(B) USE OF POINT-OF-SERVICE SYSTEM.—An eligible entity offering a Medicare Prescription Drug plan shall establish an optional point-of-service method of operation under which—

''(i) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

''(ii) the plan may charge beneficiaries through adjustments in copayments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1860D–6(c).

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity offering a Medicare Prescription Drug plan uses a formulary, the following requirements must be met:

''(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one practicing physician and at least one practicing pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

''(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

''(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

''(D) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

''(E) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

''(F) APPEALS AND EXCEPTIONS TO APPLICATION.—The eligible entity must have, as part of the appeals process under subsection (e)(3), a process for timely appeals for denials of coverage based on such application of the formulary.

''(c) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(1) IN GENERAL.—An eligible entity shall have in place the following with respect to covered drugs:

''(A) A cost-effective drug utilization management program, including incentives to reduce costs when appropriate.

''(B) Quality assurance measures to reduce medical errors and adverse drug interactions, which—

''(i) shall include a medication therapy management program described in paragraph (2); and

''(ii) may include beneficiary education programs, counseling, medication refill reminders, and special packaging.

''(C) A program to control fraud, abuse, and waste.

''(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(B) ELEMENTS.—Such program may include—

''(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

''(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

''(iii) detection of patterns of overuse and underuse of prescription drugs.

''(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

''(D) CONSIDERATIONS IN PHARMACY FEES.—The eligible entity offering a Medicare Prescription Drug plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The eligible entity offering a Medicare Prescription Drug plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

''(d) GRIEVANCE MECHANISM.—An eligible entity shall provide meaningful procedures for hearing and resolving grievances between the eligible entity (including any entity or individual through which the eligible entity provides covered benefits) and enrollees in a Medicare Prescription Drug plan offered by the eligible entity in accordance with section 1852(f).

''(e) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) IN GENERAL.—An eligible entity shall meet the requirements of section 1852(g) with respect to covered benefits under the Medicare Prescription Drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(2) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that provides for tiered cost-sharing for covered drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(3) APPEALS OF FORMULARY DETERMINATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), consistent with the requirements of section 1852(g), an eligible entity shall establish a process for individuals to appeal formulary determinations.

''(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a Medicare Prescription Drug plan offered by an eligible entity may appeal to obtain coverage for a covered drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(f) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—An eligible entity shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

''(g) UNIFORM PREMIUM.—An eligible entity shall ensure that the monthly premium for a Medicare Prescription Drug plan charged under this part is the same for all eligible beneficiaries enrolled in the plan.

''PRESCRIPTION DRUG BENEFITS

''SEC. 1860D–6. (a) REQUIREMENTS.—

''(1) IN GENERAL.—For purposes of this part and part C, the term 'qualified prescription drug coverage' means either of the following:

''(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (c)) and access to negotiated prices under subsection (e).

''(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered drugs which meets the alternative coverage requirements of subsection (d) and access to negotiated prices under subsection (e), but only if it is approved by the Administrator, as provided under subsection (d).

''(2) PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860D–13(c)(2), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered drugs that exceeds the coverage required under paragraph (1).

''(B) REQUIREMENT.—An eligible entity may not offer a Medicare Prescription Drug plan that provides additional benefits pursuant to subparagraph (A) in an area unless the eligible entity offering such plan also offers a Medicare Prescription Drug plan in the area that only provides the coverage of prescription drugs that is required under subsection (a)(1).

''(3) COST CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Drug plan or the Medicare+Choice plan may use cost control mechanisms that are customarily used in employer-sponsored health care plans that offer coverage for prescription drugs, including the use of formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies.

''(b) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

''(c) STANDARD COVERAGE.—For purposes of this part and part C, the term 'standard coverage' means coverage of covered drugs that meets the following requirements:

''(1) DEDUCTIBLE.—

''(A) IN GENERAL.—The coverage has an annual deductible—

''(i) for 2005, that is equal to $250; or

''(ii) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

''(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''(2) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

''(3) INITIAL COVERAGE LIMIT.—

''(A) IN GENERAL.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (above the annual deductible)—

''(i) for 2005, that is equal to $3,450; or

''(ii) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

''(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARY.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits with cost-sharing that is equal to 10 percent after the individual has incurred costs (as described in subparagraph (C)) for covered drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—

''(i) IN GENERAL.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(I) for 2005, is equal to $3,700; or

''(II) for a subsequent year, is equal to the amount specified in the subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

''(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''(C) APPLICATION.—In applying subparagraph (A)—

''(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

''(ii) such costs shall be treated as incurred only if they are paid by the individual (or by another individual, such as a family member, on behalf of the individual), under section 1860D–19, or under title XIX and the individual (or other individual) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement for such costs.

''(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered drugs in the United States for beneficiaries under this title, as determined by the Administrator for the 12-month period ending in July of the previous year.

''(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A Medicare Prescription Drug plan

or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (c) so long as the Administrator determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

''(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

''(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (f)) is at least equal to the actuarial value (as so determined) of standard coverage.

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (f)) exceeds the actuarial value of the amounts associated with the application of section 1860D–17(c) and reinsurance payments under section 1860D–20 with respect to such coverage.

''(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (f)), to provide for the payment, with respect to costs incurred that are equal to the sum of the deductible under subsection (c)(1) and the initial coverage limit under subsection (c)(3), of an amount equal to at least such initial coverage limit multiplied by the percentage specified in subsection (c)(2).

Benefits other than qualified prescription drug coverage shall not be taken into account for purposes of this paragraph.

''(2) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES.—The coverage provides the limitation on out-of-pocket expenditures by beneficiaries described in subsection (c)(4).

''(e) ACCESS TO NEGOTIATED PRICES.—

''(1) ACCESS.—

''(A) IN GENERAL.—Under qualified prescription drug coverage offered by an eligible entity or a Medicare+Choice organization, the entity or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of the deductible, any cost-sharing, or an initial coverage limit (described in subsection (c)(3)).

''(B) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a Medicare+Choice plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(2) CARDS OR OTHER TECHNOLOGY.—In providing the access under paragraph (1), the eligible entity or Medicare+Choice organization shall issue a card or use other technology pursuant to section 1860D–5(b)(1).

''(f) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

''(1) PROCESSES.—For purposes of this section, the Administrator shall establish processes and methods—

''(A) for determining the actuarial valuation of prescription drug coverage, including—

''(i) an actuarial valuation of standard coverage and of the reinsurance payments under section 1860D–20;

''(ii) the use of generally accepted actuarial principles and methodologies; and

''(iii) applying the same methodology for determinations of alternative coverage under subsection (d) as is used with respect to determinations of standard coverage under subsection (c); and

''(B) for determining annual percentage increases described in subsection (c)(5).

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), eligible entities and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

''REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRESCRIPTION DRUG PLANS; ESTABLISHMENT OF STANDARDS

''SEC. 1860D–7. (a) GENERAL REQUIREMENTS.—An eligible entity offering a Medicare Prescription Drug plan shall meet the following requirements:

''(1) LICENSURE.—Subject to subsection (c), the entity is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare Prescription Drug plan.

''(2) ASSUMPTION OF FINANCIAL RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860D–20, the entity assumes financial risk on a prospective basis for the benefits that it offers under a Medicare Prescription Drug plan and that is not covered under such section or section 1860D–16.

''(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

''(3) SOLVENCY FOR UNLICENSED ENTITIES.—In the case of an eligible entity that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such entity shall meet solvency standards established by the Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—The Administrator shall not permit an eligible beneficiary to elect a Medicare Prescription Drug plan offered by an eligible entity under this part, and the entity shall not be eligible for payments under section 1860D–16 or 1860D–20, unless the Administrator has entered into a contract under this subsection with the entity with respect to the offering of such plan. Such a contract with an entity may cover more than 1 Medicare Prescription Drug plan. Such contract shall provide that the entity agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(c) WAIVER OF CERTAIN REQUIREMENTS IN ORDER TO ENSURE BENEFICIARY CHOICE.—

''(1) IN GENERAL.—In the case of an eligible entity that seeks to offer a Medicare Prescription Drug plan in a State, the Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) have been met.

''(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraphs (B), (C), and (D) of section 1855(a)(2), and also include the application by a State of any grounds other than those required under Federal law.

''(3) APPLICATION OF WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

''(4) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying the provisions of section 1855(a)(2) under this subsection to Medicare Prescription Drug plans and eligible entities—

''(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

''(B) any reference to solvency standards were treated as a reference to solvency standards established under subsection (d).

''(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTITIES.—

''(1) ESTABLISHMENT AND PUBLICATION.—The Administrator, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2004, financial solvency and capital adequacy standards for entities described in paragraph (2).

''(2) COMPLIANCE WITH STANDARDS.—An eligible entity that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such eligible entities with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the eligible entity to meet other requirements imposed under this part for an eligible entity.

''(f) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for eligible entities and Medicare Prescription Drug plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by January 1, 2004.

''(g) PERIODIC REVIEW AND REVISION OF STANDARDS.—The Administrator shall periodically review the standards established under this section and, based on such review, may revise such standards if the Administrator determines such revision to be appropriate.

''(h) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to Medicare Prescription Drug plans which are offered by eligible entities under this part—

''(A) to the extent such law or regulation is inconsistent with such standards; and

''(B) in the same manner as such laws and regulations are superseded under section 1856(b)(3).

''(2) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this section:

''(A) Benefit requirements.

''(B) Requirements relating to inclusion or treatment of providers.

''(C) Coverage determinations (including related appeals and grievance processes).

''(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to—

''(A) premiums paid to the Administrator for Medicare Prescription Drug plans under this part; or

''(B) any payments made by the Administrator under this part to an eligible entity offering such a plan.

''Subpart 2—Prescription Drug Delivery System

''ESTABLISHMENT OF SERVICE AREAS

''SEC. 1860D–10. (a) ESTABLISHMENT.—

''(1) INITIAL ESTABLISHMENT.—Not later than April 15, 2004, the Administrator shall establish and publish the service areas in which Medicare Prescription Drug plans may offer benefits under this part.

''(2) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Administrator shall periodically review the service areas applicable under this section and, based on such review, may revise such service areas if the Administrator determines such revision to be appropriate.

''(b) REQUIREMENTS FOR ESTABLISHMENT OF SERVICE AREAS.—

''(1) IN GENERAL.—The Administrator shall establish the service areas under subsection (a) in a manner that—

''(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

''(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

''(2) SERVICE AREA MAY NOT BE SMALLER THAN A STATE.—A service area established under subsection (a) may not be smaller than a State.

''PUBLICATION OF RISK ADJUSTERS

''SEC. 1860D–11. (a) PUBLICATION.—Not later than April 15 of each year (beginning in 2004), the Administrator shall publish the risk adjusters established under subsection (b) to be used in computing—

''(1) under section 1860D–16(a) the amount of payment to Medicare Prescription Drug plans in the subsequent year; and

''(2) under section 1853(k)(2) the amount of payment to Medicare+Choice organizations that offer qualified prescription drug coverage in the subsequent year.

''(b) ESTABLISHMENT OF RISK ADJUSTERS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall establish an appropriate methodology for adjusting the amount of payment to Medicare Prescription Drug plans computed under section 1860D–16(a) to take into account, in a budget neutral manner, variation in costs based on the differences in actuarial risk of different enrollees being served.

''(2) CONSIDERATIONS.—In establishing the methodology under paragraph (1), the Administrator may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to Medicare+Choice organizations (with respect to enhanced medicare benefits under part E).

''SUBMISSION OF BIDS FOR PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–12. (a) IN GENERAL.—Each eligible entity that intends to offer a Medicare Prescription Drug plan in a year (beginning with 2005) shall submit to the Administrator, at such time and in such manner as the Administrator may specify, such information as the Administrator may require, including the information described in subsection (b).

''(b) INFORMATION DESCRIBED.—The information described in this subsection includes information on each of the following:

''(1) A description of the benefits under the plan (as required under section 1860D–6).

''(2) Information on the actuarial value of the qualified prescription drug coverage.

''(3) Information on the monthly premium to be charged for all benefits, including an actuarial certification of—

''(A) the actuarial basis for such premium; and

''(B) the portion of such premium attributable to benefits in excess of standard coverage; and

''(C) the reduction in such bid and premium resulting from the payments associated with section 1860D–16(c) and payments provided under section 1860D–20.

''(4) The service area for the plan.

''(5) Such other information as the Administrator may require to carry out this part.

''(c) OPTIONS REGARDING SERVICE AREAS.—

''(1) IN GENERAL.—The service area of a Medicare Prescription Drug plan shall be either—

''(A) the entire area of 1 of the service areas established by the Administrator under section 1860D–10; or

''(B) the entire area covered by the medicare program.

''(2) RULE OF CONSTRUCTION.—Nothing in this part shall be construed as prohibiting an eligible entity from submitting separate bids in multiple service areas as long as each bid is for a single service area.

''APPROVAL OF PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–13. (a) IN GENERAL.—The Administrator shall review the information filed under section 1860D–12 and shall approve or disapprove the Medicare Prescription Drug plan. The Administrator may not approve a plan if—

''(1) the plan and the entity offering the plan comply with the requirements under this part; and

''(2) the premium accurately reflects both (A) the actuarial value of the benefits provided, and (B) the payments associated with the application of 186D–16(c) and the payments under section 1860D–20 for the standard benefit.

''(b) NEGOTIATION.—In exercising the authority under subsection (a), the Administrator shall have the same authority to negotiate the terms and conditions of the premiums submitted and other terms and conditions of proposed plans as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code.

''(c) SPECIAL RULES FOR APPROVAL.—The Administrator may approve a Medicare Prescription Drug plan submitted under section 1860D–12 only if the benefits under such plan—

''(1) include the required benefits under section 1860D–6(a)(1); and

''(2) are not designed in such a manner that the Administrator finds is likely to result in favorable selection of eligible beneficiaries.

''(d) ASSURING ACCESS.—

''(1) NUMBER OF CONTRACTS.—The Administrator shall, consistent with the requirements of this part and the goal of containing costs under this title, approve at least 2 contracts to offer a Medicare Prescription Drug plan in an area.

''(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) in an area and consistent with paragraph (3), the Administrator may provide financial incentives (including partial underwriting of risk) for an eligible entity to offer a Medicare Prescription Drug plan in that area, but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1) in that area.

''(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Administrator—

''(A) shall not provide for the full underwriting of financial risk for any eligible entity;

''(B) shall not provide for any underwriting of financial risk for a public eligible entity with respect to the offering of a nationwide prescription drug plan; and

''(C) shall seek to maximize the assumption of financial risk by an eligible entity.

''(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1860D–25(c)(1)(D), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to limit the exercise of such authority, including minimizing the assumption of financial risk.

''(e) ANNUAL CONTRACTS.—A contract approved under this part shall be for a 1-year period.

''COMPUTATION OF MONTHLY STANDARD COVERAGE PREMIUMS

''SEC. 1860D–14. (a) IN GENERAL.—For each year (beginning with 2005), the Administrator shall compute a monthly standard coverage premium for each Medicare Prescription Drug plan approved under section 1860D–13.

''(b) REQUIREMENTS.—The monthly standard coverage premium for a Medicare Prescription Drug plan for a year shall be equal to—

''(1) in the case of a plan offered by an eligible entity that provides standard coverage or an actuarially equivalent coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly premium approved for the plan under section 1860D–13 for the year; and

''(2) in the case of a plan offered by an eligible entity that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2)—

''(A) an amount that reflects only the actuarial value of the standard coverage offered under the plan; or

''(B) if determined appropriate by the Administrator, the monthly premium approved under section 1860D–13 for the year for the Medicare Prescription Drug plan that (as required under subparagraph (B) of such section)—

''(i) is offered by such entity in the same area as the plan; and

''(ii) does not provide additional prescription drug coverage pursuant to such section.

''COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM

''SEC. 1860D–15. (a) COMPUTATION.—

''(1) IN GENERAL.—For each year (beginning with 2005) the Administrator shall compute a monthly national average premium equal to the average of the monthly standard coverage premium for each Medicare Prescription Drug plan (as computed under section 1860D–14).

''(2) WEIGHTED AVERAGE.—The monthly national average premium computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

''(b) SPECIAL RULE FOR 2005.—For purposes of applying this section for 2005, the Administrator shall establish procedures for determining the weighted average under subsection (a)(2) for 2004.

''PAYMENTS TO ELIGIBLE ENTITIES OFFERING MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–16. (a) PAYMENT OF PREMIUMS.—For each year (beginning with 2005), the Administrator shall pay to each entity offering a Medicare Prescription Drug plan in which an eligible beneficiary is enrolled an amount equal to the full amount of the monthly premium approved for the plan under section 1860D–13 on behalf of each eligible beneficiary enrolled in such plan for the year, as adjusted using the risk adjusters that apply to the standard coverage published under section 1860D–11.

''(b) PAYMENT TERMS.—Payment under this section to an entity offering a Medicare Prescription Drug plan shall be made in a manner determined by the Administrator and based upon the manner in which payments are made under section 1853(a) (relating to payments to Medicare+Choice organizations).

''(c) PAYMENTS TO MEDICARE+CHOICE PLANS.—For provisions related to payments to Medicare+Choice organizations offering Medicare+Choice plans that provide qualified prescription drug coverage, see section 1853(k)(2).

''(d) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''COMPUTATION OF BENEFICIARY OBLIGATION

''SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN.—In the case of an eligible beneficiary enrolled under this part and in a Medicare Prescription Drug plan, the monthly beneficiary obligation for enrollment in such plan in a year shall be determined as follows:

''(1) MEDICARE PRESCRIPTION DRUG PLAN PREMIUMS EQUAL TO THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the eligible beneficiary in that year shall be an amount equal to the applicable percent (as defined in subsection (c)) of the amount of the monthly national average premium.

''(2) MEDICARE PRESCRIPTION DRUG PLAN PREMIUMS THAT ARE LESS THAN THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium approved by the Administrator under section 1860D–13 for the Medicare Prescription Drug plan for the year is less than the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the eligible beneficiary in that year shall be an amount equal to—

''(A) the applicable percent of the amount of the monthly national average premium; minus

''(B) the amount by which the monthly national average premium exceeds the amount of the premium approved by the Administrator for the plan.

''(3) MEDICARE PRESCRIPTION DRUG PLAN PREMIUMS THAT ARE GREATER THAN THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the eligible beneficiary in that year shall be an amount equal to the sum of—

''(A) the applicable percent of the amount of the monthly national average premium; plus

''(B) the amount by which the premium approved by the Administrator for the plan exceeds the amount of the monthly national average premium.

''(b) BENEFICIARIES ENROLLED IN A MEDICARE+CHOICE PLAN.—In the case of an eligible beneficiary that is receiving qualified prescription drug coverage under a Medicare+Choice plan, the monthly obligation for such coverage shall be determined pursuant to section 1853(k)(3).

''(c) APPLICABLE PERCENT DEFINED.—For purposes of this section, except as provided in section 1860D–19 (relating to premium subsidies for low-income individuals), the term 'applicable percent' means 55 percent.

''COLLECTION OF BENEFICIARY OBLIGATION

''SEC. 1860D–18. (a) COLLECTION OF AMOUNT IN SAME MANNER AS PART B PREMIUM.—The amount of the monthly beneficiary obligation (determined under section 1860D–17) applicable to an eligible beneficiary under this part (after application of any increase under section 1860D–2(b)(1)(A)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''(b) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subsection (a), the Administrator shall transmit to the Commissioner of Social Security—

''(1) at the beginning of each year, the name, social security account number, and annual beneficiary obligation owed by each individual enrolled in a Medicare Prescription Drug plan for each month during the year; and

''(2) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

''(c) COLLECTION FOR BENEFICIARIES RECEIVING QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER A MEDICARE+CHOICE PLAN.—For provisions related to the collection of the monthly beneficiary obligation for qualified prescription drug coverage under a Medicare+Choice plan, see section 1853(k)(4).

''PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

''SEC. 1860D–19. (a) IN GENERAL.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF FEDERAL POVERTY LINE.—In the case of a subsidy-eligible individual (as defined in paragraph (3)) who is determined to have income that does not exceed 135 percent of the Federal poverty line—

''(A) section 1860D–17 shall be applied—

''(i) in subsection (c), by substituting '0 percent' for '55 percent'; and

''(ii) in subparagraphs (A) and (B) of subsection (a)(3), by substituting ''the amount of the premium for the Medicare Prescription Drug plan with the lowest monthly premium in the area that the beneficiary resides'' for ''the amount of the monthly national average premium'', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the year;

''(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to an amount equal to 5 percent of the annual deductible otherwise applicable under such section for that year;

''(C) section 1860D–6(c)(2) shall be applied by substituting '2.5 percent' for '50 percent' each place it appears;

''(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached such initial coverage limit and before the individual has reached the limitation under section 1860D–6(c)(4)(A)), that is equal to 50 percent; and

''(E) section 1860D–6(c)(4)(A) shall be applied by substituting '0 percent' for '10 percent'.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below zero.

''(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BETWEEN 135 AND 150 PERCENT OF FEDERAL POVERTY LINE.—

''(A) IN GENERAL.—In the case of a subsidy-eligible individual who is determined to have income that exceeds 135 percent, but is less than 150 percent, of the Federal poverty line—

''(i) section 1860D–17 shall be applied—

''(I) in subsection (c), by substituting 'subsidy percent' for '55 percent'; and

''(II) in subparagraphs (A) and (B) of subsection (a)(3), by substituting ''the amount of the premium for the Medicare Prescription Drug plan with the lowest monthly premium in the area that the beneficiary resides'' for ''the amount of the monthly national average premium'', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the year; and

''(ii) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached such initial coverage limit and before the individual has reached the limitation under section 1860D–6(c)(4)(A)), that is equal to 50 percent.

In no case may the application of clause (i) result in a monthly beneficiary obligation that is below zero.

''(B) SUBSIDY PERCENT DEFINED.—For purposes of subparagraph (A)(i), the term 'subsidy percent' means a percent determined on a linear sliding scale ranging from 0 percent for individuals with incomes at 135 percent of such level to 55 percent for individuals with incomes at 150 percent of such level.

