technology, but it is not for a select few; they are facilities used by all Americans in every State wherever you live.

I cannot overstate that in my region of the country or in my State it will not be a particular problem. It will be. But that burden is shared by all States. Because of this, when we confronted the issue of two previous Medicare give-back bills to compensate for the balanced budget amendment, Congress in 2000 and 2001 maintained the 6.5-percent IME adjustment. As I have noted to my colleagues, that expires on October 1. Automatically, it will return to a 5.5-percent adjustment. This is a 28-percent reduction in funding at teaching hospitals. The consequences are that over 5 years, $5.6 billion will not go for medical breakthroughs in AIDS, cancer, or heart disease; $5.6 billion is not available to teach and train the next generation of America's doctors; and $5.6 billion is not available to deal with the most difficult medical problems in the country.

This chart illustrates the degree of loss. Mr. President, 1,116 teaching hospitals in America will lose next year $784 million and, over 5 years, $4.2 billion.

In my State of New Jersey, this is as acute as anyplace in the country. In some ways, it is more so. Next year, New Jersey's teaching hospitals will lose $31 million. This is a State where 60 percent of our hospitals are now losing money. Those that are making money on average are making less than a 1 percent return on capital.

Over 5 years, New Jersey's teaching hospitals will lose $166 million. This does not just mean a reduction in services. It does not mean just a reduction in quality of care. It means that many will close.

I recognize the perception is that this is our problem, or New York's, or California's, or Illinois'. Allow me to share with my colleagues this information, lest you think this is our problem alone. We may have more teaching hospitals than anyplace in the country, but this is your problem, too. Arizona will lose $40 million; Arkansas, $13 million; Florida, $98 million; Massachusetts, $248 million; Maine, $15 million; New Mexico, $7 million; North Dakota, $3.7 million; and Oklahoma, $30 million. My colleagues, we are in this together.

The infrastructure that has created the greatest medical care in the world has been strained. Now it will be broken. Doctors will not be trained. These medical breakthroughs do not occur by chance. It has taken generations over a century to build these institutions and generations of building teaching staff and trained professionals to give us the greatest medical profession in the world.

It may be that this is concentrated in a dozen States. But the great medical centers of New York, Chicago, Massachusetts, New Jersey, Florida, and California are sending doctors to every State in the Nation. There is not one State in this country that will not this year or next year have had a doctor trained at a teaching hospital in New Jersey, or several from New York, or several from Boston, or Chicago, or Los Angeles. They go to Montana and the Dakotas. They go to New Mexico. They go to the Great Plains. They go to the Deep South. But most of them are trained in our urban centers.

Their ability to continue to train is now at its end. I don't know how the medical profession continues on its current basis. Doctors are closing offices for insurance reasons. Because Medicare payments are no longer adequate to meet the cost of service, offices are closing. Doctors move instead to practice at other hospitals. Now we are going to reduce reimbursements to hospitals. Some of those will close.

We have known for a long time that the current quality of medical care in America and the extent of service through different levels of income and class cannot be maintained. We have postponed it.

The inability of this Congress and the country to have a national system of health care delivery with privately or nationally based insurance has strained every degree of health care delivery. We have done our business to maintain it. We have even been able to maintain these hospitals by maintaining the IME system. Now that is at its end.

There is introduced in the Senate the American Hospital Preservation Act which would maintain the current IME adjustment at 6.5 percent. I am a cosponsor. Its major provisions will be before the Senate Finance Committee when we consider how to deal with the medical crisis in America.

I cannot more strongly urge my colleagues to follow the leadership of this legislation and consider seriously the consequences of allowing expiration of IME adjustment, what it will mean to these hospitals, what it will mean to the medical care profession, and what it will mean to every one of your communities and every one of your States when the local doctor who went away to the big city to become trained no longer comes home with his or her training and special skills and ability to save lives. The spigot is closed. Everybody is on their own. The teaching hospital just closed.

That, my colleagues, is no longer on the horizon. It is no longer speculation. That is exactly what we are faced with—the real consequences of losing our leadership in these technological breakthroughs and providing these very specially trained people.