''(3) DETERMINATION OF ELIGIBILITY.—

''(A) SUBSIDY-ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy-eligible individual' means an individual who—

''(i) is enrolled under this part, including an individual receiving qualified prescription drug coverage under a Medicare+Choice plan;

''(ii) has income that is less that 150 percent of the Federal poverty line; and

''(iii) meets the resources requirement described in section 1905(p)(1)(C).

''(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy-eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator.

''(C) INCOME DETERMINATIONS.—For purposes of applying this section—

''(i) income shall be determined in the manner described in section 1905(p)(1)(B); and

''(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy-eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

''(b) RULES IN APPLYING COST-SHARING SUBSIDIES.—

''(1) ADDITIONAL BENEFITS.—In applying subparagraphs (B) and (C) of subsection (a)(1) and clauses (ii) and (iii) of subsection (a)(2)(A), nothing in this part shall be construed as preventing an eligible entity offering a Medicare Prescription Drug plan or a Medicare+Choice organization offering a Medicare+Choice plan in which qualified

drug coverage is provided from waiving or reducing the amount of the deductible or other cost-sharing otherwise applicable pursuant to section 1860D–6(a)(2).

''(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subparagraphs (B) and (C) of subsection (a)(1) or under clauses (ii) and (iii) of subsection (a)(2)(A), the eligible entity offering a Medicare Prescription Drug plan or the Medicare+Choice organization offering a Medicare+Choice plan in which qualified drug coverage is provided may not charge more than the deductible or other cost-sharing required pursuant to such subsection.

''(c) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall provide a process whereby, in the case of an individual eligible for a cost-sharing under subparagraphs (B) and (C) of subsection (a)(1) or under clauses (ii) and (iii) of subsection (a)(2)(A) and who is enrolled in a Medicare Prescription Drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

''(1) the Administrator provides for a notification of the eligible entity or Medicare+Choice organization involved that the individual is eligible for a cost-sharing subsidy and the amount of the subsidy under such subsection;

''(2) the entity or organization involved reduces the cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

''(3) the Administrator periodically and on a timely basis reimburses the entity or organization for the amount of such reductions.

The reimbursement under paragraph (3) may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

''(d) RELATION TO MEDICAID PROGRAM.—

''(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

''(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

''REINSURANCE PAYMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

''SEC. 1860D–20. (a) REINSURANCE PAYMENTS.—

''(1) IN GENERAL.—The Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the reinsurance payment amount (as defined in subsection (c)), which in the aggregate is 30 percent of the total payments made by a qualifying entity for standard coverage under the respective plan, for excess costs incurred in providing qualified prescription drug coverage for qualifying covered individuals (as defined in subsection (g)(1)).

''(2) BUDGET AUTHORITY.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

''(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(1) An eligible entity offering a Medicare Prescription Drug plan under this part.

''(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C.

''(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—Subject to subsection (d)(2), the reinsurance payment amount under this subsection for a qualifying covered individual for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

''(A) For the portion of the individual's gross covered drug costs (as defined in paragraph (3)) for the year that exceeds the amount specified in paragraph (2), but does not exceed the initial coverage limit, an amount equal to 50 percent of the allowable costs (as defined in paragraph (3)) attributable to such gross covered drug costs.

''(B) For the portion of the individual's gross covered drug costs for the year that exceeds the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered drug costs.

''(2) AMOUNT SPECIFIED.—The amount specified under this paragraph—

''(A) for 2005, is equal to $2,000; and

''(B) for a subsequent year, is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in section 1860D–6(c)(5).

''(3) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered drug costs (as defined in paragraph (4)) under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid (net of average percentage rebates) under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

''(4) GROSS COVERED DRUG COSTS.—For purposes of this section, the term 'gross covered drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan (including costs attributable to administrative costs) for covered drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

''(d) ADJUSTMENT OF REINSURANCE PAYMENTS TO ASSURE 30 PERCENT LEVEL OF PAYMENT.—

''(1) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

''(A) the total payments to be made (without regard to this subsection) during a year under subsections (a) and (c); and

''(B) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

''(2) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under subsections (a) and (c) for a coverage year in such manner so that the total of the payments made under such subsections for the year is equal to 30 percent of the total payments described in subparagraph (A)(ii).

''(e) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

''(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to a qualifying covered individual who is covered under the plan, the following requirements are met:

''(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

''(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, and the accuracy of payments made.

''(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual—

''(A) is covered under the plan; and

''(B) was eligible for, but was not enrolled in, the program under this part.

''(3) DEFINITIONS.—As used in this section:

''(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(B) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''(g) GENERAL DEFINITIONS.—For purposes of this section:

''(1) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled in this part and in a Medicare Prescription Drug plan;

''(B) is enrolled in this part and in a Medicare+Choice plan that provides qualified prescription drug coverage; or

''(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan.

''(2) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

''Subpart 3—Medicare Competitive Agency; Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund

''ESTABLISHMENT OF MEDICARE COMPETITIVE AGENCY

''SEC. 1860D–25. (a) ESTABLISHMENT.—By not later than March 1, 2003, the Secretary shall establish within the Department of Health and Human Services an agency to be known as the Medicare Competitive Agency.

''(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Medicare Competitive Agency shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the

President, by and with the advice and consent of the Senate. The Administrator shall report directly to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Competitive Agency who shall be appointed by the President, by and with the advice and consent of the Senate.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with eligible entities for the offering of Medicare Prescription Drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or D, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of an interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(C) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

''(i) require a particular formulary or institute a price structure for the reimbursement of covered drugs;

''(ii) interfere in any way with negotiations between eligible entities and Medicare+Choice organizations and drug manufacturers, wholesalers, or other suppliers of covered drugs; and

''(iii) otherwise interfere with the competitive nature of providing such qualified prescription drug coverage through such entities and organizations.

''(D) ANNUAL REPORTS.—Not later than March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of the voluntary prescription drug delivery program under this part during the previous fiscal year.

''(2) STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, other than sections 3110 and 3112, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Competitive Agency. The Administrator shall employ staff with appropriate and necessary expertise in negotiating contracts in the private sector.

''(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The staff of the Medicare Competitive Agency shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 (other than section 5101) and chapter 53 (other than section 5301) of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT CMS FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Centers for Medicare & Medicaid Services and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services to conduct such functions as of the date of enactment of this Act.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.—

''(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Competitive Agency an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be a separate operating division within the Administration.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Competitive Agency, and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A, B, and E, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and E, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original

medicare fee-for-service program under parts A and B (including beneficiaries who elect to receive enhanced medicare benefits under part E), the Medicare+Choice program under part C, and the voluntary prescription drug delivery program under part D.

''(3) MEDICARE OMBUDSMAN.—

''(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

''(B) DUTIES.—The Medicare Ombudsman shall—

''(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

''(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, an eligible entity under part D, or the Secretary; and

''(II) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C or a prescription drug plan under part D; and

''(iii) submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

''(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

''(i) provide information about the medicare program; and

''(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

''(e) MEDICARE COMPETITIVE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Medicare Competitive Agency the Medicare Competitive Policy Advisory Board (in this section referred to as the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator with respect to the administration of parts C and D, including the review of payment policies under such parts.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

''(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

''(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

''(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement of efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

''(iii) QUALITY.—Recommendations on ways to improve the quality of benefits provided under plans under parts C and D.

''(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

''(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

''(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(3) DUTY OF ADMINISTRATOR.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

''(i) Three members shall be appointed by the President.

''(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

''(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Committee on Finance of the Senate.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the Board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) one shall be appointed for a term of 1 year;

''(ii) three shall be appointed for terms of 2 years; and

''(iii) three shall be appointed for terms of 3 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) IN GENERAL.—With the approval of the Board, the Director may appoint, without regard to chapter 31 of title 5, United States Code, such additional personnel as the Director considers appropriate.

''(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(D) ASSISTANCE FROM THE ADMINISTRATOR.—The Administrator shall make available to the Board such information and other assistance as it may require to carry out its functions.

''(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account), such sums as are necessary to carry out this section.

''PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860D–26. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

''(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the Account as provided in this part.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including payments to eligible entities under section 1860D–16, payments under 1860D–19 for low-income subsidy payments for cost-sharing, reinsurance payments under section 1860D–20, and payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TRANSFER TO PARTS A AND B TRUST FUNDS FOR MEDICARE+CHOICE PAYMENTS.—The Managing Trustee shall establish procedures

for the transfer of funds from the Account, in an amount determined appropriate by the Secretary, to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in order to reimburse such trust funds for payments to Medicare+Choice organizations for the provision of qualified prescription drug coverage pursuant to section 1853(k).

''(3) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

''(4) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) DEPOSITS INTO ACCOUNT.—

''(1) MEDICAID TRANSFER.—There is hereby transferred to the Account, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

''(2) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the amount by which—

''(A) the payments and transfers made from the Account under subsection (b) in the year; exceed

''(B) the premiums collected under section 1860D–18 and 1853(k)(4) (for beneficiaries receiving qualified prescription drug coverage under a Medicare+Choice plan).''.

(b) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking ''and'' before ''such amounts''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860D–26'';

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),'';

(3) in subsection (h), by inserting after ''1840(d)'' the following: ''and section 1860D–18 (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)''; and

(4) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', section 1860D–18 (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),''.

(c) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

SEC. 102. STUDY AND REPORT ON PERMITTING PART B ONLY INDIVIDUALS TO ENROLL IN MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) STUDY.—The Administrator of the Medicare Competitive Agency (as established under section 1860D–25 of the Social Security Act (as added by section 301(a))) shall conduct a study on the need for rules relating to permitting individuals who are enrolled under part B of title XVIII of the Social Security Act but are not entitled to benefits under part A of such title to buy into the medicare voluntary prescription drug delivery program under part D of such title (as so added).

(b) REPORT.—Not later than January 1, 2004, the Administrator of the Medicare Competitive Agency shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

SEC. 103. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(1) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (INCLUDING THE PRESCRIPTION DRUG ACCOUNT).—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841, including the Prescription Drug Account within such Trust Fund, (in this subsection referred to as the 'Trust Funds'). Such report shall include the following information:

''(1) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds, separately stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year, for each of the following amounts:

''(A) MEDICARE BENEFITS.—The amount expended for payment of benefits covered under this title.

''(B) ADMINISTRATIVE AND OTHER EXPENSES.—The amount expended for payments not related to the benefits described in subparagraph (A).

''(2) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph.

''(3) 10-YEAR AND 50-YEAR PROJECTIONS.—An estimate of total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 50-year period beginning with the succeeding fiscal year.

''(4) RELATION TO OTHER MEASURES OF GROWTH.—A comparison of the rate of growth of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, to the rate of growth for the same period in—

''(A) the gross domestic product;

''(B) health insurance costs in the private sector;

''(C) employment-based health insurance costs in the public and private sectors; and

''(D) other areas as determined appropriate by the Board of Trustees.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to fiscal years beginning on or after the date of enactment of this Act.

(c) CONGRESSIONAL HEARINGS.—It is the sense of Congress that the committees of jurisdiction of Congress shall hold hearings on the reports submitted under section 1817(l) of the Social Security Act (as added by subsection (a)).

SEC. 104. REFERENCE TO MEDIGAP PROVISIONS.

For provisions related to medicare supplemental policies under section 1882 of the Social Security Act (42 U.S.C. 1395ss), see section 202.

SEC. 105. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

(1) REQUIREMENT.—Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)—

(i) by striking ''and'' at the end of paragraph (64);

(ii) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(iii) by inserting after paragraph (65) the following new paragraph:

''(66) provide for making eligibility determinations under section 1935(a).''.

(2) NEW SECTION.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

''(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860D–19;

''(2) inform the Administrator of the Medicare Competitive Agency of such determinations in cases in which such eligibility is established; and

''(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D–19).

''(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

''(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows:

''(A) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 20 percent of the percentage otherwise payable (but for this subsection) by the State.

''(B) For expenditures attributable to costs incurred during 2006, the otherwise applicable Federal matching rate shall be increased by 40 percent of the percentage otherwise payable (but for this subsection) by the State.

''(C) For expenditures attributable to costs incurred during 2007, the otherwise applicable Federal matching rate shall be increased by 60 percent of the percentage otherwise payable (but for this subsection) by the State.

''(D) For expenditures attributable to costs incurred during 2008, the otherwise applicable Federal matching rate shall be increased by 80 percent of the percentage otherwise payable (but for this subsection) by the State.

''(E) For expenditures attributable to costs incurred after 2008, the otherwise applicable Federal matching rate shall be increased to 100 percent.

''(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(c)(1) for the State and the quarter''.

(2) AMOUNT DESCRIBED.—Section 1935, as added by subsection (a)(2), is amended by adding at the end the following new subsection:

''(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

''(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

''(A) STANDARD PRESCRIPTION DRUG COVERAGE UNDER MEDICARE.—With respect to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115)—

''(i) the total amount of payments made (or not collected from the individuals) in the quarter under section 1860D–19 (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to such individuals; and

''(ii) the actuarial value of standard coverage (as determined under section 1860D–6(f)) provided for all such individuals.

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

''(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

''(A) 2005 is 90 percent;

''(B) 2006 is 80 percent;

''(C) 2007 is 70 percent;

''(D) 2008 is 60 percent; or

''(E) a year after 2008 is 50 percent.''.

(c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as added by subsection (a)(2) and amended by subsection (b)(2), is amended by adding at the end the following new subsection:

''(d) ADDITIONAL PROVISIONS.—

''(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is enrolled under part D of title XVIII and entitled to medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the Medicare Prescription Drug plan or the Medicare+Choice plan selected by the individual to receive part D benefits.

''(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to enroll in part D, that the individual elect to enroll under such part.''.

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935, as added by subsection (a)(2) and amended by subsections (b)(2) and (c), is amended—

(A) in subsection (a) in the matter preceding paragraph (1), by inserting ''subject to subsection (e)'' after ''section 1903(a)'';

(B) in subsection (c)(1), by inserting ''subject to subsection (e)'' after ''1903(a)(1)''; and

(C) by adding at the end the following new subsection:

''(e) TREATMENT OF TERRITORIES.—

''(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

''(A) the previous provisions of this section shall not apply to residents of such State; and

''(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of covered drugs (as defined in section 1860D(a)(2)) to low-income medicare beneficiaries; and

''(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2005, is equal to $20,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by the annual percentage increase specified in section 1860D–6(c)(5) for the year involved.

''(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.''.

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

(e) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(1) by striking ''and'' at the end of subclause (III);

(2) by striking the period at the end of subclause (IV) and inserting ''; and''; and

(3) by adding at the end the following new subclause:

''(V) any prices charged which are negotiated under a Medicare Prescription Drug plan under part D of title XVIII with respect to covered drugs, under a Medicare+Choice plan under part C of such title with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860D(a)(3).''.

SEC. 106. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking ''17'' and inserting ''19''; and

(B) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription drug benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2004.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.—Specifically, the Commission shall review, with respect to the voluntary prescription drug delivery program under part D, competition among eligible entities offering Medicare Prescription Drug plans and beneficiary access to such plans and covered drugs, particularly in rural areas.''.

SEC. 107. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Sections 1817(b) and 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting ''the Secretary of Health and Human Services, and the Administrator of the Medicare Competitive Agency, all ex officio,''.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services.''.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2003.

TITLE II—OPTION FOR ENHANCED MEDICARE BENEFITS

SEC. 201. OPTION FOR ENHANCED MEDICARE BENEFITS.

(a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 101, is amended by inserting after part D the following new part:

''PART E—ENHANCED MEDICARE BENEFITS

''ENTITLEMENT TO ELECT TO RECEIVE ENHANCED MEDICARE BENEFITS

''SEC. 1860E–1. (a) IN GENERAL.—The Secretary shall establish procedures under which each eligible beneficiary shall be entitled to elect to receive enhanced medicare benefits under this part instead of the benefits under parts A and B.

''(b) ENHANCED MEDICARE BENEFITS TO BE AVAILABLE IN 2005.—The Secretary shall establish the procedures under subsection (a) in a manner such that enhanced medicare benefits are first provided for months beginning with January 2005.

''(c) PRESERVATION OF ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—Nothing in this part shall be construed to limit the right of

an individual who is entitled to benefits under part A or enrolled under part B to receive benefits under such part if an election to receive enhanced medicare benefits under this part is not in effect with respect to such individual.

''SCOPE OF ENHANCED MEDICARE BENEFITS

''SEC. 1860E–2. (a) IN GENERAL.—Except for the modifications described in the succeeding provisions of this section, enhanced medicare benefits shall be identical to the benefits that are available under parts A and B.

''(b) UNIFIED DEDUCTIBLE.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part—

''(A) the amount otherwise payable under part A and the total amount of expenses incurred by an eligible beneficiary during a year which would (except for this section) constitute incurred expenses from which benefits payable under section 1833(a) are determinable, shall be reduced under sections 1813(b) and 1833(b) by the amount of the unified deductible under paragraph (2); and

''(B) the eligible beneficiary shall be responsible for the payment of such amount.

''(2) AMOUNT OF UNIFIED DEDUCTIBLE.—

''(A) IN GENERAL.—The amount of the unified deductible under this subsection shall be—

''(i) for 2005, $300; or

''(ii) for a subsequent year, the amount specified in this subparagraph for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

''(B) ROUNDING.—If any amount determined under subparagraph (A) is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(3) APPLICATION.—The unified deductible under this subsection for a year shall be applied—

''(A) with respect to benefits under part A, on the basis of the amount that is payable for such benefits without regard to any other copayments or coinsurance and before the application of any such copayments or coinsurance;

''(B) with respect to benefits under part B, on the basis of the total amount of the expenses incurred by an eligible beneficiary during a year which would, except for the application of the deductible, constitute incurred expenses from which benefits payable under section 1833(a) are determinable, without regard to any other copayments or coinsurance and before the application of any such copayments or coinsurance; and

''(C) instead of the deductibles described in sections 1813(b) and 1833(b).

''(c) SERIOUS ILLNESS PROTECTION.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part, if the amount of the out-of-pocket cost-sharing of such beneficiary for a calendar year equals or exceeds the serious illness protection threshold for that year—

''(A) the beneficiary shall not be responsible for additional out-of-pocket cost-sharing incurred during that year; and

''(B) the Secretary shall establish procedures under which the Secretary shall pay on behalf of the beneficiary the amount of the additional out-of-pocket cost-sharing described in subparagraph (A) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in such proportion as the Secretary determines appropriate.

''(2) SERIOUS ILLNESS PROTECTION THRESHOLD.—

''(A) IN GENERAL.—The amount of the serious illness protection threshold under this subsection shall be—

''(i) for 2005, $6,000; or

''(ii) for a subsequent year, the amount specified in this subparagraph for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

''(B) ROUNDING.—If any amount determined under subparagraph (A) is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(3) OUT-OF-POCKET COST-SHARING DEFINED.—In this subsection, the term 'out-of-pocket cost-sharing' means, with respect to an eligible beneficiary, the amount of costs incurred by the beneficiary that are attributable to deductibles, coinsurance, and copayments imposed under part A or B (as modified by this part), without regard to whether the beneficiary or another person, including a State program or other third-party coverage, has paid for such costs.

''(d) ENHANCED HOSPITAL BENEFITS.—

''(1) ELIMINATION OF DURATIONAL LIMITS ON INPATIENT HOSPITAL SERVICES.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part—

''(A) there shall be no spell of illness limit or lifetime limit on inpatient hospital services under subsections (a)(1) and (b)(1) of section 1812 during the period in which the election of the beneficiary to receive enhanced medicare benefits under this part is in effect; and

''(B) section 1812(c) shall not be applied during such period.

''(2) REVISION OF INPATIENT HOSPITAL COINSURANCE.—

''(A) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part, after the application of the unified deductible under subsection (b), instead of imposing any coinsurance under the second sentence of section 1813(a)(1), the amount payable under part A for inpatient hospital services or inpatient critical access hospital services furnished to the eligible beneficiary during any year, shall be reduced by the amount of the inpatient hospital copayment specified in subparagraph (B) for each period of hospitalization and the beneficiary shall be responsible for payment of such amount for each such period.

''(B) AMOUNT OF INPATIENT HOSPITAL COPAYMENT.—

''(i) IN GENERAL.—The amount of the inpatient hospital copayment under this paragraph shall be—

''(I) for 2005, $400; or

''(II) for a subsequent year, the amount specified in this clause for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

''(ii) ROUNDING.—If any amount determined under clause (i) is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(C) PERIOD OF HOSPITALIZATION DEFINED.—In this subsection, the term 'period of hospitalization' means the period that begins on the date that the eligible beneficiary is admitted to the hospital and ends on the date on which the beneficiary has not been hospitalized for a 72-hour period.

''(D) COLLECTION OF COPAYMENTS.—For purposes of section 1866(a)(2)(A), hospitals shall substitute the imposition of the inpatient hospital copayment under this paragraph for the hospital coinsurance described in the second sentence of section 1813(a)(1).

''(e) ELIMINATION OF COST-SHARING FOR PREVENTIVE HEALTH CARE ITEMS AND SERVICES.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part, the unified deductible under subsection (b) and deductibles and the coinsurance otherwise applicable under subsections (a) and (b) of section 1833 shall not be applied with respect to expenses incurred for any preventive health care items and services (and no charges may be imposed under section 1866(a)(2) where such deductibles and coinsurance are not imposed).

''(2) PREVENTIVE HEALTH CARE ITEMS AND SERVICES DEFINED.—In this subsection, the term 'preventive health care items and services' means any of the following health care items and services:

''(A) Screening mammography under section 1861(s)(13).

''(B) Screening pap smear and screening pelvic examinations under section 1861(s)(14).

''(C) Bone mass measurement under section 1861(s)(15).

''(D) Prostate cancer screening tests under section 1861(s)(2)(P).

''(E) Colorectal cancer screening under section 1861(s)(2)(R).

''(F) Blood testing strips, lancets, and blood glucose monitors for individuals with diabetes under section 1861(n).

''(G) Diabetes outpatient self-management training services under section 1861(s)(2)(S).

''(H) Pneumococcal, influenza, and hepatitis B vaccines and administration under section 1861(s)(10).

''(I) Screening for glaucoma under section 1861(s)(2)(U).

''(J) Medical nutrition therapy services under section 1861(s)(2)(V).

''(f) SIMPLIFICATION OF COST-SHARING.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part, the following cost-sharing rules shall apply:

''(1) MODIFICATION OF SKILLED NURSING FACILITY COST-SHARING.—Instead of the coinsurance established under section 1813(b) for extended care services, under section 1888(e)—

''(A) the payment amount under paragraph (1)(B) of such section shall be equal to the amount otherwise provided minus the amount described in subparagraph (B); and

''(B) the eligible beneficiary shall be responsible for a copayment amount for each of the 100 days of care for which payment is made on behalf of an eligible beneficiary under that section equal to—

''(i) for 2005, $60; and

''(ii) for a subsequent year, the amount specified in this subparagraph for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

If any amount determined under this subparagraph is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(2) APPLICATION OF HOME HEALTH SERVICE COINSURANCE.—

''(A) IN GENERAL.—The amount of the payment otherwise made under section 1895 for home health services (other than such services for which payment is made under section 1834(a)) shall be reduced by the amount described in clause (ii).

''(B) COPAYMENT AMOUNT.—

''(i) IN GENERAL.—Subject to clause (ii), the eligible beneficiary shall be responsible for a copayment amount for each of the first 5 visits during an episode of care for which payment is made on behalf of an eligible beneficiary under section 1895 equal to—

''(I) for 2005, $10; and

''(II) for a subsequent year, the amount specified in this clause for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

If any amount determined under this clause is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(ii) ANNUAL LIMIT.—For each year in which an election to receive enhanced medicare benefits under this part is in effect, the eligible beneficiary shall not be responsible for the payment of any copayment amount under this subparagraph after the date on which the amount of payments made as a result of the application of this paragraph equals $300.

''(3) BLOOD DEDUCTIBLE.—The Secretary shall not apply the deductible under sections 1813(a)(2) and 1833(b) for blood or blood cells furnished to an eligible beneficiary during the period in which an election of the beneficiary to receive enhanced medicare benefits under this part is in effect.

''PAYMENT OF BENEFITS

''SEC. 1860E–3. Payment for enhanced medicare benefits on behalf of an eligible beneficiary who has elected to receive such benefits under this part shall be made in the same manner as payment for such benefits would have been made under parts A and B, subject to the modifications described in section 1860E–2, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in such proportion as the Secretary determines appropriate.

''ELIGIBLE BENEFICIARIES; ELECTION OF ENHANCED MEDICARE BENEFITS; TERMINATION OF ELECTION

''SEC. 1860E–4. (a) ELIGIBLE BENEFICIARY DEFINED.—For purposes of this part, the term 'eligible beneficiary' has the meaning given that term in section 1860D(a)(3).

''(b) ELECTION OF ENHANCED MEDICARE BENEFITS.—

''(1) ELECTION BY INDIVIDUALS WHO BECOME ELIGIBLE BENEFICIARIES AFTER JANUARY 1, 2005.—

''(A) INITIAL ELECTION.—Any individual whose initial election period begins after September 30, 2004, shall be deemed to have elected to receive enhanced medicare benefits under this part as of the date on which such individual first becomes entitled to benefits under part A or eligible to enroll for benefits under part B, whichever is later, unless that individual affirmatively elects (in such form and manner as the Secretary may specify) to receive benefits under parts A and B.

''(B) INITIAL ELECTION PERIOD.—For purposes of this paragraph, the term 'initial election period' means, with respect to an individual, the period that begins on the first day of the third month before the month in which such individual first becomes entitled to benefits under part A or eligible to enroll for benefits under part B, whichever is later, and ends 7 months later.

''(C) EFFECT OF ELECTION.—If an individual makes an election under subparagraph (A) and such individual is not entitled to benefits under part A or enrolled for benefits under part B at the time of such election, such individual shall be deemed—

''(i) to have elected to enroll for benefits under such part under section 1818 or 1837 (as appropriate) if such individual is eligible to enroll for benefits under such section, as of the date of such election; or

''(ii) if such individual is not eligible to enroll for benefits under section 1818 or 1837, to have elected to enroll under part B as of the first date on which the individual is eligible to enroll under such part.

''(2) SPECIAL ELECTION PERIODS.—The Secretary shall establish special election periods for individuals under this part who have elected not to make an election (or to be deemed to have made such an election) under this part that are similar to the special enrollment periods under section 1837(i) for individuals described in such section.

''(3) TRANSITIONAL ELECTION FOR INDIVIDUALS WHO BECOME ELIGIBLE BENEFICIARIES ON OR BEFORE JANUARY 1, 2005.—

''(A) IN GENERAL.—In the case of an individual who is an eligible beneficiary as of January 1, 2005, the Secretary shall establish procedures under which such beneficiary may affirmatively elect to receive enhanced medicare benefits under this part during the 7-month period that begins on April 1, 2004, and ends on November 30, 2004, for such election to take effect on January 1, 2005.

''(B) EFFECT OF MEDICARE+CHOICE ENROLLMENT.—If an eligible beneficiary enrolls in a Medicare+Choice plan under part C during November 2004, such individual shall be deemed to have elected to receive enhanced medicare benefits under subparagraph (A).

''(4) CHANGES IN ELECTION.—

''(A) IN GENERAL.—An individual who has elected (or is deemed to have elected) to receive enhanced medicare benefits under this part under paragraph (1), (2), or (3) may change such election during an annual, coordinated election period and such election shall take effect on January 1 of the subsequent year. In no case shall such a change of election take effect on a date other than on January 1 of a year (unless the election is automatic pursuant to a termination resulting from a loss or termination of coverage under part A or part B).

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 2005), the month of November preceding such year.

''(5) PROCEDURES.—The Secretary shall establish procedures for the termination and reinstatement of an election under this section.

''(c) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PART A OR B.—

''(1) IN GENERAL.—The Secretary shall terminate an individual's coverage under this part if the individual is no longer enrolled in both parts A and B.

''(2) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if earlier) under part B.

''PREMIUM ADJUSTMENTS; LATE ELECTION PENALTY

''SEC. 1860E–5. (a) GENERAL RULE OF NO CHANGE IN AMOUNT OF PREMIUMS.—Except as provided in this section, an election to receive enhanced medicare benefits under this part shall not affect the amount of any premium charged under part A or B.

''(b) LATE ELECTION PENALTY.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who does not elect to receive enhanced medicare benefits under this part during an election period described in paragraph (1), (2), or (3) of section 1860E–4(b) of that beneficiary, reinstates such an election under the procedures established under paragraph (5) of such section, or otherwise does not have such an election continuously in effect from the first date on which such election could be in effect, the premium otherwise imposed under part B (taking into account any late enrollment penalty under section 1839(b)) shall be increased during the period in which such individual has an election to receive enhanced medicare benefits under this part in effect by an amount that the Secretary determines is actuarially sound (based on the financial impact on the program under this part of the late election of the beneficiary or of the reinstatement of an election of the beneficiary) for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have elected to receive enhanced medicare benefits under this part but did not elect to receive such benefits.

''(2) PROCEDURES.—In applying the late election penalty under paragraph (1), the Secretary shall establish procedures for applying the penalty under this subsection that are similar to the procedures for applying the late enrollment penalty under section 1839(b).

''(c) LATE REVERSAL OF ELECTION PENALTY.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part and terminates such election under the procedures established under section 1860E–4(b)(5) on a date that is more than 1 year after the date on which such beneficiary first elected to receive enhanced medicare benefits under this part, the premium otherwise imposed under part B (taking into account any late enrollment penalty under section 1839(b)) shall be increased during the period in which such individual is enrolled under such part by an amount that the Secretary determines is actuarially sound based on the financial impact on the program under this part of the reversal of the election of the beneficiary.

''(2) PROCEDURES.—In applying the late reversal of election penalty under paragraph (1), the Secretary shall establish procedures for applying the penalty under this subsection that are similar to the procedures for applying the late enrollment penalty under section 1839(b).''.

(b) PROVIDING INFORMATION TO BENEFICIARIES.—During 2004, the Secretary shall provide for an extensive, national educational and publicity campaign to inform eligible beneficiaries (and prospective eligible beneficiaries) regarding the enhanced medicare benefits to be made available under part E of title XVIII of the Social Security Act (as added by subsection (a)).

(c) CONFORMING ADJUSTMENTS TO PART A AND B PREMIUMS.—

(1) EFFECT OF PART E ON PART A PREMIUM.—Section 1818(d)(1) (42 U.S.C. 1395i–2(d)(1)) is amended by adding at the end the following new sentence: ''In making the estimate under the previous sentence, the Secretary shall take into account the effect of elections to receive enhanced medicare benefits under part E on the amounts paid from such Trust Fund.''.

(2) EFFECT OF PART E ON PART B PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(A) in paragraph (1)—

(i) by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''age 65 and over''; and

(ii) by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''age 65 and older'';

(B) in paragraph (2), by inserting '', as adjusted under section 1860E–5'' before the period at the end;

(C) in paragraph (3)—

(i) by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''age 65 and over''; and

(ii) by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''age 65 and older''; and

(D) in paragraph (4)—

(i) in the first sentence, by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''under age 65''; and

(ii) in the second sentence, by striking ''under age 65 which'' and inserting ''under age 65 (including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)''.

(d) CLARIFICATION OF APPLICATION OF EXCLUSIONS FROM COVERAGE TO PART E.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by inserting ''(including for enhanced medicare benefits under part E)'' after ''for items or services''.

SEC. 202. RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE; ESTABLISHMENT OF ENHANCED MEDICARE FEE-FOR-SERVICE MEDIGAP POLICIES.

(a) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

''(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE TO PART D ENROLLEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2005, no medicare supplemental policy that provides coverage of expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under part D.

''(B) PENALTIES.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of subparagraph (A).

''(2) ISSUANCE OF SUBSTITUTE POLICIES IF THE POLICYHOLDER OBTAINS PRESCRIPTION DRUG COVERAGE UNDER PART D.—

''(A) IN GENERAL.—The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F' (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)), or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the open enrollment period established under section 1860D–2(b)(2) and who submits evidence that they meet the requirements under subparagraph (B) along with the application for such medicare supplemental policy.

''(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual who—

''(i) enrolls in the medicare prescription drug delivery program under part D; and

''(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' (including the benefit package classified as 'J' with a high deductible feature, as described in section 1882(p)(11)) under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

''(C) ENFORCEMENT.—The provisions of subparagraph (A) shall be enforced as though they were included in subsection (s).

''(3) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860D–2(b)(2), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer that provides some coverage of expenses for prescription drugs (at the most recent available address of that individual) of—

''(i) the ability to enroll in a new medicare supplemental policy pursuant to paragraph (2); and

''(ii) the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible for coverage of prescription drugs under part D and ineligible to elect to receive enhanced medicare benefits under part E.

''(B) COORDINATION.—The notice provided under subparagraph (A) shall be coordinated with the notice required under subsection (v)(4)(A)(i).

''(4) CLARIFICATION REGARDING ONE-TIME AVAILABILITY OF A GUARANTEED ISSUE POLICY FOR BENEFICIARIES WHO LOSE COVERAGE UNDER A MEDICARE+CHOICE PLAN OF JANUARY 1, 2005, BECAUSE THEY ELECT NOT TO RECEIVE ENHANCED PART E BENEFITS.—In the case of a beneficiary who is enrolled in a Medicare+Choice plan as of December 31, 2004, will not be eligible to be enrolled under such plan as of January 1, 2005, because the beneficiary has elected not to receive enhanced medicare benefits under part E—

''(A) such beneficiary shall be deemed to be described in subsection (s)(3)(B)(ii); and

''(B) for purposes of (s)(3)(E)(ii), the date of the termination of coverage shall be January 1, 2005.''.

(b) ESTABLISHMENT OF ENHANCED MEDICARE FEE-FOR-SERVICE MEDIGAP POLICIES.—Section 1882 (42 U.S.C. 1395ss), as amended by subsection (a), is amended by adding at the end the following new subsection:

''(w) ENHANCED MEDICARE FEE-FOR-SERVICE SUPPLEMENTAL POLICIES.—

''(1) ADDITIONAL BENEFIT PACKAGES.—

''(A) ESTABLISHMENT.—

''(i) IN GENERAL.—In addition to the benefit packages classified under the standards established by subsection (p)(2), there shall be established benefit packages that may only be purchased by beneficiaries who have elected to receive enhanced medicare benefits under part E that—

''(I) complement but do not duplicate enhanced medicare benefits described in section 1860E–2;

''(II) do not provide for coverage of the unified deductible under section 1860E–2(b);

''(III) subject to clause (ii), do not provide coverage for more than 50 percent of the amount of coinsurance and copayments applicable under section 1860E–2;

''(IV) do not provide for coverage of expenses for prescription drugs;

''(V) provide a range of coverage options for beneficiaries; and

''(VI) use uniform language, definitions, and format with respect to the coverage provided under a policy.

''(ii) ONE PACKAGE REQUIRED TO COVER ALL COST-SHARING.—

''(I) IN GENERAL.—One of the benefit packages established under clause (i) shall include coverage of all coinsurance and copayments applicable under section 1860E–2.

''(II) AVAILABILITY LIMITED TO BENEFICIARIES THAT ENROLLED IN PART E DURING CERTAIN PERIODS.—The benefit package that includes the coverage described in subclause (II) shall only be made available to beneficiaries who elect to receive enhanced medicare benefits under part E during the beneficiary's initial election period (as defined in paragraph (1)(B) of section 1860D–4(b)), during a special election period described in paragraph (2) of such section, or during the transitional election period under paragraph (3) of such section.

''(B) MANNER OF ESTABLISHMENT.—The benefit packages established under this section shall be established in the manner described in subparagraph (E) of subsection (p)(1), except that for purposes of subparagraph (C) of such subsection, the standards established under this subsection shall take effect not later than January 1, 2005.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in this subsection shall be construed to affect the benefit packages classified as 'A' through 'J' under the standards established by subsection (p)(2) (including the benefit packages classified as 'F' and 'J' with a high deductible feature, as described in subsection (p)(11)).

''(3) GUARANTEED ISSUANCE AND RENEWAL OF ENHANCED MEDICARE FEE-FOR-SERVICE SUPPLEMENTAL POLICIES.—The provisions of subsections (q) and (s), including provisions of subsection (s)(3) (relating to special enrollment periods in cases of termination or disenrollment), shall apply to medicare supplemental policies established under this subsection in a similar manner as such provisions apply to medicare supplemental policies issued under the standards established under subsection (p).

''(4) OPPORTUNITY OF CURRENT POLICYHOLDERS TO PURCHASE ENHANCED MEDICARE FEE-FOR-SERVICE SUPPLEMENTAL POLICIES.—

''(A) REQUIREMENTS FOR ISSUERS OF POLICIES WITH RESPECT TO CURRENT POLICYHOLDERS.—No medicare supplemental policy of an issuer with a benefit package that is established under paragraph (1) shall be deemed to meet the standards in subsection (c) unless the issuer does all of the following:

''(i) NOTICE TO CURRENT POLICYHOLDERS.—Provide written notice during the 60-day period immediately preceding the period established under section 1860E–4(b)(1), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer (at the most recent available address of that individual) of the offer described in clause (ii) and of the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible to elect enhanced medicare benefits under part E.

''(ii) OFFER FOR CURRENT POLICYHOLDERS.—Offer the policyholder or certificate holder under the terms described in subparagraph (C), during at least the period established under section 1860E–4(b)(1), a medicare supplemental policy established under paragraph (1) with the benefit package that the Secretary determines is most comparable to the policy in which the individual is enrolled with coverage effective as of the effective date of the election of the individual under part E.

''(iii) OFFER FOR INDIVIDUALS COVERED UNDER POLICIES ISSUED BY OTHER ISSUERS IF THAT ISSUER IS NOT GOING TO OFFER ENHANCED MEDICARE FEE-FOR-SERVICE SUPPLEMENTAL POLICIES.—Offer an individual described in subparagraph (B), under the terms described in subparagraph (C), and during at least the period established under section 1860E–4(b)(1), a medicare supplemental policy established under paragraph (1) with the benefit package that the Secretary determines

is most comparable to the policy in which the individual is enrolled with coverage effective as of the effective date of the election of the individual under part E.

The notice provided under clause (i) shall be coordinated with the notice required under subsection (v)(3)(A).

''(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual who is a policyholder or certificate holder of a medicare supplemental policy issued by an issuer who is not going to offer a policy with a benefit package established under paragraph (1).

''(C) TERMS OF OFFER DESCRIBED.—The terms described in this subparagraph are terms which do not—

''(i) deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (A)(ii) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition; or

''(iii) impose an exclusion of benefits based on a preexisting condition under such policy.

''(5) PROHIBITION OF SALE OF ENHANCED POLICIES TO ORIGINAL MEDICARE FEE-FOR-SERVICE ENROLLEES; PROHIBITION OF SALE OF ORIGINAL POLICIES TO ENHANCED MEDICARE FEE-FOR-SERVICE ENROLLEES.—

''(A) PROHIBITION.—No person may sell, issue, or renew a medicare supplemental policy with—

''(i) a benefit package established under this subsection to an individual who has not elected to receive enhanced medicare benefits under part E; or

''(ii) a benefit package classified as 'A' through 'J' under the standards established by subsection (p)(2) (including the benefit packages classified as 'F' and 'J' with a high deductible feature, as described in subsection (p)(11)) to an individual who has elected to receive enhanced medicare benefits under part E.

''(B) PENALTY.—Any person who violates the provisions of subparagraph (A) shall be subject to a civil money penalty in an amount that does not exceed $25,000 (or $15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(6) OTHER PROHIBITIONS AND PENALTIES.—Each penalty under this section shall apply with respect to policies established under this subsection as if such policies were issued under the standards established under subsection (p), including the penalties under subsections (a), (d), (p)(8), (p)(9), (q)(5), (r)(6)(A), (s)(4), and (t)(2)(D).''.

TITLE III—MEDICARE+CHOICE COMPETITION

SEC. 301. ANNUAL CALCULATION OF BENCHMARK AMOUNTS BASED ON FLOOR RATES AND LOCAL FEE-FOR-SERVICE RATES.

(a) ANNUAL CALCULATION OF BENCHMARK AMOUNTS BASED ON FLOOR RATES AND LOCAL FEE-FOR-SERVICE RATES.—Section 1853(a) (42 U.S.C. 1395w–23(a)) is amended by adding at the end the following new paragraph:

''(4) ANNUAL CALCULATION OF BENCHMARK AMOUNTS.—For each year, the Secretary shall calculate a benchmark amount for each Medicare+Choice payment area for each month for such year with respect to coverage of enhanced medicare benefits under part E equal to the greatest of the following amounts:

''(A) MINIMUM AMOUNT.—1/12 of the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for the payment area for the year; or

''(B) LOCAL FEE-FOR-SERVICE RATE.—The local fee-for-service rate for such area for the year (as calculated under paragraph (5)).''.

(b) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—Section 1853(a) (42 U.S.C. 1395w–23(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the term 'local fee-for-service rate' means the amount of payment for a month in a Medicare+Choice payment area for benefits under this title and associated claims processing costs for an individual who has elected to receive enhanced medicare benefits under part E (but, if the Medicare+Choice plan offers prescription drug coverage, excluding any costs associated with part D), and not enrolled in a Medicare+Choice plan under this part. The Secretary shall annually calculate such amount in a manner similar to the manner in which the Secretary calculated the adjusted average per capita cost under section 1876, except that such calculation shall include in such amount, to the extent practicable, any amounts that would have been paid under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

''(B) REMOVAL OF MEDICAL EDUCATION COSTS FROM CALCULATION OF LOCAL FEE-FOR-SERVICE RATE.—

''(i) IN GENERAL.—In calculating the local fee-for-service rate under subparagraph (A) for a year, the amount of payment described in such subparagraph shall be adjusted to exclude from such payment the payment adjustments described in clause (ii).

''(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

''(I) IN GENERAL.—Subject to subclause (II), the payment adjustments described in this subparagraph are payment adjustments that the Secretary estimates were payable during each month for direct graduate medical education costs under section 1886(h).

''(II) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that the amount of the local fee-for-service rates reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

''(C) SPECIAL RULE FOR RURAL AREAS.—

''(i) IN GENERAL.—Subject to clause (ii), in calculating the local fee-for-service rates under subparagraph (A) for a year, the Secretary shall calculate such costs for rural areas (as defined in section 1886(d)(2)(D)) of a State as if each rural area were part of a single Medicare+Choice payment area.

''(ii) LIMITATION.—Payment amounts determined under subparagraph (A) may not be less than the amounts that would have been paid if clause (i) did not apply.''.

(c) CPI INCREASES IN FLOOR PAYMENT RATES.—Section 1853(c)(1)(B) (42 U.S.C. 1395w–23(c)(1)(B)) is amended—

(1) in clause (iv), by striking ''and each succeeding year,'' and inserting '', 2003, and 2004,''; and

(2) by adding at the end the following new clause:

''(v) For 2005 and each succeeding year, the minimum amount specified in this clause (or clause (iv)) for the preceding year increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(d) FURNISHING OF CLAIMS DATA BY VA AND DOD.—Upon the request of the Secretary of Health and Human Services, the Secretary of Veterans Affairs and the Secretary of Defense shall provide such claims data as the Secretary of Health and Human Services may require to determine the amount that would have been paid under the medicare program under title XVIII of the Social Security Act if individuals entitled to benefits under such program had not received services from facilities of the Department of Veterans Affairs or the Department of Defense for purposes calculating the amounts under section 1853(a)(5) of such Act (as added by subsection (b)) and section 1853(c)(8) of such Act (as added by section 312(b)).

SEC. 302. APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.

Section 1853(a)(3) is amended to read as follows:

''(3) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—

''(A) APPLICATION OF METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to 100 percent of the amount of the plan bids under section 1853(d)(1) and the weighted service area benchmark amounts calculated under section 1853(d)(3).

''(B) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY DESCRIBED.—The comprehensive risk adjustment methodology described in this subparagraph is the risk adjustment methodology that would apply with respect to Medicare+Choice plans offered by Medicare+Choice organizations in 2004, except that if such methodology does not apply to groups of beneficiaries who are aged or disabled and groups of beneficiaries who have end-stage renal disease, the Secretary shall revise such methodology to apply to such groups.