I know earlier in the day Senator SCHUMER, Senator CLINTON, Senator CORZINE, and Senator DURBIN were to be here to share in these remarks. Regrettably, they were delayed because our colleagues were speaking, understandably and justifiably, on other issues. I know that on other days they will come to the Chamber to speak about these same concerns. Each of them would like to be identified with this case. We will come back to fight this on other days. This is not going away. We are not going to be silent.

I yield the floor.

The PRESIDING OFFICER (Mr. NELSON of Nebraska). The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent to speak for up to 10 minutes in morning business.

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

PRESCRIPTION DRUGS

Ms. STABENOW. Mr. President, I come to the floor today to respond to a proposal of principles that has been released this morning by our Republican colleagues in the House of Representatives.

First of all, I commend them for speaking out in support of prescription drugs and lowering the costs. But I come today, along with other colleagues, to ask them to join with us in doing more than just offering principles, but, as my colleague who is now presiding has indicated, show me the money—show me the resources. Unfortunately, for a senior who got up this morning and had to decide whether or not to eat or take their medicine, a set of principles will not purchase those prescription drugs. What they need is action. They need action now from us. We have the ability, the capacity to do that.

The first principle that has been put forward by the Speaker of the House is to lower the cost of prescription drugs now. I could not agree more. We have put forward a set of proposals to do exactly that, to increase the ability to use generic drugs, to open our borders with Canada so that our American consumers can purchase American-made drugs sold in Canada for half the price. So that our business community, our hospitals can have free and open trade with Canada to bring back drugs at half the price and sell them to our consumers. We can do that right now. It does not cost anything. Just take down the wall at the Canadian border.

We also know that we need to encourage the drug companies to put as much emphasis on research as they do on advertising. Right now, they are allowed to write off advertising costs deduct them. Taxpayers subsidize that. We know they are deducting twice as much on advertising as they do on research, and we know if we simply said, you can deduct as much on advertising as you do on research, we would save money, and we could put that money into Medicare for a prescription drug benefit.

We also know that the State of Maine has taken leadership in bulk purchasing, so that, on behalf of their consumers and their pharmacies, hospitals, and doctors, they are going to begin the process of purchasing in bulk to get a group discount. It is common

sense to get a group discount. We believe we ought to make that same approach available to all of our States that choose to do that.

Right now, that is being challenged in court by the pharmaceutical drug companies. So we welcome—I welcome—the House joining with us. We have legislation to lower the cost now.

The second principle is to guarantee all seniors prescription drug coverage. Certainly, our caucus—and a majority in this Senate—has been fighting very hard for this. We, again, are ready to do that right now. But it has to be real. One of my concerns is that our seniors have been hearing, for a long time, about updating Medicare and that we are going to provide Medicare coverage. We all know it has to be done.

In 1965, when Medicare was developed, it covered the way health care was provided at the time: You went into the hospital, you might have penicillin, you had procedures in the hospital. At that time, Medicare covered the way health care was provided.

Health care coverage has changed. Treatment has changed. We now rely to a great extent on medications. We are proud that those are developed in our country and that we have these new opportunities for treatment. I am proud, as an American, to be able to have that. But we also know it does not work if those who use the most prescriptions, the older Americans, do not have prescription drug coverage under Medicare. So there is no question that we are ready to do that in the Budget Committee.

I am very proud to have been part of the Budget Committee putting forward a resolution this year that would place a substantial amount—$500 billion—into Medicare and prescription drug coverage that we would put aside, as a country, to begin to address in a very substantive way what our seniors have to deal with every single day when they are struggling to pay for their prescription drug coverage.

My concern is that when you add up—and we have had a chance to look at an initial review of some of the principles from a wire story this morning that spells out the premiums, the copays, and the deductibles, and all of that—when you add it all up, unfortunately, what our Republican colleagues in the House are talking about just isn't good enough. It just simply is not good enough.