''(C) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the comprehensive risk adjustment methodology established under this paragraph shall be applied uniformly without regard to the type of plan.

''(D) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations to submit such data and other information as the Secretary deems necessary.

''(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this paragraph, the Secretary may revise the comprehensive risk adjustment methodology described in subparagraph (B) from time to time to improve payment accuracy.''.

SEC. 303. ANNUAL ANNOUNCEMENT OF BENCHMARK AMOUNTS AND OTHER PAYMENT FACTORS.

Section 1853(b) (42 U.S.C. 1395w–23(b)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107–188; 116 Stat. 696), is amended—

(1) in the heading, by striking ''PAYMENT RATES'' and inserting ''PAYMENT FACTORS'';

(2) by striking paragraph (1) and inserting the following:

''(1) ANNUAL ANNOUNCEMENT.—Beginning in 2004, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

''(A) The benchmark amount for each Medicare+Choice payment area (as calculated under subsection (a)(4)) for the year.

''(B) The factors to be used for adjusting payments under the comprehensive risk adjustment methodology described in subsection (a)(3)(B) with respect to each Medicare+Choice payment area for the year.'';

(3) in paragraph (3), by striking ''monthly adjusted'' and all that follows before the period at the end and inserting ''each payment factor described in paragraph (1)''; and

(4) by striking paragraph (4).

SEC. 304. SUBMISSION OF BIDS BY MEDICARE+CHOICE ORGANIZATIONS.

Section 1854(a) (42 U.S.C. 1395w–24(a)), as amended by section 532(b)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107–188; 116 Stat. 696), is amended to read as follows:

''(a) SUBMISSION OF BIDS BY MEDICARE+CHOICE ORGANIZATIONS.—

''(1) IN GENERAL.—Not later than the second Monday in September (or July 1 of each year before 2002) and except as provided in paragraph (3), each Medicare+Choice organization shall submit to the Secretary, in such form and manner as the Secretary may specify, for each Medicare+Choice plan that the organization intends to offer in a service area in the following year—

''(A) notice of such intent and information on the service area of the plan;

''(B) the plan type for each plan;

''(C) if the Medicare+Choice plan is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in paragraph (2) with respect to each payment area;

''(D) the enrollment capacity (if any) in relation to the plan and each payment area;

''(E) the expected mix, by health status, of enrolled individuals; and

''(F) such other information as the Secretary may specify.

''(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—For a Medicare+Choice plan that is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in this paragraph is as follows:

''(A) INFORMATION REQUIRED WITH RESPECT TO BENEFITS UNDER PART E.—Information relating to the coverage of benefits under part E as follows:

''(i) The plan bid, which shall consist of a dollar amount that represents the total amount that the plan is willing to accept (after the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of the benefits under part E to an individual enrolled in the plan that resides in the service area of the plan for a month.

''(ii) For the supplemental benefits package offered (if any)—

''(I) the adjusted community rate (as defined in subsection (g)(3)) of the package;

''(II) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(C));

''(III) a description of any cost-sharing; and

''(IV) such other information as the Secretary considers necessary.

''(iii) The assumptions that the Medicare+Choice organization used in preparing the plan bid with respect to numbers, in each payment area, of enrolled individuals and the mix, by health status, of such individuals.

''(B) INFORMATION REQUIRED WITH RESPECT TO PART D.—If the Medicare+Choice organization elects to offer prescription drug coverage, the information required to be submitted by an eligible entity under section 1860D–12, including the monthly premiums for standard coverage and any other qualified prescription drug coverage available to individuals enrolled under part D.

''(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described in section 1851(a)(2)(B), the information described in this paragraph is the information that such a plan would have been required to submit under this part if the 21st Century Medicare Act had not been enacted.

''(4) REVIEW.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the Medicare+Choice monthly basic and supplemental beneficiary premiums filed under this subsection and shall approve or disapprove such rates and amounts so submitted. The Chief Actuary of the Medicare Competitive Agency shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(B) EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3).''.

SEC. 305. ADJUSTMENT OF PLAN BIDS; COMPARISON OF ADJUSTED BID TO BENCHMARK; PAYMENT AMOUNT.

(a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) by redesignating subsections (d) through (i) as subsections (e) through (j), respectively; and

(2) by inserting after subsection (c) the following new subsection:

''(d) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR ENHANCED MEDICARE BENEFITS.—

''(1) ADJUSTMENT OF PLAN BIDS.—The Secretary shall adjust each plan bid submitted under section 1854(a) for the coverage of benefits under part E using the comprehensive risk adjustment methodology applicable under subsection (a)(3) based on the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

''(2) DETERMINATION OF WEIGHTED SERVICE AREA BENCHMARK AMOUNTS.—The Secretary shall calculate a weighted service area benchmark amount for enhanced medicare benefits under part E for each plan equal to the weighted average of the benchmark amounts for enhanced medicare benefits under such part for the payment areas included in the service area of the plan using the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

''(3) DETERMINATION OF PLAN BENCHMARK.—The Secretary shall calculate the plan benchmark amount by adjusting the weighted service area benchmark amount determined under paragraph (1) using—

''(A) the comprehensive risk adjustment methodology applicable under subsection (a)(3); and

''(B) the assumptions contained in the plan bid that the plan used with respect to numbers of enrolled individuals.

''(4) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under paragraph (1)) and the plan benchmark amount (as determined under paragraph (3)) for purposes of determining—

''(A) the payment amount under paragraph (5); and

''(B) the part E premium reductions and Medicare+Choice monthly basic beneficiary premiums.

''(5) DETERMINATION OF PAYMENT AMOUNT.—The Secretary shall determine the payment amount for plans as follows:

''(A) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—The amount of each monthly payment to a Medicare+Choice organization with respect to each individual enrolled in a plan shall be the plan benchmark amount.

''(B) BIDS BELOW THE BENCHMARK.—The amount of each monthly payment to a Medicare+Choice organization with respect to each individual enrolled in a plan shall be the plan benchmark amount reduced by 25 percent of the difference between the bid and the benchmark amount and further reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(6) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR MEDICARE+CHOICE ORGANIZATIONS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to paragraph (7), the Secretary shall use, for purposes of adjusting plan bids and calculating plan benchmarks under this subsection—

''(A) with respect to benefits under part E—

''(i) the benchmark amount for the Medicare+Choice payment area announced under section 1854(a)(1)(A); and

''(ii) the health status and other demographic adjustment factors for the Medicare+Choice payment area announced under section 1854(a)(1)(B); and

''(B) if the Medicare+Choice organization elects to offer prescription drug coverage, the risk adjusters published under section 1860D–11 applicable with respect to such coverage.

''(7) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice organizations of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall appropriately adjust the benchmark amounts or payment amounts (as determined by the Secretary). Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Competitive Medicare Agency of the actuarial costs associated with the new benefits.''.

(b) CONFORMING AMENDMENT.—Section 1853(c)(7) (42 U.S.C. 1395w–23(c)(7)) is repealed.

SEC. 306. DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.

(a) CALCULATION OF BENEFICIARY PREMIUMS.—Section 1854 (42 U.S.C. 1395–24) is amended by—

(1) redesignating subsections (d) through (h) as subsections (e) through (i), respectively; and

(2) inserting after subsection (c) the following new subsection:

''(d) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—

''(1) BIDS BELOW THE BENCHMARK.—

''(A) IN GENERAL.—If the Secretary determines under section 1853(d)(4) that the plan benchmark amount exceeds the plan bid, the Secretary shall require the plan to return 75 percent of such excess to the enrollee in the form of, at the option of the organization offering the plan—

''(i) subject to subparagraph (B), a monthly medicare premium reduction for individuals enrolled in the plan;

''(ii) a reduction in the actuarial value of plan cost-sharing for plan enrollees;

''(iii) subject to subparagraph (C), such additional benefits as the organization may specify; or

''(iv) any combination of the reductions and benefits described in clauses (i) through (iii).

''(B) LIMITATION ON PREMIUM REDUCTIONS.—The amount of the reduction under subparagraph (A)(i) with respect to any enrollee in a Medicare+Choice plan—

''(i) may not exceed the premium described in section 1839(a)(3), as adjusted under section 1860E–5; and

''(ii) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.

''(C) REQUIREMENT OF ENROLLMENT IN PART D TO RECEIVE PRESCRIPTION DRUG BENEFITS.—An organization may not specify any additional benefit that provides for the coverage of any prescription drug (other than that required under part E).

''(2) BIDS ABOVE THE BENCHMARK.—If the Secretary determines under section 1853(d)(4) that the plan bid (as adjusted under section 1853(d)(1)) exceeds the plan benchmark amount (determined under section 1853(d)(3)), the amount of such excess shall be the Medicare+Choice monthly basic beneficiary premium (as defined in section 1854(b)(2)(A)).''.

(b) CONFORMING PART E PREMIUM REDUCTION AMENDMENTS.—

(1) ADJUSTMENT AND PAYMENT OF PART E PREMIUMS.—Section 1860E–5 (as added by section 201) is amended—

(A) in subsection (a), by inserting '', except as reduced by the amount of any reduction elected under section 1854(d)(1)(A)(i)'' before the period at the end; and

(B) by adding at the end the following new subsection:

''(c) MEDICARE+CHOICE PREMIUM REDUCTIONS.—In the case of an individual enrolled in a Medicare+Choice plan, the Secretary shall reduce (but not below zero) the amount of the monthly beneficiary premium to reflect any reduction elected under section 1854(d)(1)(A)(i). Such premium adjustment may be provided in such manner as the Secretary may specify.''.

(2) TREATMENT OF REDUCTION FOR PURPOSES OF DETERMINING GOVERNMENT CONTRIBUTION UNDER PART E.—Section 1844(c) (42 U.S.C. 1395w) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(d)(1)(A)(i)''.

(c) SUNSET OF SPECIFIC REQUIREMENTS FOR ADDITIONAL BENEFITS.—Section 1854(g) (as redesignated by subsection (a)(1)) is amended—

(1) in paragraph (1)(A), by striking ''Each Medicare+Choice organization'' and inserting ''For years before 2005, each Medicare+Choice organization''; and

(2) in paragraph (2), by striking ''A Medicare+Choice organization'' and inserting ''For years before 2005, a Medicare+Choice organization''.

(d) LIMITATION ON ENROLLEE LIABILITY.—

(1) FOR BENEFITS UNDER PART E.—Section 1854(f)(1) (as redesignated by subsection (a)(1)) is amended to read as follows:

''(1) FOR ENHANCED MEDICARE BENEFITS.—The sum of—

''(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments (taking into account any reductions in cost-sharing described in subsection (d)(1)(A)(ii)) applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in subparagraph (A) or (C) of section 1851(a)(2) of an organization with respect to required benefits described in section 1852(a)(1)(A) and any additional benefits described in subsection (a)(2)(A)(iii) for a year; must equal

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals who have elected to receive enhanced medicare benefits under part E if they were not members of a Medicare+Choice organization for the year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).''.

(2) FOR SUPPLEMENTAL BENEFITS.—Section 1854(f)(2) (as so redesignated) is amended to read as follows:

''(2) FOR SUPPLEMENTAL BENEFITS.—If the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in subparagraph (A) or (C) of section 1851(a)(2) with respect to supplemental benefits relating to benefits under part E described in section 1852(a)(3)(A), the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits for a year must equal the adjusted community rate (as defined in subsection (g)(3)) for such benefits for the year.''.

(e) PREMIUMS CHARGED; PREMIUM TERMINOLOGY.—Section 1854(b) (42 U.S.C. 1395w–24) is amended to read as follows:

''(b) MONTHLY PREMIUMS CHARGED.—

''(1) IN GENERAL.—

''(A) COORDINATED CARE AND PRIVATE FEE-FOR-SERVICE PLANS.—The monthly amount of the premium charged to an individual enrolled in a Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization shall be equal to the sum of the following:

''(i) The Medicare+Choice monthly basic beneficiary premium (if any).

''(ii) The Medicare+Choice monthly supplemental beneficiary premium (if any).

''(iii) The Medicare+Choice monthly obligation for qualified prescription drug coverage (if any).

''(B) MSA PLANS.—The rules under this section that would have applied with respect to an MSA plan if the 21st Century Medicare Act had not been enacted shall continue to apply to MSA plans after the date of enactment of such Act.

''(2) PREMIUM TERMINOLOGY.—For purposes of this part:

''(A) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly basic beneficiary premium' means, with respect to a Medicare+Choice plan, the amount required to be charged under subsection (d)(2) for the plan.

''(B) MEDICARE+CHOICE MONTHLY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'Medicare+Choice monthly obligation for qualified prescription drug coverage' means, with respect to a Medicare+Choice plan, the amount determined under section 1853(k)(3).

''(C) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly supplemental beneficiary premium' means, with respect to a Medicare+Choice plan, the amount required to be charged under subsection (f)(2) for the plan, or, in the case of an MSA plan, the amount filed under subsection (a)(3).

''(D) MEDICARE+CHOICE MONTHLY MSA PREMIUM.—The term 'Medicare+Choice monthly MSA premium' means, with respect to a Medicare+Choice plan, the amount of such premium filed under subsection (a)(3) for the plan.''.

(f) CONFORMING AMENDMENTS.—

(1) Section 1851(d)(2)(D) (42 U.S.C. 1395w–21(d)(2)(D)) is amended by inserting ''and Medicare+Choice monthly obligation for qualified prescription drug coverage'' after ''Medicare+Choice monthly basic and supplemental beneficiary premiums''.

(2) Section 1851(g)(3)(B)(i) (42 U.S.C. 1395w–21(g)(3)(B)(i)) is amended by striking ''any Medicare+Choice monthly basic and supplemental beneficiary premiums'' and inserting ''any Medicare+Choice monthly basic beneficiary premium, Medicare+Choice monthly obligation for qualified prescription drug coverage, Medicare+Choice monthly supplemental beneficiary premium,''.

(3) Section 1852(c)(1)(F) (42 U.S.C. 1395w–22(c)(1)(F)) is amended to read as follows:

''(F) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including the supplemental benefits covered and the Medicare+Choice monthly supplemental beneficiary premium for such benefits.''.

(4) Section 1853(f)(1) (as redesignated by section 305(1)) is amended by striking ''(as defined in section 1854(b)(2)(C))'' and inserting ''(as defined in section 1854(b)(2)(D))''.

(5) Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended by striking ''The Medicare+Choice monthly basic and supplemental beneficiary premium'' and inserting ''The Medicare+Choice monthly basic beneficiary premium, the Medicare+Choice monthly obligation for qualified prescription drug coverage, or the Medicare+Choice monthly supplemental beneficiary premium''.

(6) Section 1854(e) (as redesignated by subsection (a)(1)) is amended by inserting ''and the Medicare+Choice monthly obligation for qualified prescription drug coverage'' after ''Medicare+Choice monthly basic and supplemental beneficiary premiums''.

(7) Section 1859(c)(4) (42 U.S.C. 1395w–28(c)(4)) is amended to read as follows:

''(4) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICARE+CHOICE MONTHLY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE; MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The terms 'Medicare+Choice monthly basic beneficiary premium', 'Medicare+Choice monthly obligation for qualified prescription drug coverage', and 'Medicare+Choice monthly supplemental beneficiary premium' are defined in section 1854(b)(2).''.

SEC. 307. ELIGIBILITY, ELECTION, AND ENROLLMENT IN COMPETITIVE MEDICARE+CHOICE PLANS.

(a) ELIGIBILITY.—Section 1851(a)(3) is amended to read as follows:

''(3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—In this title, the term 'Medicare+Choice eligible individual' means an individual who—

''(A) is entitled to benefits under part A and enrolled under part B; and

''(B) has elected to receive enhanced medicare benefits under part E.''.

(b) ELECTIONS.—

(1) IN GENERAL.—Section 1851(a)(1)(A) is amended by inserting ''(including through the election of enhanced medicare benefits under part E) and, if elected by the beneficiary and offered by the Medicare+Choice plan, through the voluntary prescription drug delivery program under part D'' after ''parts A and B''.

(2) DEFAULT ELECTION.—Section 1851(c)(3) (42 U.S.C. 1395w–21(c)(3)) is amended by inserting ''to receive enhanced medicare benefits under part E of the'' after ''deemed to have chosen''.

(3) COVERAGE ELECTION PERIODS.—Section 1851(e)(1) (42 U.S.C. 1395w–21(e)(1)) is amended by striking ''entitled to benefits under part A and enrolled under part B'' and inserting ''eligible to elect to receive enhanced medicare benefits under part E''.

(4) GUARANTEED ISSUANCE AND RENEWAL.—Section 1851(g)(3)(C) (42 U.S.C. 1395w–21(g)(3)(C)) is amended—

(A) in clause (i), by inserting ''elected to receive enhanced medicare benefits under part E of the'' after ''deemed to have''; and

(B) in clause (ii), by striking ''deemed to have chosen to change coverage to'' and inserting ''deemed to have elected to receive enhanced medicare benefits under part E through the''.

(5) EFFECT OF ELECTION OF MEDICARE+CHOICE PLAN OPTION.—Section 1851(i) (42 U.S.C. 1395w–21(i)) is amended—

(A) in paragraph (1)—

(i) by striking ''1853(g), 1853(h)'' and inserting ''1853(h), 1853(i)''; and

(ii) by inserting ''(as modified under part E)'' after ''parts A and B''; and

(B) in paragraph (2), by striking ''1853(e), 1853(g), 1853(h)'' and inserting ''1853(f), 1853(h), 1853(i)''.

(c) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) GENERAL INFORMATION ON BENEFITS.—Section 1851(d)(3) (42 U.S.C. 1395w–21(d)(3)) is amended—

(A) by striking subparagraph (A) and inserting the following:

''(A) BENEFITS UNDER ENHANCED MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the enhanced medicare benefits covered under the original medicare fee-for-service program under parts A and B for individuals who have elected to receive such benefits under part E, including—

''(i) covered items and services;

''(ii) beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts; and

''(iii) any beneficiary liability for balance billing.'';

(B) by redesignating subparagraphs (B) through (E) as subparagraphs (C) through (F), respectively;

(C) by inserting after subparagraph (A) the following new subparagraph:

''(B) OUTPATIENT PRESCRIPTION DRUG COVERAGE BENEFITS.—For Medicare+Choice eligible individuals who are enrolled under part D, the information required under section 1860D–4 if the Medicare+Choice organization elects to offer prescription drug coverage.''; and

(D) in subparagraph (D) (as redesignated by subparagraph (B)), by inserting ''(with the enhanced medicare benefits under part E)'' after ''the original medicare fee-for-service program''.

(2) INFORMATION COMPARING PLAN OPTIONS.—Section 1851(d)(4) (42 U.S.C. 1395w–21(d)(4)) is amended—

(A) in subparagraph (A), by adding at the end the following new clause:

''(ix) For Medicare+Choice eligible individuals who are enrolled under part D, the comparative information described in section 1860D–4(b)(2) if the Medicare+Choice organization elects to offer prescription drug coverage.''; and

(B) in subparagraph (D), by inserting ''with respect to eligible beneficiaries who elect to receive enhanced medicare benefits under part E'' after ''under parts A and B''.

SEC. 308. BENEFITS AND BENEFICIARY PROTECTIONS UNDER COMPETITIVE MEDICARE+CHOICE PLANS.

(a) BASIC BENEFITS.—Section 1852(a) (42 U.S.C. 1395w–22(a)(1)(A)) is amended—

(1) in paragraph (1)—

(A) by striking subparagraph (A) and inserting the following new subparagraph:

''(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan and who have elected to receive enhanced medicare benefits under part E;'';

(B) by redesignating subparagraph (B) as subparagraph (C);

(C) by inserting after subparagraph (A) the following new subparagraph:

''(B) if the Medicare+Choice organization elects to offer prescription drug coverage, prescription drug coverage under part D to individuals who are enrolled under that part and who reside in the area served by the plan; and''; and

(D) in subparagraph (C) (as redesignated by paragraph (2)), by striking ''1854(f)(1)(A)'' and inserting ''1854(d)(1)'';

(2) in paragraph (2), by striking ''parts A and B (including any balance billing permitted under such parts'' and inserting ''part E (including any balance billing permitted under such part'';

(3) in paragraph (3), by adding at the end the following new subparagraph:

''(D) REQUIREMENT OF ENROLLMENT IN PART D TO RECEIVE PRESCRIPTION DRUG BENEFITS.—Notwithstanding the preceding provisions of this paragraph, the Secretary may not approve any supplemental health care benefit that provides for the coverage of any prescription drug (other than that required under part E).''; and

(4) in paragraph (5), by striking ''Health Care Financing Administration'' and inserting ''Medicare Competitive Agency'' in the flush matter following subparagraph (B).

(b) ESRD ANTIDISCRIMINATION.—Section 1852(b)(1) (42 U.S.C. 1395w–22(b)(1)) is amended to read as follows:

''(1) BENEFICIARIES.—A Medicare+Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.''.

(c) DISCLOSURE REQUIREMENTS.—Section 1852(c)(1)(B) (42 U.S.C. 1395w–22(c)(1)(B)) is amended by striking ''section 1851(d)(3)(A)'' and inserting ''subparagraphs (A) and (B) of section 1851(d)(3)''.

(d) ASSURING ACCESS TO SERVICES IN MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—Section 1852(d)(4)(A) is amended by striking ''part A, part B, or both, for such services, or'' and inserting ''part E for such services (and, if the Medicare+Choice organization elects to offer prescription drug coverage, that are not less than the payment rates provided under part D for such services for Medicare+Choice eligible individuals enrolled under that part); or''.

(e) INFORMATION ON BENEFICIARY LIABILITY FOR MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—Section 1852(k)(2)(C)(i) (42 U.S.C. 1395w–22(k)(2)(C)(i)) is amended by striking ''parts A and B'' and inserting ''part E, under part D for individuals enrolled under that part (if the Medicare+Choice organization elects to offer prescription drug coverage),''.

SEC. 309. PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS FOR ENHANCED MEDICARE BENEFITS UNDER PART E BASED ON RISK-ADJUSTED BIDS.

(a) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23(a)(1)(A)) is amended to read as follows:

''(1) MONTHLY PAYMENTS.—Under a contract under section 1857 and subject to subsections (f), (h), and (j) and section 1859(e)(4), the Secretary shall make, to each Medicare+Choice organization, with respect to coverage of an individual for a month under this part in a Medicare+Choice payment area, separate monthly payments with respect to—

''(A) enhanced medicare benefits under part E in accordance with subsection (d); and

''(B) if the Medicare+Choice organization elects to offer prescription drug coverage, benefits under part D in accordance with subsection (k) for individuals enrolled under that part.''.

(b) CONFORMING AMENDMENT.—Section 1853(g)(1)(A) (42 U.S.C. 1395w–23(g)(1)(A)) is amended by inserting ''as part of the enhanced medicare benefits elected under part E of'' before ''the original medicare fee-for-service program option''.

SEC. 310. SEPARATE PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS FOR PART D BENEFITS.

(a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–27) is amended by adding at the end the following new subsection:

''(k) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

''(1) SCOPE OF PRESCRIPTION DRUG BENEFITS.—

''(A) AVAILABILITY OF STANDARD COVERAGE.—If a Medicare+Choice organization elects to offer prescription drug coverage under a Medicare+Choice plan, such organization shall make such coverage (other than that required under part E) available to each enrollee under that plan who is also enrolled under part D that includes only standard coverage and that meets the requirements of this subsection.

''(B) ADDITIONAL QUALIFIED PRESCRIPTION DRUG COVERAGE.—In addition to the standard coverage option made available to each enrollee under paragraph (1), a Medicare+Choice plan may make available to each enrollee that is also enrolled under part D, other qualified prescription drug coverage (other than that required under part E) that meets the requirements of this subsection under a Medicare+Choice plan offered under this part.

''(C) REQUIREMENT OF ENROLLMENT IN PART D TO RECEIVE PRESCRIPTION DRUG BENEFITS.—A Medicare+Choice organization may not provide for the coverage of any prescription drugs (other than that required under part E) to an enrollee unless that enrollee is also enrolled under part D.

''(2) PAYMENT OF FULL AMOUNT OF PREMIUM TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—For each year (beginning with 2005), the Secretary shall pay to each Medicare+Choice organization offering a Medicare+Choice plan that provides qualified prescription drug coverage in which a Medicare+Choice eligible individual is enrolled, an amount equal to the full amount of the monthly premium submitted under section 1854(a)(2)(B) on behalf of each such individual enrolled in such plan for the year, as adjusted using the risk adjusters that apply to the standard coverage under section 1853(b)(4)(B).

''(3) AMOUNT OF MEDICARE+CHOICE MONTHLY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of a Medicare+Choice eligible individual receiving qualified prescription drug coverage under a Medicare+Choice plan, the obligation for qualified prescription drug coverage of such individual in a year shall be determined as follows:

''(A) PREMIUMS EQUAL TO THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium for qualified prescription drug coverage submitted under section 1854(a)(2)(B) for the plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the individual in that year shall be an amount equal to the applicable percent (as defined in section 1860D–17(c)) of the amount of the monthly national average premium.

''(B) PREMIUMS THAT ARE LESS THAN THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium for qualified prescription drug coverage submitted under section 1854(a)(2)(B) for the plan for the year is

less than the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the individual in that year shall be an amount equal to—

''(i) the applicable percent (as defined in section 1860D–17(c)) of the amount of the monthly national average premium; minus

''(ii) the amount by which the monthly national average premium exceeds the amount of the premium submitted under section 1854(a)(2)(B).

''(C) PREMIUMS THAT ARE GREATER THAN THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium for qualified prescription drug coverage submitted under section 1854(a)(2)(B) for the plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the individual in that year shall be an amount equal to the sum of—

''(i) the applicable percent (as defined in section 1860D–17(c)) of the amount of the monthly national average premium; plus

''(ii) the amount by which the premium submitted under section 1854(a)(2)(B) exceeds the amount of the monthly national average premium.

''(4) COLLECTION OF MEDICARE+CHOICE MONTHLY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The provisions of section 1860D–18, including subsection (b) of such section, shall apply to the amount of the monthly premium required to be paid by a Medicare+Choice eligible individual receiving qualified prescription drug coverage under a Medicare+Choice plan (as determined under paragraph (3)) in the same manner as such provisions apply to the monthly beneficiary obligation required to be paid by an eligible beneficiary enrolled in a Medicare Prescription Drug plan.

''(5) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860D–5, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to an eligible entity and a Medicare Prescription Drug plan under part D. The Secretary shall waive such requirements to the extent the Secretary determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(6) COVERAGE OF PRESCRIPTION DRUGS FOR ENROLLEES IN PLANS THAT DO NOT OFFER PRESCRIPTION DRUG COVERAGE.—If an individual who is enrolled under part D is enrolled in a Medicare+Choice plan that does not offer prescription drug coverage, such individual shall be permitted to enroll for prescription drug coverage under such part in the same manner as if such individual was not enrolled in a Medicare+Choice plan.

''(7) AVAILABILITY OF PREMIUM SUBSIDY AND COST-SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES.—For provisions—

''(A) providing premium subsidies and cost-sharing reductions for low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860D–19; and

''(B) providing a Medicare+Choice organization with insurance subsidy payments for providing qualified prescription drug coverage through a Medicare+Choice plan, see section 1860D–20.

''(8) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in paragraphs (9) and (10), respectively, of section 1860D.''.

(b) SANCTIONS FOR IMPROPER PRESCRIPTION DRUG COVERAGE.—Section 1857(g)(1) (42 U.S.C. 1395w–27(g)(1)) is amended—

(1) in subparagraph (F), by striking ''or'' after the semicolon at the end;

(2) in subparagraph (G), by adding ''or'' after the semicolon at the end; and

(3) by adding at the end the following new subparagraph:

''(H) charges any individual an amount in excess of the Medicare+Choice monthly obligation for qualified prescription drug coverage under section 1853(k)(3), provides coverage for prescription drugs that is not qualified prescription drug coverage (as defined in section 1853(k)(7)), offers prescription drug coverage, but does not make standard prescription drug coverage available (as defined in such section), or provides coverage for prescription drugs (other than those covered under part E) to an individual who is not enrolled under part D;''.

SEC. 311. ADMINISTRATION BY THE MEDICARE COMPETITIVE AGENCY.

On and after January 1, 2005, the Medicare+Choice program under part C of title XVIII of the Social Security Act shall be administered by the Medicare Competitive Agency in accordance with subpart 3 of part D of such title (as added by section 101), and, in accordance with section 1860D–25(c)(3)(C) of such Act (as added by section 101), each reference to the Secretary made in this title, or the amendments made by this title, shall be deemed to be a reference to the Administrator of the Medicare Competitive Agency.

SEC. 312. CONTINUED CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.

(a) CONTINUED CALCULATION.—

(1) IN GENERAL.—Section 1853(c) (as amended by subsection (b)) is amended by adding at the end the following new paragraph:

''(7) TRANSITION TO MEDICARE+CHOICE COMPETITION.—

''(A) IN GENERAL.—For each year (beginning with 2005) payments to Medicare+Choice plans shall not be computed under this subsection, but instead shall be based on the payment amount determined under subsection (d).

''(B) CONTINUED CALCULATION OF CAPITATION RATES.—For each year (beginning with 2004) the Secretary shall calculate and publish the annual Medicare+Choice capitation rates under this subsection and shall use the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for purposes of determining the benchmark amount under subsection (a)(4).''.

(2) CONFORMING AMENDMENT.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by striking ''For purposes of this part, subject to paragraphs (6)(C) and (7),'' and inserting ''For purposes of making payments under this part for years before 2004 and for purposes of calculating the annual Medicare+Choice capitation rates under paragraph (7) beginning with such year, subject to paragraph (6)(C),'' in the matter preceding subparagraph (A).

(b) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES IN CONTINUED CALCULATION.—Section 1853(c) (42 U.S.C. 1395w–23(c)), as amended by subsection (a)(1), is amended by adding at the end the following new paragraph:

''(8) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—For purposes of determining the blended capitation rate under subparagraph (A) of paragraph (1) and the minimum percentage increase under subparagraph (C) of such paragraph for a year, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in such rate, to the extent practicable, the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.''.

SEC. 313. FIVE-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

(a) IN GENERAL.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of BIPA (114 Stat. 2763A–568), is amended by striking ''2004'' and inserting ''2009''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

SEC. 314. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in section 306(b)(1)(B), section 313(b), and subsection (b), the amendments made by this title shall apply to plan years beginning on and after January 1, 2005.

(b) MEDICARE+CHOICE MSA PLANS.—Notwithstanding any provision of this title, the Secretary shall apply the payment and other rules that apply with respect to an MSA plan described in section 1851(a)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)(B)) as if this title had not been enacted.

SA 4311. Mr. REID (for Mr. WYDEN (for himself and Mr. ALLEN) proposed an amendment to the bill S. 2037, to mobilize technology and science experts to respond quickly to the threats posed by terrorist attacks and other emergencies, by providing for the establishment of a national emergency technology guard, a technology reliability advisory board, and a center for evaluating antiterrorism and disaster response technology within the National Institute of Standards and Technology; as follows:

On page 26, line 19, after the period, insert ''In completing the report, representatives of the commercial wireless industry shall be consulted, particularly to the extent that the report addresses commercial wireless systems.''.

On page 26, strike lines 22 and 23, and insert the following:

(1) developing a system of priority access for certain governmental officials to existing commercial wireless systems, and the impact such a priority access system would have on both emergency communications capability and consumer access to commercial wireless services;

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry Subcommittee on Production and Price Competitiveness be authorized to conduct a hearing on July 18, 2002 in SR–3328A at 2:00 p.m. The purpose of this hearing will be to discuss S. 532, the Pesticide Harmonization Act.

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and

Transportation be authorized to meet on Thursday, July 18, 2002, at 11 a.m. on examining Enron: Enron Energy Services and its role in the western state electricity crisis.

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Thursday, July 18, 2002, at 2:30 p.m. on the nomination of Frederick Gregory to be Deputy Administrator of NASA, Kathie Olsen and Richard Russell to be Associate Directors of OSTP.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to hold a Hearing during the session of the Senate on Thursday, July 18, 2002, at 2:30 p.m. in SD–366. The purpose of this hearing is to receive testimony on the following bills:

S. 1865, to authorize the Secretary of the Interior to study the suitability and feasibility of establishing the Lower Los Angeles River and San Gabriel River watersheds in the State of California as a unit of the National Park System, and for other purposes;

S. 1943, to expand the boundary of the George Washington Birthplace National Monument, and for other purposes;

S. 2571, to direct the Secretary of the Interior to conduct a special resources study to evaluate the suitability and feasibility of establishing the Rim of the Valley Corridor as a unit of the Santa Monica Mountains National Recreation Area;

S. 2595, to authorize the expenditure of funds on private lands and facilities at Mesa Verde National Park, in the State of Colorado, and for other purposes; and

H.R. 1925, to direct the Secretary of the Interior to study the suitability and feasibility of designating the Waco Mammoth Site Area in Waco, Texas, as a unit of the National Park System, and for other purposes.

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

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works be authorized to meet on Thursday, July 18, 2002, at 10:00 a.m. to conduct a hearing to hear from the following nominees: John S. Bresland to be a Member of the Chemical Safety and Hazard Investigation Board, and Carolyn W. Merritt to be a Member and Chair of the Chemical Safety and Hazard Investigation Board.

The hearing will be held in SD–406.

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

COMMITTEE ON INDIAN AFFAIRS

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet on Thursday, July 18, 2002, at 10:00 a.m. in Room 485 of the Russell Senate Office Building to conduct a hearing on a bill to approve the settlement of water rights claims of the Zuni Indian Tribe in Apache County, Arizona, and for other purposes.

I also ask unanimous consent that the Committee on Indian Affairs be authorized to meet on Thursday, July 18, 2002, at 2:00 p.m. in Room 485 of the Russell Senate Office Building to conduct a hearing on S. 2065, a bill to Ratify an Agreement to Regulate Air Quality on the Southern Ute Indian Reservation.

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

COMMITTEE ON THE JUDICIARY

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a markup on Thursday, July 18, 2002 at 10:00 a.m., in SD–226.

TENTATIVE AGENDA

I. Bills.—S. 486, Innocence Protection Act [Leahy/Smith]; H.R. 3375, Embassy Employee Compensation Act [Blunt]; S. 862, State Criminal Alien Assistance Program Reauthorization Act of 2001 [Feinstein/Kyl/Durbin/Cantwell]; S. 2395, Anticounterfeiting Amendments of 2002 [Biden/Hatch/Leahy/Feinstein/DeWine]; S. 2513, DNA Sexual Assault Justice Act of 2002 [Biden/Cantwell/Specter/Clinton/Carper].

II. Resolutions.—S. Res. 293, A resolution designating the week of November 10 through November 16, 2002, as ''National Veterans Awareness Week'' to emphasize the need to develop educational programs regarding the contributions of veterans to the country. [Biden/Kohl].

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

SPECIAL COMMITTEE ON AGING

Ms. STABENOW. Mr. President, I ask unanimous consent that the Special Committee on Aging be authorized to meet on Thursday, July 18, 2002 from 9:30 a.m.–12:00 p.m. in Dirksen 628 for the purpose of conducting a hearing.

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

SELECT COMMITTEE ON INTELLIGENCE

Ms. STABENOW. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Thursday, July 18, 2002 at 10:00 a.m. and 2:30 p.m. to hold a closed hearing on the Joint Inquiry into the events of September 11, 2001.

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

SUBCOMMITTEE ON CONSUMER AFFAIRS, FOREIGN COMMERCE AND TOURISM

Ms. STABENOW. Mr. President, I ask unanimous consent that the Subcommittee on Consumer Affairs, Foreign Commerce and Tourism of the Committee on Commerce, Science, and Transportation be authorized to meet on Thursday, July 18, 2002, at 9:30 a.m., on perspective on improving corporate responsibility.

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

PRIVILEGES OF THE FLOOR

Mrs. CLINTON. Madam President, I ask unanimous consent that Suzanne Johnson, a legislative fellow in my office, be permitted on the Senate floor throughout the debate on S. 812, and other prescription drug issues.

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

Mr. GRAHAM. Madam President, I ask unanimous consent that Dr. Howard Forman, from my office, be granted floor privileges for the duration of debate on this legislation.

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

SCIENCE AND TECHNOLOGY EMERGENCY MOBILIZATION ACT

Mr. REID. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 459, S. 2037.

The PRESIDING OFFICER. The bill will be stated by title.

The assistant legislative clerk read as follows:

A bill (S. 2037) to mobilize technology and science experts to respond quickly to the threats posed by terrorist attacks and other emergencies, by providing for the establishment of a national emergency technology guard, a technology reliability advisory board, and a center for evaluating antiterrorism and disaster response technology within the National Institute of Standards and Technology.

There being no objection, the Senate proceeded to consider the bill which had been reported from the Committee on Commerce, Science, and Transportation, with an amendment to strike all after the enacting clause and inserting in lieu thereof the following:

[Strike the part in black brackets and insert the part printed in italic]

S. 2037

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Science and Technology Emergency Mobilization Act''.

SEC. 2. CONGRESSIONAL FINDINGS AND PURPOSE.

(a) FINDINGS.—The Congress finds the following:

(1) In the aftermath of the terrorist attacks of September 11, 2001, many private-sector technology and science experts provided valuable assistance to rescue and recovery efforts by donating their time and expertise. However, many who wished to help had significant difficulty determining how they could be most useful. They were hampered by the lack of any organizational structure to harness their abilities and coordinate their efforts.

(2) A prompt and well-coordinated volunteer base of technology and science expertise could help save lives, aid rescue efforts, and rebuild

critical technology infrastructures in the event of a future major terrorist attack, natural disaster, or other emergency. Technology and science expertise also could help minimize the vulnerability of critical infrastructure to future attacks or natural disasters.

(3) Police, fire personnel, and other local emergency responders frequently could benefit from timely technological assistance, and efforts to organize a system to assist in locating the desired help should be expedited.

(4) Efforts to develop and deploy innovative new technologies for use by government emergency prevention and response agencies would be improved by the designation of a clear contact point within the federal government for intake and evaluation of technology ideas.

(5) The creation of compatible communications systems would strengthen emergency response efforts of police, fire, and other emergency response personnel to communicate effectively with each other and with their counterparts from nearby jurisdictions. Some programs, such as the Capital Wireless Integrated Network (CapWIN), have made significant progress in addressing the issue of interoperable communications between emergency service providers in particular urban areas and the Federal government has sought to address the issue through the Public Safety Wireless Networks program. Relatively few States and localities, however, have achieved a sufficient level of communications interoperability.

(b) PURPOSE.—The purpose of this Act is to reinforce, focus, and expedite ongoing efforts to mobilize America's extensive capability in technology and science in responding to the threats posed by terrorist attacks, natural disasters, and other major emergencies, by creating—

(1) a national emergency technology guard or ''NET Guard'' that includes—

(A) rapid response teams of volunteers with technology and science expertise, organized at the local level; and

(B) opportunities for NET Guard volunteers to assist with non-emergency tasks related to local preparedness and prevention, including reducing the vulnerability of government information technology systems;

(2) a national clearinghouse for innovative civilian technologies relating to emergency prevention and response; and

(3) a pilot program to assist state efforts to achieve the interoperability of communications systems used by fire, law enforcement, and emergency preparedness and response agencies.

SEC. 3. ESTABLISHMENT OF NATIONAL EMERGENCY TECHNOLOGY GUARD.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the President shall designate an appropriate department, agency, or office to compile and maintain a repository database of nongovernmental technology and science experts who have offered, and who can be mobilized, to help Federal agencies counter terrorism.

(b) NET GUARD DISASTER RESPONSE TEAMS.—

(1) CERTIFICATION PROCEDURES.—The President shall also designate an appropriate department, agency, or office (which may be the department, agency, or office designated under subsection (a)) to develop a procedure to encourage groups of volunteers with technological or scientific expertise to team with individuals from State and local governments, local emergency response agencies, and nongovernmental emergency aid, assistance, and relief organizations.

(2) TEAM FORMATION.—The department, agency, or office designated under paragraph (1) may develop and implement a system for facilitating the formation of local teams of such volunteers by helping individuals that wish to participate in such teams to locate and contact one another.

(3) CRITERIA FOR CERTIFICATION.—The department, agency, or office designated under paragraph (1) shall establish criteria for the certification of such teams, including—

(A) the types of expertise, capabilities, and equipment required; and

(B) minimum training and practice requirements, including participation in not less than 2 emergency drills each year.

(4) CERTIFICATION AND CREDENTIALS.—The department, agency, or office designated under paragraph (1) shall—

(A) certify any group of individuals requesting certification as a NET Guard disaster response team that complies with the procedures established under paragraph (1) and meets the criteria established under paragraph (3);

(B) issue credentials and forms of identification as appropriate identifying each such team and its members; and

(C) suspend, withdraw, or terminate certification of and recover credentials and forms of identification from any NET Guard disaster response team, or any member thereof, when the head of the entity designated deems it appropriate.

(5) COMPENSATION; PER DIEM, TRAVEL, AND TRANSPORTATION EXPENSES.—The department, agency, or office designated under paragraph (1) may authorize the payment to a member of a NET Guard disaster response team, for the period that member is engaged in performing duties as such member at the request of the United States—

(A) compensation as employees for temporary or intermittent services as experts or consultants under section 3109 of title 5, United States Code; and

(B) travel or transportation expenses, including per diem in lieu of subsistence, as provided by section 5703 of title 5.

(c) ADDITIONAL AUTHORITIES.—The head of the department, agency, or office designated under paragraph (1) may—

(1) activate NET Guard disaster response teams in an emergency (as defined in section 102(1) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122(1)) or a major disaster (as defined in section 102(2) of that Act);

(2) provide for access by team members to emergency sites; and

(3) assign, on a voluntary basis, NET Guard volunteers to work, on a temporary basis on—

(A) the development and maintenance of the database described in subsection (a) and the procedures for access to the database; and

(B) such other technology related projects to improve emergency preparedness and prevention as may be appropriate.

SEC. 4. CENTER FOR CIVILIAN HOMELAND SECURITY TECHNOLOGY EVALUATION.

(a) IN GENERAL.—The President shall establish a Center for Civilian Homeland Security Technology Evaluation within the Executive Branch to evaluate innovative technologies relating to security and emergency preparedness and response and to serve as a national clearinghouse for such technologies.

(b) FUNCTION.—The Center shall—

(1) serve as a principal, national contact point for the intake of innovative technologies relating to security and emergency preparedness and response;

(2) evaluate promising new technologies relating to security and emergency preparedness and response;

(3) assure persons and companies that have submitted a technology receive a timely response to inquiries;

(4) upon request by Federal agencies consult with and advise Federal agencies about the development, modification, acquisition, and deployment of technology relating to security and emergency preparedness and response; and

(5) provide individuals and companies that have submitted information about a technology the ability to track, to the extent practicable, the current status of their submission online.

(c) MODEL.—The Center may be modeled on the Technical Support Working Group that provides an interagency forum to coordinate research and development of technologies for combating terrorism.

(d) INTERNET ACCESS.—

(1) IN GENERAL.—The President shall create an online portal accessible through the FirstGov Internet website (www.firstgov.gov), or any successor to such website, to provide individuals and companies with innovative technologies a single point of access to the Center and a single point of contact at each Federal agency participating in the Center.

(2) FUNCTIONS.—The Center portal shall—

(A) provide individuals and companies with an online opportunity to obtain information about various open solicitations relevant to homeland security and points of contact for submission of solicited and unsolicited proposals; and

(B) include safeguards to ensure that business proprietary information is protected and that no personally identifiable information is accessible to unauthorized persons.

(e) PROCUREMENT NOT CONDITIONED ON SUBMISSION.—Nothing in this section requires a technology to be submitted to, or evaluated by, the Center in order to be eligible for procurement by Federal agencies.

SEC. 5. COMMUNICATIONS INTEROPERABILITY PILOT PROJECTS.

(a) IN GENERAL.—The President shall establish within an appropriate department, agency, or office a pilot program for planning or implementation of interoperable communications systems for appropriate emergency response agencies.