There are not enough resources. In fact, in looking in my State at an average senior who might be spending $300, as an example, per month on prescription drugs. For instance, a breast cancer survivor who is spending $136 a month on tamoxifen, and possibly needing cholesterol medication or blood pressure medication, or some other combination. With all those, a $300-a-month bill is not unheard of. Many of our seniors pay that. But if you add up what we are finding—and if this is not accurate, we welcome hearing the specifics—it appears from the paper they are suggesting something in the range of a $37-a-month premium, with a $250 deductible, that 80 percent up to $1,000 would be paid, and that 50 percent up to $2,000 would be paid. But for anyone who is spending between $2,000 and $5,000 a year—and that is many of our older Americans, or a family with a disabled child, or someone else with a health problem—there would be no assistance whatsoever.

When we add that all up, for someone who might be spending $300 a month for prescription drugs, it ends up being less than 20 percent of their bill being covered under what is being talked about by our Republican colleagues in the House of Representatives. It would end up, for $3,600 a year, that senior being out of pocket about $2,795, leaving them to get $805 in support through Medicare. That is just not enough. That is not enough. That is not what our seniors expect. That is not what people have talked about. That is not what was talked about in the Presidential campaigns. That is not what we know we need to do on behalf of our seniors. Less than 20 percent of the bill is just not good enough.

It also appears that this is something that would be turned over to private insurance companies, which I understand actually are very reluctant right now to do this. We are hearing from them that the private insurance companies would administer the plans, even though they are saying they are very reluctant.

We have had a similar experience with Medicare+Choice where HMOs and insurance companies have left the plan. We know about the problems there. Why in the world would we want to make the same mistakes with the prescription drug benefit?

So I see something being proposed that is inadequate—woefully inadequate—being administered by those who say they do not want to administer the program. We have experience that tells us it is not the best way to proceed.

We also know that under private plans the premiums could vary and, for the first time in the history of Medicare, we could have inconsistent premiums from region to region.

So there are a lot of concerns with the proposals we have seen from the other side of the Capitol, from our colleagues on the Republican side of the aisle in the House of Representatives.

My biggest concern is that while we continue to see people talk about principles—principles that talk about lowering prescription drug costs and talk about Medicare coverage—those principles alone will not buy one pill for a senior in Michigan. It will not buy one month's prescription for a family with a disabled child. It will not help one small business lower their cost and their health care premiums so they can make sure they cover their employees.

We need action now. We need the same sense of urgency in this Senate and in the House of Representatives that every family in America feels on this issue. We need the same sense of urgency that every senior citizen in this country feels when they walk into that pharmacy and today pay the highest prices in the world for their prescription drugs.

Shame on us for not acting. Principles are fine, but they are not enough. I know that the people I represent in Michigan are way beyond principles. They know what the principles are. They want to know when we are going to act on them, when we are going to cut the costs and provide prescription drug coverage under Medicare. They want to know when we are going to stop talking and start doing.

So I call upon my colleagues to take those principles and put them into legislation immediately. Let's make sure that it will work, that it covers more than 20 percent of costs under Medicare, and to join with us in a focused effort to lower the costs of prescription drugs for all of our citizens.

I thank the chair. I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. Mr. President, I need 1 minute to confer with the Senator from Michigan. I suggest the absence of a quorum and ask unanimous consent for 1 minute when I am recognized.

Mr. REID. Reserving the right to object, I say to my friend from New York, I think under the agreement, our time is about up. We have 2 minutes left on our time.

Mr. SCHUMER. Then I will speak for 2 minutes.

Mr. REID. I say to my friend, there is no one here from the Republican side, so there being nobody here, until someone shows up, he can speak for up to 10 minutes without any problem.

Mr. SCHUMER. I thank the Senator.

Mr. President, I ask to speak for 10 minutes under morning business.

The PRESIDING OFFICER. The Senator is recognized.

Mr. SCHUMER. Mr. President, I compliment the Senator from Michigan for the great work she has done in leading our caucus to discuss the issue of prescription drugs. We all know we are in a real dilemma. The dilemma is a very simple one. We have, praise God, these miracle drugs. You take a pill and it makes you better. You take a pill and you don't have to go under the knife for an operation. You take a pill and you live longer and healthier and happier. It is amazing.