(b) GRANTS.—The head of the department, agency, or office in which the program is established under subsection (a) shall make grants of $5,000,000 each to 7 different States for pilot projects under the program.

(c) CRITERIA; ADMINISTRATIVE PROVISIONS.—The head of the department, agency, or office in which the program is established under subsection (a), in consultation with other appropriate agencies, shall prescribe such criteria for eligibility for projects and for grantees, including applications, fund use assurance and accounting, and reporting requirements as the head of the entity deems appropriate. In prescribing such criteria, the head of the department, agency, or office shall consult with the administrators of existing projects designed to facilitate public safety communications interoperability concerning the best practices and lessons learned from such projects.

SEC. 6. REPORTS.

(a) WIRELESS COMMUNICATIONS CAPABILITIES FOR FIRST RESPONDERS.—Within 1 year after the date of enactment of this Act, the President shall designate an appropriate department, agency, or office to submit a report to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Science of the House of Representatives setting forth policy options for ensuring that emergency officials and first responders have access to effective and reliable wireless communications capabilities. The report shall include an examination of the possibility of—

(1) developing a system of priority access to existing commercial wireless systems;

(2) designating national emergency spectrum to be held in reserve for public safety and emergency purposes; and

(3) creating a specialized public safety communications network or networks for use with wireless devices customized for public safety use.

(b) IN-KIND DONATIONS.—Within 1 year after the date of enactment of this Act, the Federal Emergency Management Agency, in consultation with other appropriate Federal agencies, shall submit to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Science of the House of Representatives a report on the barriers to acceptance by Federal agencies of in-kind donations of technology and services during emergency situations.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

(a) NATIONAL EMERGENCY TECHNOLOGY GUARD.—There are authorized to be appropriated $5,000,000 for each of fiscal years 2003 and 2004 to carry out section 3.

(b) PILOT PROGRAMS.—There are authorized to be appropriated to the department, agency, or office in which the program is established under section 5(a) $35,000,000 for fiscal year 2003 to carry out section 5 of this Act, such sums to remain available until expended.

(c) REPORT.—There are authorized to be appropriated to the department, agency, or office designated in section 6(a) $500,000 for fiscal year 2003 to carry out section 6(a) of this Act.

SEC. 8. EMERGENCY RESPONSE AGENCIES.

In this Act, the term ''emergency response agency'' includes agencies providing any of the following services:

(1) Law Enforcement services.

(2) Fire services.

(3) Emergency Medical services.

(4) Public Safety Communications.

(5) Emergency Preparedness.

Mr. WYDEN. Mr. President, as America mobilizes to protect itself from terrorism, a key weapon in its defensive arsenal is its great technological prowess. From high-tech ''cyber attacks'' to more conventional threats, many of the solutions for reducing America's vulnerabilities at home will be rooted in technology. And much of the country's science and technology expertise resides outside the government in the dynamic arena of private sector entrepreneurship.

Therefore, it is essential to ensure that America's antiterrorism efforts tap the tremendous science and technology talents of the private sector. To that end, the Science and Technology Emergency Mobilization Act will help forge strong partnerships between the government and private sector science and technology experts, in order to provide the best protection and response for the American people.

The legislation the Senate is approving today has been in the works since shortly after September 11. The Subcommittee on Science and Technology held a series of hearings in 2001–2002 on the best way to mobilize science and technology experts, drawing on first-hand accounts of those who sought to offer help in the aftermath of the terrorist attacks. The subcommittee's ranking Republican, Senator ALLEN, joined me as a cosponsor and helped to draft the bill. House Science Committee Chairman BOEHLERT participated as well, making this a bipartisan and bicameral effort. The bill also bears the imprint of various executive branch agencies: we worked very closely with the Office of Management and Budget, the Office of Science and Technology Policy, the Commerce Department's Technology Administration, FEMA, and NIST to shape the original legislation into a finely-turned and targeted bill. On May 17, it was approved by the Commerce Committee without dissent.

The legislation provides for the creation of a database of private sector science and technology experts whom government officials may call upon in emergencies. It provides for the creation of National Emergency Technology Guard, NET Guard, teams of volunteers with technology and science expertise, organized in advance and available to be mobilized on short notice, similar to existing urban search and rescue teams.

It also calls for the creation of a Center for Civilian Homeland Security Technology Evaluation, modeled on the existing Technical Support Working Group, to serve as a single point of contact and clearinghouse for innovative technologies relating to emergency prevention and response. The center will have an online portal, so that the numerous small businesses that have been struggling to negotiate the maze of bureaucracy will finally have a way to get their bright technology ideas into the right hands. In addition, the legislation provides for pilot projects to improve the interoperability of communications systems used by fire, law enforcement, and emergency preparedness and response agencies.

The legislation does not create a large bureaucracy, nor does it seek to micromanage; instead, it gives the President flexibility to decide where within the executive branch the different functions set forth in the bill should be placed. This is particularly important in light of the pending proposals for reorganizing the Federal Government's homeland security functions. This bill is flexible enough to fit comfortably within whatever structure is ultimately adopted.

I express my appreciation to Senator ALLEN for his efforts on the bill; to the distinguished chairman of the Commerce Committee, Senator HOLLINGS, for his help and support as the bill was considered by the committee; and to Mitch Daniels, Director of the Office of Management and Budget, for mobilizing his staff to work with us on the fine points of the legislation. I also thank all the private sector organizations and individuals who provided important advice throughout the process, and in particular those who have expressed formal support for the legislation, including Intel, Microsoft, America Online, Oracle, the National Association of Manufacturers, and the Biotechnology Industry Organization.

Mr. ALLEN. Mr. President, today I rise to thank my colleagues for their unanimous support of S. 2037, the Science and Technology Emergency Mobilization Act. I also thank Senator WYDEN for his leadership and continued tenacious work on pushing this important measure through the Senate.

S. 2037 highlights the vital role technology and innovation play in our Nation's war to protect our homeland from terrorism. As this body has highlighted time and time again, new technologies are being developed every day that can help save lives and improve the ability of our firefighters, police, and first responders to react quickly and effectively to a catastrophic event.

As our Nation becomes more dependent upon technology in nearly every aspect of our lives, the level of vulnerability to technological disruptions rises accordingly. We all saw with the problems following the attacks of September 11, the promptness and quality of the technological response to terrorist attacks or natural disasters could mean the difference between life and death.

S. 2037, the Net Guard bill, will play a major role in preventing many of the problems that occurred during the attacks against New York and the Pentagon. September 11 taught us two things: (1) how much technological improvements are needed for State, local, and Federal services, and (2) the depth of the reservoir of American goodwill to provide solutions.

S. 2037 will call upon the ideas of the best and the brightest minds in the American technology workforce to act as an all-volunteer force to help restore communications and infrastructure operations after a major national disaster. Like all Americans, I was heartened by the volunteer efforts of companies, like Verizon, Intel, IBM, Accenture, and Cingular Wireless, that volunteered both staff and equipment to restore communications in New York and the Washington, DC area.

This bill will simply add structure to private sector efforts and encourages the participation of the Nation's science and technology experts to respond to national emergencies. Additionally, this bill creates a ''virtual technology reserve'' consisting of a database of private-sector expertise and equipment that can be called upon, at any moment, by emergency officials during a crisis situation.

I believe the all-volunteer teams of science and technology personnel in conjunction with the virtual technology reserve that are created by this legislation will help many Americans by restoring vital services in times of need.

There are many enterprises and commercial applications that can be adapted to meet the Government's needs, however currently there is no central location for evaluation or mechanism for recommendation within the Government. I, along with other Senators, receive volumes of information from numerous companies on their different products and ideas regarding the defense of our homeland. As public servants we want to be sure the Government has the necessary structure and process in place to test and apply new technologies to meet our homeland security needs.

S. 2037 establishes of a Center for Civilian Homeland Security Technology Evaluation and an online, Internet portal within the Executive Branch. This Center will perform the important task of matching the inventions of the private sector to the needs of our Nation's homeland defense. Additionally, the Internet portal will provide individuals and companies with a single point to access the center and a single point of

contact at each federal agency participating in the Center for Civilian Homeland Security.

Mr. President, I am glad to see the Senate come together and pass this important legislation and again thank my colleague from Oregon for his leadership. I have truly enjoyed working with him for the successful passage of this positive, constructive utilization of the advances in technology to improve the security of Americans.

Mr. REID. Mr. President, Senators WYDEN and ALLEN have an amendment at the desk, and I ask unanimous consent that the amendment be considered and agreed to, the motion to reconsider be laid upon the table, the committee substitute amendment, as amended, be agreed to, the bill, as amended, be read the third time and passed, and the motion to reconsider be laid upon the table, and that any statements relating thereto be printed in the RECORD as if read, with no intervening action or debate.

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

The amendment (No. 4311) was agreed to, as follows:

(Purpose: To ensure that private sector input is considered in the wireless communications capabilities policy options report required by section 6)

On page 26, line 19, after the period, insert ''In completing the report, representatives of the commercial wireless industry shall be consulted, particularly to the extent that the report addresses commercial wireless systems.''.

On page 26, strike lines 22 and 23, and insert the following:

(1) developing a system of priority access for certain governmental officials to existing commercial wireless systems, and the impact such a priority access system would have on both emergency communications capability and consumer access to commercial wireless services;

The committee amendment in the nature of a substitute, as amended, was agreed to.

The bill (S. 2307), as amended, was read the third time and passed, as follows:

(The bill will be printed in a future editing of the RECORD.)

BORN-ALIVE INFANTS PROTECTION ACT OF 2001

Mr. REID. Mr. President, I ask unanimous consent that the Senate proceed to the consideration of Calendar No. 323, H.R. 2175.

The PRESIDING OFFICER. The bill will be stated by title.

The assistant legislative clerk read as follows:

A bill (H.R. 2175) to protect infants who are born alive.

There being no objection, the Senate proceeded to consider the bill.

Mr. REID. Mr. President, I ask unanimous consent that the bill be read the third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

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

The bill (H.R. 2175) was read the third time and passed.

RECOGNIZING THE ACCOMPLISHMENTS OF IGNACY JAN PADEREWSKI

Mr. REID. Mr. President, I ask unanimous consent that the Foreign Relations Committee be discharged from further consideration of S. Res. 296 and the Senate proceed to its consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The resolution will be stated by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 296) recognizing the accomplishments of Ignacy Jan Paderewski as a musician, composer, statesman, and philanthropist and recognizing the 10th anniversary of the return of his remains to Poland.

There being no objection, the Senate proceeded to consider the resolution.

Mr. REID. Mr. President, I ask unanimous consent that the resolution and preamble be agreed to en bloc, the motion to reconsider be laid upon the table, and that any statements relating thereto be placed in the RECORD as if read at the appropriate place.

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

The resolution (S. Res. 296) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 296

Whereas Ignacy Jan Paderewski, born in Poland in 1860, was a brilliant and popular pianist who performed hundreds of concerts in Europe and the United States during the late 19th and early 20th centuries;

Whereas Paderewski often donated the proceeds of his concerts to charitable causes;

Whereas, during World War I, Paderewski worked for the independence of Poland and served as the first Premier of Poland;

Whereas in December 1919, Paderewski resigned as Premier of Poland, and in 1921 he left politics to return to his music;

Whereas the German invasion of Poland in 1939 spurred Paderewski to return to political life;

Whereas Paderewski fought against the Nazi dictatorship in World War II by joining the exiled Polish Government to mobilize the Polish forces and to urge the United States to join the Allied Forces;

Whereas Paderewski died in exile in America on June 29, 1941, while war and occupation imperiled all of Europe;

Whereas by the direction of United States President Franklin D. Roosevelt, Paderewski's remains were placed along side America's honored dead in Arlington National Cemetery, where President Roosevelt said, ''He may lie there until Poland is free.'';

Whereas in 1963, United States President John F. Kennedy honored Paderewski by placing a plaque marking Paderewski's remains at the Mast of the Maine at Arlington National Cemetery;

Whereas in 1992, United States President George H.W. Bush, at the request of Lech Walesa, the first democratically elected President of Poland following World War II, ordered Paderewski's remains returned to his native Poland;

Whereas June 26, 1992, the remains of Paderewski were removed from the Mast of the Maine at Arlington National Cemetery, and were returned to Poland on June 29, 1992;

Whereas on July 5, 1992, Paderewski's remains were interned in a crypt at the St. John Cathedral in Warsaw, Poland; and

Whereas Paderewski wished his heart to be forever enshrined in America, where his lifelong struggle for democracy and freedom had its roots and was cultivated, and now his heart remains at the Shrine of the Czestochowa in Doylestown, Pennsylvania: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the accomplishments of Ignacy Jan Paderewski as a musician, composer, statesman, and philanthropist; and

(2) acknowledges the invaluable efforts of Ignacy Jan Paderewski in forging close Polish-American ties, on the 10th Anniversary of the return of Paderewski's remains to Poland.

APPOINTMENT

The PRESIDING OFFICER. The Chair, on behalf of the President pro tempore and upon the recommendation of the Republican Leader, pursuant to Public Law 98–183, as amended by Public Law 103–419, reappoints Russell G. Redenbaugh of Pennsylvania to the United States Commission on Civil Rights.

ORDERS FOR FRIDAY, JULY 19, 2002

Mr. REID. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m., Friday, July 19; that following the prayer and the pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and there be a period for morning business until 11:30 a.m., with Senators permitted to speak therein for up to 10 minutes each, with the time equally divided between the two leaders or their designees; further, that the cloture vote scheduled for 10:30 a.m. on Tuesday, July 23, occur at 10:45 a.m.

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

PROGRAM

Mr. REID. Mr. President, tomorrow there is as much time as Senators may want to talk about the pending amendments or any topic related to this bill. The leader has said we will convene in the afternoon on Monday. There are no votes on Monday. If Senators want to talk about the pending amendments or the bill tomorrow, there will be available as many hours as Senators wish to speak, and then all day Monday. These are two very important amendments, and people should feel inclined to talk about them if they desire. We cannot have anyone carping and saying: I did not have time to talk. Senators have all the time that can possibly be needed to talk about these two important amendments.

There will be no rollcall votes tomorrow or Monday. As I indicated in the request the Chair has granted, we will vote at 10:45 a.m. on Tuesday.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. REID. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 8:03 p.m., adjourned until Friday, July 19, 2002, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate July 18, 2002:

DEPARTMENT OF TRANSPORTATION

ROGER P. NOBER, OF MARYLAND, TO BE A MEMBER OF THE SURFACE TRANSPORTATION BOARD FOR A TERM EXPIRING DECEMBER 31, 2005, VICE WILLIAM CLYBURN, JR., TERM EXPIRED.

DEPARTMENT OF THE TREASURY

PAMELA F. OLSON, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF THE TREASURY, VICE MARK A. WEINBERGER, RESIGNED.

THE JUDICIARY

S. JAMES OTERO, OF CALIFORNIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE CENTRAL DISTRICT OF CALIFORNIA, VICE RICHARD A. PAEZ, ELEVATED.

ROBERT G. KLAUSNER, OF CALIFORNIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE CENTRAL DISTRICT OF CALIFORNIA, VICE WILLIAM D. KELLER, RETIRED.

ROBERT A. JUNELL, OF TEXAS, TO BE UNITED STATES DISTRICT JUDGE FOR THE WESTERN DISTRICT OF TEXAS, VICE HIPOLITO FRANK GARCIA, DECEASED.

JAMES E. KINKEADE, OF TEXAS, TO BE UNITED STATES DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF TEXAS, VICE JOE KENDALL, RESIGNED.

WILLIAM E. SMITH, OF RHODE ISLAND, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF RHODE ISLAND, VICE RONALD R. LAGUEUX, RETIRED.

IN THE COAST GUARD

THE FOLLOWING NAMED INDIVIDUALS FOR APPOINTMENT AS PERMANENT COMMISSIONED REGULAR OFFICERS IN THE UNITED STATES COAST GUARD IN THE GRADE INDICATED UNDER SECTION 211, TITLE 14, U.S. CODE:

To be commander

GEORGE H. TEUTON, 4988

To be lieutenant

BLAKE L. NOVAK, 5248

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be general

LT. GEN. CHARLES F. WALD, 1222

THE FOLLOWING NAMED INDIVIDUAL FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE AIR FORCE UNDER TITLE 10, U.S.C., SECTION 12203.

To be colonel

FREDERIC A. MARKS, 2079

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE AND FOR REGULAR APPOINTMENT (IDENTIFIED BY AN ASTERISK (*)) UNDER TITLE 10, U.S.C., SECTIONS 624 AND 531:

To be major

MEREDITH L. *ADAMS, 9432
JAMES W. BARBER, 0277
CRAIG T. *BARD, 7892
PAUL O. *BEGNOCHE, 5518
MARY ANN BEHAN, 0980
DANNY L. *BLAKE, 0412
DUANE M. *BRAGG, 3514
MICHAEL S. BURKE, 3168
RICHARD E. CUTTS, 3455
JOHN H. *DANIELS, 2008
GREGORY B. *DEWOLF, 6486
ANNETTE I. *DORRIS, 1488
BRENT A. *EPLING, 5157
MATTHEW B. *ESCHER, 5682
CHARLES B. *FARLEY, 9049
LOUIS A. *FERRUCCI JR., 0110
KEVIN M. *FRANKE, 5234
DAVID V. *GILL, 9792
MATTHEW A. *GRINSTAFF, 4208
CHARLES A. *GROH, 7025
SEAN A. *HOLLOWAY, 4108
JAMES M. *HUGHES, 2546
KARL D. *HUTH, 0005
GENE C. *KRAFT, 4316
BARNA C. *LAMBERT, 1508
DWIGHT E. *LISLE, 5219
CHRISTOPHER P. MARCUS, 8979
RODNEY K. *MCCURDY, 8285
RICK A. *MOORE, 9411
STEPHEN M. MOUNTS, 9535
ERICH P. *MURRELL, 5279
CHRISTOPHER A. *PHILLIPS, 5476
STEPHEN D. *SPEECE, 3163
MICHAEL C. *SUMNER, 4647
CATHERINE A. *TARABINI, 4725
STEVEN P. *VANDEWALLE, 0010
CHRISTOPHER L. *VROOMAN, 4778
EDWIN W. *WRIGHT, 1239

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE AND FOR REGULAR APPOINTMENT (IDENTIFIED BY AN ASTERISK (*)) UNDER TITLE 10, U.S.C., SECTIONS 624 AND 531:

To be major

SARA K. *ACHINGER, 9414
MARK E. *ALLEN, 8464
BRUCE A. *BARNARD, 6295
TERESA H. *BARNES, 6422
GREGORY A. *BAXLEY, 6964
NOAH J. *BLEDSTEIN, 4865
ROBERT F. *BOOTH, 8941
JEFFREY *BRANSTETTER, 0900
ROBIN L. *BRODRICK, 7069
LEONARD L. *BURRIDGE, 3767
ROBERT C. *BURTON, 1023
CYNTHIA *BUXTON, 9033
CHRISTOPHER L. COLCLASURE, 0066
CHRISTA S. *COTHREL, 7060
MICHELLE S. *CRAMER, 3346
RONALD S. *CRAMER, 4418
DAVID M. *CUNNINGHAM, 8525
GORDON P. *DAVIS, 5530
KIM M. *DIPPOLITO, 0918
BRETT W. *DOWNEY, 3026
JEFFREY A. *FERGUSON, 6542
DAVID J. R. *FRAKT, 6612
PETER *GALINDEZ JR., 7819
FRANK T. *GIAMBATTISTA, 8276
MICHAEL W. *GOLDMAN, 0872
SHANNON R. *HANSCOM, 3150
KRISTINE R. *HOFFMAN, 6594
DARREN C. *HUSKISSON, 4313
KYLE R. *JACOBSON, 7534
DIANA L. *JOHNSON, 1696
JOSHUA E. *KASTENBERG, 6631
MARCI A. *LAWSON, 2691
MICHAEL A. *LEWIS, 1052
TRACEY Y. *MADSEN, 9248
BRYAN T. MARTIN, 3347
TODD E. MCDOWELL, 2914
MARTIN T. *MITCHELL, 6595
KYLE W. *NOLTE, 9120
RICHARD S. *PAKOLA, 9295
IRA *PERKINS, 0082
CHARLES L. *PLUMMER, 1440
TERESA L. *REED, 8557
NATALIE D. *RICHARDSON, 5242
TAMAIRA *RIVERA, 1532
THOMAS A. *ROGERS JR., 0744
DEREK S. *SHERRILL, 9178
JOHN D. SMITH, 7612
HUGH A. *SPIRES JR., 0366
MICHAEL A. *SUMNER, 1569
ERIK A. *TROFF, 1079
RACHEL E. VANLANDINGHAM, 4594
REBECCA R. *VERNON, 2209
STACIE A. *VEST, 8005
MATTHEW S. *WARD, 4967
PATRICK J. *WELLS, 9401
ERIC J. *WERNER, 4000
LYNNE A. *WHITTLER, 1865
JONATHAN P. *WIDMANN, 2165
CHARLES E. *WIEDIE JR., 0551

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE AND FOR REGULAR APPOINTMENT (IDENTIFIED BY AN ASTERISK (*)) UNDER TITLE 10, U.S.C., SECTIONS 624 AND 531:

To be major

CHRISTOPHER R. *ABRAMSON, 8302
ORLANDO A. ACOSTA, 1662
BRIAN E. *ADAMCIK, 1999
ANDREW J. ADAMS, 7167
DAVID E. *ADAMS, 9598
DENNIS P. *ADAMS, 9300
SHAWN J. *ADKINS, 5368
MICHAEL P. AERSTIN, 3152
THANOON J. *AGHA, 7020
LATHEEF N. *AHMED, 2579
MARK J. *AHRENS, 3299
RICKY L. *AINSWORTH, 1795
SUSAN M. *AIROLA, 8536
ANTHONY J. AJELLO JR., 3160
MICHAEL J. *AKOS, 5632
KRISTINA M. *ALBERTWYMS, 4931
CHARLYNN M. *ALDERMAN, 8278
PATRICK L. *ALDERMAN, 9705
JOSE M. *ALEMAN, 8287
LEWIS E. ALFORD III, 7224
DAVID T. *ALLEN, 7461
THADDEUS P. ALLEN, 0150
WALTER C. ALLEN II, 2117
NATHAN A. ALLERHEILIGEN, 1678
MATTHEW W. ALLINSON, 4888
CHARLES R. ALMQUIST, 5256
CLIFFORD G. *ALTIZER, 3019
RAYMOND ALVES II, 3574
KELLY JAY *AMEDEE, 7146
CHRISTOPHER C. *AMENTA, 9000
STEVEN C. AMMONS, 9566
DAVID J. *ANASON, 8176
KEVIN P. *ANCHOR, 8850
CORNELIUS T. *ANDERSON, 9483
DAGVIN R. M. ANDERSON, 5448
DOUGLAS C. *ANDERSON, 2886
LEIGHTON T. ANDERSON JR., 1733
MICHAEL A. *ANDERSON, 2119
MONTE D. ANDERSON, 3076
ROBERT E. *ANDERSON JR., 2313
STEVEN E. ANDERSON, 2260
THEODORE J. ANDERSON, 7103
TIMOTHY W. ANDERSON, 1528
JOSE ZL *ANDIN, 0254
MICHAEL S. *ANGLE, 1122
STEVEN E. *ANKERSTAR, 4890
CHRISTOPHER T. ANTHONY, 5134
WILLIAM B. *APODACA, 1170
JOHN E. *ARD, 5377
JASON R. ARMAGOST, 5374
JOHN H. *ARMSTRONG JR., 2244
JONATHAN D. ARNETT, 8296
CHARLES F. *ARNOLD JR., 5205
JOSEPH E. *ARTHUR, 8028
REGINALD E. G. *ASH III, 8035
JOEL E. ATKINSON, 7871
TAFT O. AUJERO, 1108
SCOTT J. BABBITT, 0710
LESLIE P. BABICH, 3076
JEREMY O. BAENEN, 5479
MARK E. *BAER, 6866
FRED P. *BAIER, 5558
ROBERT D. *BAIER, 5488
CHARLES P. *BAILEY JR., 4381
DARRIN E. *BAILEY, 3407
JAMES B. *BAILEY JR., 2679
RICHARD J. BAILEY JR., 2223
BRANDON E. BAKER, 7302
CRAIG R. BAKER, 4552
GILBERT W. BAKER, 3250
JESSICA *BAKER, 0632
JOHN P. *BAKER, 3559
RICHARD W. *BAKER, 3842
JONATHAN P. *BAKONYI, 9239
RUSSELL L. *BALL, 1547
MICKEY L. BALLARD, 3406
THOMAS C. *BALLARD, 3073
DAVID BALLEW, 8776
KEITH W. BALTS, 0238
ANTHONY E. BAMSEY, 4199
MARTIN J. *BANGERT, 5048
DAVID D. BANHOLZER, 8080
ERIC J. BARELA, 8483
ALEXANDER J. *BARELKA, 1792
MICHAEL D. BARG, 8646
MATTHEW A. BARKER, 6864
GARY A. *BARLET, 0581
GEOFFREY C. *BARNES, 0391
DANIEL J. *BARONE, 8692
MARK A. BARONI, 8321
FRANKLIN D. *BARROW, 5892
STEPHEN P. BARROWS, 2051
DEREK S. BARTHOLOMEW, 0909
ROBERT A. *BASKETTE, 4826
SAMUEL D. *BASS, 7221
ANDREW J. BATES, 6936
TIMOTHY D. *BATSON, 7591
LOREN E. *BATTELS JR., 0124
ROBERT G. *BATTEMA, 9497
JOSEPH T. *BATTLE JR., 4166
KURT P. *BAUER II, 8438
JONATHAN M. BAUGHMAN, 9655
STEPHEN J. BAUMGARTE, 4092
STEPHEN C. *BAXTER, 8071
JOSEPH G. *BEAHM JR., 9288
DONALD C. *BEAL, 0034
CATHY *BEASLEY, 8276
DAVID L. BEAVER, 6392
MATTHEW R. BECKLEY, 7636
ANDREA D. BEGEL, 1143
ANDREW J. *BELANGER, 1136
DEAN C. *BELLAMY, 2046
KELLY S. *BELLAMY, 8356
ALFRED P. *BELLO III, 2691
KYLE G. *BELLUE, 9810
CHRISTOPHER *BEMBENICK, 5564
ROBERT J. *BEMENT, 9446
MICHAEL R. *BENHAM, 2507
VERONICA P. *BENNET, 5223
JAMES S. *BENOIT, 7204
LYNN *BENTLEY III, 1067
RICHARD F. *BENZ, 2369
DANIELLE E. BERNARD, 8081
JESSICA ANNE BERTINI, 5390
GREG D. BIGLEY, 4877
PETER M. BILODEAU, 9794
CHRISTOPHER D. *BIRKHEAD, 8780
JERRY W. *BISHOP JR., 0126
FREDERICK C. *BIVETTO, 9907
SHAWN L. BLACK, 6094
DOUGLAS F. BLACKLEDGE, 2784
BARRY A. BLANCHARD, 2266
CHRISTOPHER J. *BLANEY, 9525
THOMAS R. *BLAZEK, 0665
JENNIFER A. BLOCK, 4350
JAMES A. BLOIR, 5606
THEODORE B. BLOOMER, 1980

STEPHEN J. *BLOSE, 1329
GREGORY D. *BLOUNT, 6986
TRACY A. *BOBO, 2166
JAMES E. *BODDY JR., 2682
RON W. *BODINE, 5079
DEAN G. BOERRIGTER, 9868
EDMUND J. BOHN, 6794
ERIC J. *BOLLINGER, 7030
PETER J. *BOLLINGER, 1068
ROBERT P. *BONGIOVI, 6760
NICOLE A. BONTRAGER, 8473
BRENT M. *BOOKER, 9806
EUGENE A. BOOTH JR., 1312
RALPH W. *BOOTH, 6964
DONALD J. *BORCHELT, 9279
JAMES B. *BORDERS, 8660
BRETT J. *BORGHETTI, 5743
OLEG BORUKHIN, 6838
WILLIAM K. BOSCH, 6193
SCOTT L. BOUSHELL, 0504
PAUL S. BOVANKOVICH, 4460
SCOTT R. *BOWEN, 9084
CORY W. BOWER, 2511
ANDREW S. *BOYD, 2182
MARK H. BOYD, 3155
CHERRYL A. *BOYETTE, 7987
ROOSEVELT F. BOYLAND JR., 1967
ANDREW J. BRACKEN, 3571
ERIC D. *BRADSHAW, 7413
DANIEL M. *BRANAN, 8898
DANIEL E. *BRANT, 3082
TROY A. J. BRASHEAR, 1967
JAMES A. *BRAUNSCHNEIDER, 0949
FREDERICK C. BRAVO, 2448
PAUL D. *BRAWLEY JR., 4863
PATRICK R. *BREAUX, 8146
STEVEN J. BREEZE, 5684
JASON M. *BRENNEMAN, 2901
JOSEPH D. BREWER, 9612
JOHN A. *BREWSTER, 0698
ALEXANDER W. BRID, 3665
YUSEF D. BRIDGES, 5225
LARA C. *BRINSON, 6129
RICHARD S. *BRISCOE, 1518
KERRY D. *BRITT, 0982
EDWARD S. BRODERICK JR., 7434
KEVIN W. *BROOKS, 0975
ERIC D. *BROWN, 6304
HAL D. BROWN, 8449
NICOLE R. *BROWN, 5102
ROBERT G. *BROWN, 8912
SCOTT M. *BROWN, 1502
DAVID F. *BROWNING, 6342
KENNETH W. *BROWNING, 1919
DENISE M. BRUCE, 8774
BRIAN R. *BRUCKBAUER, 8225
NEAL W. *BRUEGGER, 0325
MARY J. *BRUNE, 1459
MICHAEL A. BRUZZINI, 6077
JOHN N. *BRYAN, 2562
ALBERT D. BRYSON, 3218
BRIAN G. *BUCK, 9765
JOHN S. *BULLDIS, 3762
RICHARD K. *BULLOCK, 3759
LANCE R. BUNCH, 1100
DONALD D. *BUOL, 7318
JEFFREY S. BURDETT, 5521
CHRISTOPHER W. *BURELLI, 9019
JOSHUA C. BURGESS, 3040
MICHAEL D. *BURK, 6272
STEVEN J. BURNS, 5573
BRIAN J. *BURNSIDE, 7605
ALVIN F. *BURSE, 9011
DEANNA M. BURT, 8952
ANGELA J. *BURTH, 3970
THOMAS F. BURTSCHI, 4354
FREDERICK E. *BUSH III, 9362
VIVIAN *BUSH, 4171
BRENT B. BUSS, 9590
RICHARD D. *BUTLER, 4774
WADE C. BUXTON, 4852
STEVEN M. *BUZON, 3271
CHRISTINE M. *BYERS, 7762
CHRISTOPHER L. BYROM, 2064
DENNIS O. *BYTHEWOOD, 5904
STEVEN R. CABOSKY, 8755
WILLIAM M. *CAHILL, 7470
JOHN D. *CAIN, 9855
PAUL D. CAIRNEY, 9640
LLENA C. *CALDWELL, 0442
PHILIP M. *CALI, 8642
KENNETH D. CALLAHAN, 3466
JAMES H. CAMARENA, 6575
JEFFREY B. *CAMPBELL, 7895
JEFFREY S. CAMPBELL, 5220
MICHAEL G. *CANCELLIER, 7605
JIMMY R. *CANLAS, 4467
MONTE R. CANNON, 3520
TODD D. *CANTERBURY, 9540
CHRISTOPHER E. *CANTRELL, 4313
ANTHONY B. CAPOBIANCO II, 2238
CHRISTOPHER P. CAPUTO, 9968
MICHAEL R. CARDOZA, 5612
SCOTT H. CARDOZO, 1966
JOEL L. CAREY, 1142
LANCE A. *CARMACK, 5870
STEVEN C. *CARMICAL, 6274
DENNIS F. *CARON, 6059
BRIAN L. CARR, 2135
KELVIN B. *CARR, 5771
ERIN Y. *CARRAHER, 7968
STEPHEN T. CARSON, 6344
BRENDA P. *CARTIER, 1884
ALAN M. *CARVER, 7013
KENNETH R. CARYER, 3757
DONALD *CASNE, 1577
EUGENE G. CASSINGHAM, 8481
ELIZABETH A. CASSTEVENS, 9245
DEAN J. CATALANO, 8522
GREGORY T. *CATARRA, 9974
JOHN M. *CATES, 6025
JOSEPH R. CDEBACA, 7873
BRYAN K. CESSNA, 2514
MICHAEL W. *CEULE, 3868
TIMOTHY P. *CHAMERNIK, 0785
JACK G. *CHARLESWORTH, 8807
HASTINGS M. CHASE, 5862
ROBERT M. *CHAVEZ, 9302
SAMUEL J. CHESNUT IV, 2364
JASON J. E. *CHILDS, 7384
VINCENT J. CHIOMA, 2540
DAVID B. CHISENHALL JR., 9301
DAVID P. *CHRISMAN, 0814
KENT A. *CHRISTEN, 0673
TERRY L. CHRISTIANSEN, 9711
ROWENA *CHRISTIE, 0512
CHAD L. *CHRISTOPHERSON, 4663
MATTHEW C. CICCARELLO, 2918
JEFFREY S. *CIESLA, 8384
ROBERT O. *CIOPPA, 7236
ANNE L. CLARK, 5975
MICHAEL J. CLARK, 6011
JONATHAN B. CLAUNCH, 7149
CHRISTINA M. CLAUSNITZER, 9402
JOSEPH R. *CLAWSON JR., 3015
HERBERT L. CLAYTON, 6655
JOHN D. *CLAYTON, 1665
JAMES *CLEGERN, 2755
JASON E. CLEMENTS, 7866
PHILIP A. CLINTON, 0419
MELISSA A. COBURN, 8425
NILES M. COCANOUR, 6142
STEPHEN B. *COCKS, 6187
SHAWN M. *COCO, 7064
JED S. *COHEN, 3960
PETER J. COHEN, 0210
DEIRDRE A. *COKER, 5519
CHRISTOPHER R. COLBERT, 2385
OMAR S. *COLBERT, 0451
MICHAEL D. *COLBURN, 0324
BARRY W. COLE, 8496
DARREN R. COLE, 6528
HERMAN A. COLE III, 2608
STAN G. COLE, 4137
JAMES E. COLEBANK, 4913
ANTHONY E. COLEMAN, 4007
BRIAN D. COLLINS, 0925
TODD A. *COLLINS, 0168
MARK W. P. *COLLISON, 1946
KEITH A. COMPTON JR., 5215
MICHAEL J. *COMTOIS, 7188
VERNON W. CONAWAY IV, 0495
CHAD L. *CONERLY, 8557
KURT E. *CONKLIN, 3868
WILLIAM J. CONLEY, 9657
JOHN P. CONMY, 3699
SIDNEY S. CONNER, 6647
MICHAEL A. CONNOLLY, 4739
DEREK T. *CONTRERAS, 3484
JOEL O. *COOK, 6740
MICHAEL R. *COOK JR., 2832
WANDA D. *COOK, 6650
BERT *COOL, 1722
BRYAN S. COON, 1968
CHARLES J. COOPER, 2238
JAMES A. COPHER, 7914
THOMAS *COPPERSMITH, 3362
CHRISTINE E. *CORBETTCOLE, 4947
DAVID A. CORBY, 0090
CHARLES S. CORCORAN, 7428
GREGORY B. *CORKERN, 9131
SIMON D. *CORLEY, 7943
DYLAN R. CORNWELL, 3591
MATTHEW M. P. *COSTA, 9337
MICHAEL L. *COTE, 7564
SHERMAN L. COTTRELL, 0797
JON E. COUNSELL, 1298
MICHAEL S. COURINGTON, 7702
WILLIAM R. *COVERT, 0347
CHRISTOPHER C. *COX, 8469
STEVEN M. COX, 5650
ROBERT D. *COXWELL, 0352
ANGERNETTE E. *COY, 5991
MICHELLE L. *COZORT, 0712
CHRISTOPHER P. COZZI, 2898
ADRIANE B. *CRAIG, 9692
TODD A. CRAIGIE, 1137
JAMES W. CREESE, 1003
BRENT R. *CRIDER, 8589
BRADLEY M. *CRITES, 8574
IRIS I. *CRITTEN, 6879
BARRY L. *CROOK, 8634
BEN D. *CRUNK, 1777
ALBERTO E. CRUZ, 6871
BERNARD A. *CRUZ, 1028
ENRIQUE A. CRUZ, 4985
KEVIN P. CULLEN, 3508
WILLIAM C. CULVER, 2071
MICHAEL W. CUMMINGS, 2841
FRANKLIN E. *CUNNINGHAM JR., 7838
SEAN T. CURRAN, 7739
KENT S. CURRIE, 2523
JACKSON BENITA F. *CURRY, 6962
LAVERN E. *CURRY JR., 4022
ELIZABETH D. *CURTIS, 4897
RUSSELL V. *CUSTER, 8938
TIMOTHY S. CUTLER, 4136
ROGER C. *CUTSHAW, 9254
ALEXANDER J. *CZERNECKI III, 4470
PATRICK W. DABROWSKI, 8790
MICHAEL P. *DAHLSTROM, 5947
SCOTT C. *DAIGLE, 6860
DANIEL F. DAILEY, 7737
GEORGE C. *DALTON II, 8874
DEAN M. *DANAS, 2942
JANINE L. *DARBY, 0719
RENE W. *DARBY, 7911
ARTHUR D. *DAVIS, 1522
DEREK C. *DAVIS, 6120
DONALD J. DAVIS, 1287
ERIC S. *DAVIS, 3746
GEOFFREY V. *DAVIS II, 4502
LEVERTIS *DAVIS JR., 3065
PATRICK W. *DAVIS, 3173
THOMAS E. DAVIS, 5256
MICHAEL J. DEAN, 4288
ERIC F. *DELAGE, 7726
BRIAN J. DELAMATER, 9181
DOUGLAS C. DELAMATER, 4958
CHARLES J. DELAPP II, 5666
JAMES W. *DELOACH, 0919
JAMES M. *DELONG, 6617
SCOTT A. *DELORENZI, 3260
CHRISTOPHER *DELOSSANTOS, 1765
ELIZABETH A. DEMMONS, 1196
RICHARD W. *DEMOUY, 9024
THOMAS E. DEMPSEY III, 2783
JEFFREY G. *DEMUTH, 7337
GARY D. *DENNEY, 6118
CHAD P. *DERANGER, 0570
MARK M. DERESKY, 1604
ABNER *DEVALLON, 3219
JEFFREY W. DEVORE, 0183
LARUE R. DEWALD III, 4562
JAMES C. *DEWEY, 1656
JOHN H. DEYARMON, 6231
BRIAN C. *DICKINSON, 7948
MICHAEL A. *DICKINSON, 0639
DAVID W. *DIEHL, 9147
TOR F. *DIETRICHS, 9508
BEBE D. *DIGGINS, 4616
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ROBERT J. DITTMAN, 4672
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BRANDON K. DOAN, 2145
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CASEY P. *DODDS, 1027
MICHAEL A. DODSON, 8265
MICHAEL R. *DOMBROWSKI, 7056
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ROBERT A. DOWNEY, 7275
JAMES F. *DOWNS, 2214
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NORMAN A. DOZIER, 0301
TODD A. DOZIER, 8748
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KERRY A. *DRAKE, 7030
THOMAS G. DRAPE, 1310
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JAMES D. DRYJANSKI, 9365
ANTHONY W. DUBOSE, 1041
BRIAN A. DUDAS, 4896
PETER A. *DUGAS, 7676
MICHAEL T. *DUMOND, 7675
PERCY E. DUNAGIN III, 5908
WALTER E. *DUNBAR III, 4629
JAMES W. DUNN, 7264
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CHARLES A. DURFEE, 9592
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DAVID W. *DYE, 1511
DIANNE C. *DZIALO, 2835
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MICHAEL B. *ELTZ, 6396
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JAMES N. ENGLE, 9338
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STEPHANIE F. *EPPLER, 4063
JOHN W. *ERICKSON, 0481
JOHN B. *ESCH, 5120
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JOHN L. *FENTON, 0025
KAREN M. FERGUSON, 9219
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DANIEL J. *FIEDLER, 8456
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THOMAS J. FINNERAN, 7531
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JERRY J. FLANNERY, 5183
ROBERT L. FLETCHER, 8029
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MICHAEL R. FLORIO, 4659
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TODD A. *FOGLE, 4124
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BRYAN W. *FOREMAN, 8001
SCOTT A. *FOREMAN, 9999
MARK A. *FORMICA, 1268
KYLE C. *FORRER, 7612
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SCOTT A. *FOY, 7979
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JOHN H. *FRASER, 8918
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RICHARD P. *GALLEY, 6588
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ALEJANDRO *GOMEZ JR., 5806
JAIME *GOMEZ JR., 5143
HECTOR L. *GONZALEZ, 0626
LONGINOS GONZALEZ JR., 4990
PEDRO I. GONZALEZ, 8246
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DANIEL F. *GOTTRICH, 9413
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JAMES E. *GRAY, 5186
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TREVOR E. GRAY II, 0496
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JASON D. GREEN, 7278
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JAMES C. *GREENE, 7497
KEVIN D. *GREENE, 4156
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MICHAEL D. *HADDOCK, 3587
KEVIN R. HAFF, 7701
THOMAS M. HAGAN, 1141
DIANA L. *HAJEK, 6686
ALEXANDER G. HALDOPOULOS, 0496
CHARLES T. *HALEY III, 8237
JOSEPH E. HALL, 3348
TIMOTHY J. *HALL, 5091
WILLIAM D. *HALL, 8073
BRIAN K. *HALLER, 5422
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VINCENT L. HAMACHER, 1366
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STEPHEN F. *HAMLIN, 4252
TODD E. HAMMONDS, 1452
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FREDERICK G. *HARMON, 1746
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RODNEY C. HARRIS, 5334
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JARROD H. *HATFIELD, 4830
JANET J. *HAUG, 3260
HANS P. *HAUSSLER, 8191
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JAMES A. *HAWKINS JR., 0762
JAMES M. *HAYES, 0765
RUSSELL A. *HAYES, 8958
STEPHEN P. *HAYES, 9798
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JAMES M. *HAYNIE, 8178
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ARTHUR J. *HEAPHY III, 0671
DAVID *HEDGER, 1138
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BARRY T. *HEILING, 4519
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TIMREK C. HEISLER, 1240
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LANDON L. *HENDERSON, 9074
PAUL E. *HENDERSON, 1369
RICHARD D. *HENDERSON, 2186
JEFFEREY T. *HENNES, 2670
JOHN S. *HENRY, 8919
DONALD M. HENSLEY JR., 8338
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BRETT T. *HERMAN, 4432
MICHAEL F. HERNANDEZ, 6749
ROBERT E. HERNDON JR., 0250
STEPHEN J. *HERRMANN, 1448
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MARCUS W. HERVEY, 6727
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WILLIAM K. *HIBBARD, 0200
SHAUN R. *HICK, 7971
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LAWRENCE C. *HICKS, 6546
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DWIGHT H. *HINTZ JR., 7349
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MICHAEL S. HOPKINS, 4709
MARK D. *HORONY, 5772
MICHAEL S. *HOUGH, 3447
BRET L. HOUK, 4997
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JEFFREY F. *HUBER, 0872
THOMAS C. HUDNALL, 4057
ANDREW D. *HUGG, 1332
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JEFFREY W. HUMPHRIES, 1478
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RHYS W. *HUNT, 7287
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GARY G. *HUTFLES, 8220
JOHN P. HUTTON, 1022
RONALD E. *HUZZARD, 6253
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GEORGE W. *IRVING IV, 7470
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JEAN K. IWAI, 7974
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JOHN W. *JACKSON, 8182
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CRAIG P. JOHNSON, 8520
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DERRICK W. *JOHNSON, 0598
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JESSE L. JOHNSON JR., 2225
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MONTE A. JOHNSON, 9024
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RAY A. *JONES, 2359
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WILLIAM R. *JONES, 8974
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ELLIOTT G. *JOURDAN, 6099
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MACE R. KANT, 0152
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GREG A. *KENT, 3013
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AZAD Y. *KEVAL, 4976
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JOHN F. *LANDOLT III, 6060
LANCE K. LANDRUM, 8015
GRANT E. *LANG, 9801
JARA N. LANG, 0255
ANDREW D. *LANGFELD, 7529
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JEFFRY P. *LAUTH, 6204
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MICHAEL D. LAY, 8059
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DOUGLAS J. *LEE, 3568
JEFFREY A. *LEE, 6220
RICHARD E. *LEE, 7023
JEFFREY P. *LEEDER, 3942
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CHAD E. *LEMAIRE, 5727
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CLARENCE W. LUKES JR., 4529
LOUISE J. *LYLE, 5285
MARC A. *LYNCH, 7842
JOHN W. LYONS, 2413
JOSEPH E. *MACCAFFREY, 8122
ROBERT S. MACKENZIE, 7539
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WILLIAM J. *MACLEAN, 0100
WILLIAM M. MACMILLAN IV, 1693
MARK W. *MADAUS, 4120
TRACI R. *MADISON, 6883
STEPHEN W. MAGNAN, 9758
MATTHEW T. *MAGNESS, 6445
DOUGLAS L. *MAGOFFIN, 7310
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NATHANIEL E. *MAJEAN, 2642
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PAUL G. *MALACHOWSKI, 3511
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JOHN D. *MARTIN, 1271
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SCOTT B. *MATTHEWS, 8941
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DAVID L. *MCCLANAHAN, 8422
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CHRISTOPHER R. *MCCORMICK, 4017
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BRIAN V. *MCDANIEL, 0580
KENNETH R. *MCDONALD, 7618
SEAN R. *MCELHANEY, 2840
GAYLORD E. *MCFALLS, 9849
BRIAN P. MCGILL, 7514
STEPHEN F. MCGRATH, 6973
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WILLIAM A. MCGUFFEY, 2416
ROBERT H. *MCINTYRE, 5026
SEAN S. *MCKENNA, 8439
RICHARD J. *MCMULLAN, 1475
DANIEL W. MCNEILL, 4850
TIMOTHY T. *MCNICHOLS, 3164
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WILLIAM PAUL MILLER JR., 8966
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DARRYL L. *MITCHELL, 2050
MICHAEL R. *MITCHELL, 8591
MICHAEL J. *MLYNARCZYK, 9850
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JACQUELINE M. MONGEON, 9181
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WADE A. *MUELLER, 8511
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JOHN R. *MURRAY, 0232
JOSEPH W. MURRIETTA, 2280
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JOHN P. *NELSON, 3796
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KARA K J *NEUSE, 6840
ARTHUR J. NEWSOME, 7973
HIEN T. NGUYEN, 3733
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BRADLEY W. *NICHOLS, 6149
DANIEL C. *NICHOLS, 2761
JOHN J. NICHOLS, 4377
DAVID M. *NICHOLSON, 2423
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ALLAN ANDREW *NILLES, 9158
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JEREMY J. *NOVAK, 7232
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SCOTT R. NOWLIN, 9177
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EDWARD M. *OCHOA, 0560
RUSSELL G. *OCHS, 4019
JOHN P. *OCONNOR, 4083
MICHAEL A. OCONNOR, 5209
BRIAN D. *OELRICH, 0509
MARGARET M. *OHARA, 7902
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JON M. OLEKSZYK, 2054
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PHILLIP STEVEN *OPELA, 5694
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DEAN P. ORFIELD, 9716
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AARON M. *ORR, 0598
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JOHN D. *PASSMORE, 0384
REGAN J. *PATRICK, 9426
TIMMOTHY L. PATTERSON, 4501
CHAD A. *PATTON, 0196
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DEREK J. PAULK, 9985
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DAVID A. *PAVILAITIS, 5404
JEFFREY P. *PEARSON, 7742
MARK E. *PEARSON, 1656
TROY D. *PEARSON, 3583
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STEVEN A. PEEPLES, 0314
KENNETH V. PEIFER, 8827
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DANA C. *PELLETIER, 6487
KEITH A. PELOQUIN, 0298
TOMAS A. *PENA, 4244
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DOUGLAS W. *PENTECOST, 8757
LINDA N. PEPIN, 5542
PAUL E. PEREIRA, 2128
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ROBERT L. *PHILLIPS, 5159
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BRIAN S. *PITCHER, 9333
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WILLIAM H. *POE, 6521
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MARK E. POLOMSKY, 6906
STEPHEN A. *POLOMSKY, 2669
JEFFREY D. POMEROY, 0054
JAMES S. *POMPANO, 8949
JOSEPH G. *PORRAZZO, 3234
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JAMES A. *POTZAUF, 4980
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DANIEL T. *POWERS, 7860
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ARTHUR W. PRIMAS JR., 3853
DENNIS L. *PRIMOLI II, 6461
JONATHAN M. *PRINDLE, 6141
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JOHN G. *PUGH, 8171
SHAWN C. PURVIS, 4349
TIMOTHY K. *PYEATT, 8144
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DANIEL R. *QUEEN, 8663
ROBERT J. *QUIGG IV, 5127
MARK D. *QUIGLEY, 9934
PAUL J. QUIGLEY, 2968
AARON S. QUINICHETT, 5259
JAMES A. *QUINN, 2091
MICHAEL R. QUINTINI JR., 7444
JOHN F. RADCLIFFE, 4685
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BLANE J. RASCH, 9208
CLINT L. *RASIC, 6580
BRUCE J. *RASK, 4486
CHRISTOPHER R. RATE, 3538
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MICHAEL T. *RAWLS, 3720
BRIAN J. *RAY, 0461
THOMAS P. REARDON, 3366
HOWARD T. REDD, 7230
KEITH W. REEVES, 8228
BRAXTON D. *REHM, 7999
RHONDA K. REICHEL, 8450
JAMES R. *REID JR., 3693
JOSEPH T. REIDY, 9324
CHRISTOPHER S. *REIFEL, 2972
WILLIAM C. *REIGELSPERGER, 1698
MARK P. *REIMANN, 2146
MICHAEL C. *REINERS, 6125
SCOTT W. REINHARD, 7980
GREGORY S. *REINHARDT, 9929
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ROBERT A. *RENNER, 5161
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JOSEPH P. RICHARDS, 4777
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THOMAS E. *RICHARDSON, 8175
DAVID A. *RICHESON, 8091
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GLEN A. *ROBERTS, 6715
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AMY R. ROBINSON, 0750
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DWAYNE M. *ROBISON, 6242
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SCOTTLAND L. RODDY, 0437
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ROBERT L. K. ROE, 8444
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RICHARD D. *ROGERS, 2453
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CHAD W. *RUSSELL, 9278
JOHN H. RUSSELL, 4149
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ANDREW J. RYAN, 4278
DANIEL B. *RYAN, 2462
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MATTHEW B. RYTTING, 5901
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JAMES R. *SAGE, 6900
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DANIEL E. *SALGADO, 0598
CARLOS V. *SALINAS, 8678
BENNETT T. SAMUELS, 8438
FRANK D. *SAMUELSON, 8904
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BRIAN S. *SANDLIN, 1407
DORAL E. SANDLIN, 9764
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TIMOTHY A. *SANDS, 8962
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MATTHEW D. *SANFORD, 7606
MICHAEL G. *SANJUME, 1589
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REX E. SAUKKONEN, 4047
TODD A. *SAULS, 0115
MICHAEL W. *SAUTER, 8930
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DOMINIC R. *SAYMO, 6338
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JEFFREY S. *SCARBROUGH, 3549
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HERMAN D. *SCHIRG, 2105
MICHAEL *SCHLOTTERBACK, 4828
THOMAS L. *SCHMIDT, 3194
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JOHN P. SCHOEPPNER III, 9913
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SCOTT S. *SHIGETA, 0162
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JOHN W. *SHIRLEY, 3473
LISA C. *SHOEMAKER, 8369
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CHRISTOPHER M. SMITH, 8204
DAVID C. *SMITH, 4524
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JASON A. SMITH, 0932
JEFFREY T. *SMITH, 6116

KENNETH A. *SMITH, 2920
KEVIN D. *SMITH, 7022
LESLIE T. SMITH JR., 6287
MARK D. SMITH, 6215
MATTHEW D. SMITH, 0507
MATTHEW T. *SMITH, 7992
MICHAEL R. *SMITH, 8842
RANDALL E. *SMITH, 9466
RICHARD L. *SMITH, 7641
ROBERT E. SMITH II, 8431
STEPHEN F. SMITH JR., 5296
WILLIAM G. SMITH, 9960
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DAVID W. *SNODDY, 6547
ROBERT D. *SNODGRASS, 1403
LISA M. *SNOW, 2614
MATTHEW O. SNYDER, 6936
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ALAN N. *SPARKS, 4201
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AARON W. STEFFENS, 5201
CONRAD R. STEGEMAN, 0235
MARK A. STEGER, 9887
CINDY D. STEIN, 3161
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RONALD D. STENGER, 8839
RODNEY A. STEPHAN, 6510
MARK A. STEPHENS, 1711
MICHAEL D. *STEPHENS, 5285
MICHAEL J. *STETINA, 0564
LAWRENCE J. *STETZ, 9348
TODD A. *STEVENS, 1280
LISA Y. STEVENSON, 3576
MICHAEL S. STEVENSON, 9725
PHILLIP A. *STEWART, 2239
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WILLIAM M. *STOWE III, 6722
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MARK E. *STRATTON, 7242
PHILLIP G. *STRATTON, 7174
WILLIAM J. STRAUS III, 9992
SUZANNE M. STREETER, 8164
KRISTIN M. STREUKENS, 2692
SCOTT L. *STROHECKER, 6825
BERNARD J. STROUTH, 0423
GENA R. STUCHBERY, 3000
STEVE S. SUGIYAMA, 4881
CHRISTOPHER P. *SULLIVAN, 0689
JIMMIE E. *SULLIVAN JR., 0753
SHANE T. *SULLIVAN, 9189
TROY L. SULLIVAN III, 4197
WILLIAM S. *SULLIVAN, 2490
BRIAN A. *SUNDERMEYER, 3639
TIMOTHY J. SUNDVALL, 7870
JONATHAN A. *SUTHERLAND, 9193
DAVID K. SUTTON, 1797
RICHARD C. *SUTTON, 2139
THOMAS T. *SWAIM, 2232
JENNIFER E. SWAIN, 4608
DAVID J. SWANKE, 2097
SCOTT R. SWANSON, 8484
TIMOTHY J. *SWEENEY, 5972
ZACHARY S. *SWEENEY, 0492
DOUGLAS H. *SWIFT, 4230
CARRIE R. *SYCK, 5720
DAVID H. *TABOR, 2151
RANDALL A. *TABOR, 4416
JAMES W. TANIS, 0017
DAVID A. *TAYLOR, 3721
FRED D. TAYLOR, 7252
JAMES M. *TAYLOR, 6228
JOHN D. TAYLOR, 1074
ROBERT M. TAYLOR II, 6499
CHRISTINE A. TEDROW, 2778
MARK A. *TEDROW, 7373
RAYMUND MICHAEL *TEMBREULL, 0487
MICHAEL E. TENNEY, 7054
RONALD J. TEWKSBURY II, 2729
CRAIG G. THEISEN, 1826
ALLAN P. *THILMANY, 3232
ANTHONY L. *THOMAS, 9169
GREGORY D. THOMAS, 0616
JOHN J. *THOMAS, 0724
JOHN N. *THOMAS, 0840
SPENCER S. *THOMAS, 3986
IAN O. THOMPSON, 9392
NEAL R. THOMPSON, 2703
PHILLIP J. THOMPSON, 9823
SCOTT T. THOMPSON, 0241
DANIEL M. THORN, 2664
DENNIS R. *THORNE, 5717
BRIAN C. *TICHENOR, 2824
SEAN P. *TIERNAN, 3474
KENT J. *TIFFANY, 3528
DARREN W. *TILLMAN, 1032
JASON A. *TIMM, 7140
ROBERT M. TOBLER, 9357
JOHN T. *TODD, 9103
PAUL A. *TOMBARGE, 5323
DAVID R. *TONI, 8271
STEPHON J. TONKO, 4478
THOMAS D. TORKELSON, 3294
STEPHEN B. *TORRES, 5471
KELVIN J. *TOWNSEND, 9946
TIMOTHY J. TOWNSEND II, 6539
BRIAN M. TOY, 7316
MICHAEL J. TRAVIS, 2029
EDWARD D. V. *TREANOR, 6607
JOSEPH M. *TRECHTER, 9117
STERLING E. TREE, 3059
BRIAN H. *TRENHOLM, 7892
ROBERT B. *TREPTON, 3757
ROBERT W. *TRIPLETT, 4957
GEORGE E. *TROMBA, 6569
DAVID C. *TRUCKSA, 4890
PETER A. *TSCHOHL, 1270
CLAUDE K. *TUDOR JR., 8459
DANIEL H. *TULLEY, 6654
DAVID P. TUPAJ, 5126
MICHAEL E. *TURBYFILL, 4600
ERIC S. *TURNER, 4927
JEFFERSON E. *TURNER, 5035
CHRISTAN L. *TUTTLE, 0996
JAMES R. TWIFORD, 9431
ROBERT T. *TYNAN, 8485
MICHAEL D. TYYNISMAA, 8720
ERIC A. UJFALUSY, 1101
AARON L. *ULLMAN, 9499
JOHN R. *UNDERHILL, 5646
SHAWN C. *UNDERWOOD, 9655
SAMUEL B. *URSO III, 4611
DAVID A. *VALENTINE, 3051
ANTHONY E. VALERIO, 7163
JAMES P. *VALLEY, 2494
WENDY R. *VAN EYK, 2410
TODD C. *VANDYKE, 3125
JEFFREY *VANSANFORD, 4828
DEREK D. VARBLE, 9445
RUBEN C. *VARGAS, 7166
CARLOS A. *VECINO, 5341
PETER C. VEHLOW, 6381
ROBERT J. *VERCHER, 4975
JAMES K. *VICKERS, 0935
JESSE E. VICKERS, 3155
ROBERT A. VICKERS, 2050
ORLANDO E. *VILCHES, 6488
JEFFREY A. VISH, 4414
CHRISTOPHER L. *VOEHL, 4110
SCOTT J. *VOLK, 0325
JOHN C. VOORHEES, 0931
WILLIAM E. *WADE JR., 3539
MICHAEL V. WAGGLE, 9343
SAMUEL D. *WAGNER, 4879
RALPH J. WAITE IV, 0898
TODD S. WALDVOGEL, 2391
JEFFREY R. *WALES, 9995
ALEXANDER W. *WALFORD, 8797
BRIAN P. WALKER, 0797
MARK M. *WALLACE, 7398
MATTHEW V. *WALLACE, 0477
JENNIFER L. WALLER, 3844
KARL C. *WALLI, 2511
JOERG D. *WALTER, 2469
MARK D. *WALTERS, 0927
EDWINA M. WALTON, 2164
ROBERT W. *WANNER, 9175
DAVID J. *WAPELHORST, 0892
BRADLEY J. WARD, 9257
DONNA M. WARD, 4746
SCOTT C. WARD, 6721
SCOTT L. *WARD, 0005
JEFFREY S. WARDELL, 5454
JAMES E. H. WARMA, 7775
JEFFREY E. WARMKA, 9314
RONALD B. WARREN, 9785
MICHAEL P. *WATERS, 7642
MARY MELISSA N. *WATKINS, 9279
AARON C. WATSON, 9358
ERIK D. *WEAVER, 3938
GAIL M. *WEAVER, 7281
TERI J. *WEAVER, 3064
ANDREW G. *WEBSTER, 6370
RICKY A. *WEDDLE, 5524
SCOTT D. *WEENUM, 7354
CHRISTOPHER M. *WEGNER, 2295
THEODORE G. WEIBEL, 9800
TROY B. *WEINGART, 5138
MICHAEL T. WEISS, 3218
MICHAEL R. *WELBORN, 0270
KEITH A. *WELCH, 8637
JULIE L. *WENDE, 5024
BRADLEY R. WENSEL, 6490
EDWARD J. WERNER, 6560
KEVIN G. WESTBURG, 3438
DANIEL J. *WHANNELL, 3023
MICHAEL D. WHEELER, 4581
TERENCE D. *WHEELER, 7938
VICTOR B. *WHEELER, 6986
WESLEY L. *WHITAKER, 3643
CHAD H. WHITE, 8728
CRYSTAL A. *WHITE, 2031
GARY L. *WHITE, 1389
JASON D. WHITE, 4566
SAMUEL G. WHITE III, 9080
STEVEN D. *WHITE, 4007
TED N. *WHITE, 7042
TODD A. *WHITE, 1501
EVAN L. *WHITEHOUSE, 8359
BRENT R. *WHITNEY, 0933
JAMES T. *WICKTOM, 7815
SCOTT D. WIERZBANOWSKI, 9204
MARA C. *WIGHT, 6345
LANCE R. WIKOFF, 9180
JOHN T. WILCOX II, 7544
DAVID P. *WILDER, 3622
VICTOR D. *WILEY, 3409
RICHARD *WILGOS, 0507
SHANE C. *WILKERSON, 8530
BRETT D. *WILKINSON, 3861
JON C. *WILKINSON, 1718
CHRISTOPHER S. WILKOWSKI, 4563
BENJAMIN G. WILLIAMS, 9708
CHARLES L. *WILLIAMS, 3555
DARRELL L. *WILLIAMS, 9197
KENT A. *WILLIAMS, 6825
PAUL N. WILLIAMS, 6185
RASHEAD J. WILLIAMS, 8679
STEVEN D. WILLIAMS, 2122
MARK L. WILLIAMSON, 9234
DARRYL M. *WILLIS, 0592
DANIEL L. *WILSON, 2513
JACQUE J. WILSON, 0675
JACQUELINE R. *WILSON, 8382
JOEL B. *WILSON, 4066
JOHN H. WILSON, 4069
KEVIN A. WILSON, 1731
WILLIAM V. WINANS, 4806
RANDOLPH L. *WINGE, 2531
JENNIFER L. *WINSLOW, 4212
LYNN H. WINWARD, 3185
GARY L. WITOVER, 0949
MARK D. WITZEL, 9140
JASON D. WOLF, 3412
PATRICK F. WOLFE, 0259
TIMOTHY A. *WOLIVER, 6094
STUART L. *WOLTHUIS, 8080
ANN *WONGJIRU, 6299
ZUN YING *WOO, 8749
BRIAN S. *WOOD, 6203
CAROLYN L. WOOD, 5521
MARK A. *WOODARD, 0374
BOBBY C. *WOODS JR., 9194
JAMES J. *WOODS JR., 6363
RANDAL W. *WORKMAN, 4413
CHRISTOPHER A. WORLEY, 1365
DALE W. *WRIGHT, 3270
DONALD L. *WRIGHT JR., 8196
JENNIFER L. WRYNN, 1115
TINA M. *WYANT, 5672
MARK A. *WYATT, 8513
HERBERT D. *WYMS, 6628
DIANA J. *WYRTKI, 8359
SCOTT D. YANCY, 6035
DAVID J. *YAO, 6334
CULLA L. YARBOROUGH, 8087
ROBERT L. YARBROUGH JR., 5324
WALTER K. *YAZZIE, 0036
MATTHEW H. YETISHEFSKY, 0956
DAVID T. YOUNG, 0611
THOMAS R. *YOUNG, 0461
THEODORE T. *YUN, 6827
KENNETH J. *YUNEVICH, 9137
ROBERT L. ZABEL JR., 4428
TIMOTHY A. ZACHARIAS, 2198
DENNIS K. ZAHN, 9337
JAMES C. *ZEGEL, 9363
MATTHEW S. *ZICKAFOOSE, 4229
DAVID Q. *ZIEGLER, 6699
SEAN E. ZORTMAN, 2672
MATTHEW E. ZUBER, 0755
PAUL M. *ZULUAGA, 4651
ANNAMARIE *ZURLINDEN, 2429

IN THE ARMY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

WILLIAM A. BENNETT, 2216
RUTH M. HARRIS, 4937
MURTY SAVITALA, 7912
CHARLES B. TEMPLETON, 0117

THE FOLLOWING NAMED ARMY NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12211:

To be colonel

JOHN W. BAILEY, 3874
VINCENT J. DEMAGGIO, 6902
REYNOLD N. HOOVER, 9679
THEODORE D. JOHNSON, 0232
ANTHONY P. LIBRI JR., 0867
DANIEL N. RODECK, 2993
MARVIN R. SCHLATTER, 7821
JAMES R. SMITH II, 0328
JOYCE L. STEVENS, 9764

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY UNDER TITLE 10, U.S.C., SECTION 624:

To be lieutenant colonel

ALONZO C. CUTLER, 6560

THE FOLLOWING NAMED ARMY NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12211:

To be colonel

DOMINIC D. ARCHIBALD, 9006
DAVID N. BLACKORBY, 8651
JAMES T. KEEFNER, 4151
PAUL J. PENA, 1936
EDWARD J. ROUGEMONT, 9902
MICHAEL A. SAINZ, 7960
RICHARD L. THOMAS, 3659

THE FOLLOWING NAMED ARMY NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12211:

To be colonel

RICKY W. BRANSCUM, 1922
MICHAEL T. HAMIL, 4230
RAYMOND L. HULINGS, 8450
JEFFERY D. KINARD, 7057
KENNETH D. LEE, 6094
RICHARD N. MEADOWS, 7324
JERRY E. REEVES, 0285
FREDERICK O. STEPAT, 9592

THE FOLLOWING NAMED ARMY NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12211:

To be colonel

CURTIS W. ANDREWS, 6511
RUFINO I BETANCOURT, 8399
JAMES E. GRAYSON JR., 1309
WILLIAM J. HORAM, 8207
TERRY A. JOHNSON, 3095
MARTIN E. KIDNER, 6820
DAVID F. SCHMIDT, 3959
DANNY K. SPEIGNER, 8891
THOMAS F. STEPHENSON, 4772

CONFIRMATION

Executive nomination confirmed by the Senate July 18, 2002:

THE JUDICIARY

RICHARD R. CLIFTON, OF HAWAII, TO BE UNITED STATES CIRCUIT JUDGE FOR THE NINTH CIRCUIT.