All of us recognize that those pills don't grow on trees. It takes lots of research and effort to come up with them. But we are facing a dilemma in America—a dilemma faced by senior citizens; by young families who may have a child who needs one of these miracle pills; by small business men and women who have to pay for health care; by HMOs; by General Motors and the UAW. The cost of these medications is getting to be so high that we are living in a bifurcated society.

There are those who can afford them because they have wealth or because they are lucky enough to have a comprehensive health care plan, who live better and longer, and those who can't afford them who live worse.

It is not part of the American credo. We are happy to say, if you are wealthy, you drive a Cadillac and have a five-bedroom house; if you are poor, you drive a Chevy and rent a flat. I don't think we are ready to say in American society that if you are wealthy, you can live better and longer and get better medicine than if you are poor.

So I join my colleague from Michigan in asking, in demanding that we begin to do something about prescription drugs, that we make these drugs available to all people.

We have to do it in two ways: One, we have to make sure Medicare adds prescription drugs—it was the big thing left out of Medicare back in the 1960s; of course, back then we didn't have these miracle pills—and second, that we lower the cost.

We can do that by the methods on which I have been focusing, generic drugs, which lower the cost and provide the same availability without crimping the free market. And there are other proposals out there such as reimportation. But we have to lower costs for everybody.

We are here to respond to this: ''House Republican Principles to Strengthen Medicare with Prescription Drug Coverage.'' First, I would like to welcome my colleagues in the House, Republicans, for getting involved in the issue. With this little thing they have put out, you haven't even put your little baby toe in the water. Jump in. Join us.

They have principles: Lower the cost of prescription drugs now—how are you going to do it? I don't see anything as part of this that talks about that—guarantee all senior citizens prescription drug coverage. Let me tell my colleagues over in the House, if you are going to only allocate a small amount of money, you are not going to be able to do this. You may be able to help the very poor and those with catastrophic illness, but you will leave out the huge middle class. That is where it seems they are headed.

They say: Improve Medicare with more choices and more savings. It seems to me I smell a little rat in that one. To rob Peter to pay Paul, to say we are going to pay for prescription drugs by cutting back on other parts of Medicare, I can tell you how our hospitals are hurting. I can tell you how doctors throughout New York and America are no longer taking Medicare. You are going to make that worse.

This Republican plan seems to be saying: For a very few people we will make prescription drugs available, but we will take away the doctors who will be able to prescribe them.

Finally, they say: Strengthening Medicare for the future, yes, we agree with that. Making permanent a huge tax cut which has already thrown us more deeply into deficit than the war on terrorism and saying you are going to strengthen Medicare is a contradiction. You have to decide which one is more important. I think we have, many of us. I like cutting taxes. I voted for many tax cuts. But making it permanent now when you say we know what jeopardy Medicare is in and we know we need prescription drugs? I will tell you what side of the fence most New Yorkers would be on, particularly when they know the tax cuts go mainly, predominantly to the very people who can afford these prescription drugs on their own. They don't need the tax cut to do that.

Again, to my colleagues from the other side, from the other House, from the other party, welcome to the debate. We have been waiting for you. Let's get real. Let's not have a list of high-minded and somewhat contradictory principles. Put your money where your mouth is. What is your plan? What are you going to do? Many of us have specific proposals that we have been working towards. We would like you to support those. If you don't agree with those, what do you agree with?

Ms. STABENOW. Will the Senator from New York yield?

Mr. SCHUMER. I am happy to yield.

Ms. STABENOW. I commend the Senator for his efforts regarding generic drugs. There is no question that this is the heart of the matter. I know he has held hearings. He has a bill that is moving forward. I commend him for going right to the heart of the issue. Hopefully, our colleagues on the other side of the aisle and in the other Chamber will be willing to embrace what is a very tangible way to cut the cost, which he has been working on, holding hearings on, and moving forward on. I commend him on this issue to all those listening. The leadership of the Senator from New York has been absolutely superb on this.

Mr. SCHUMER. I thank my colleague from Michigan for those nice words and, more importantly, for the great work she does. Our generic bill is bipartisan. Senator MCCAIN and I are lead sponsors in the Senate. We have sponsors in the House.

Can you hear me over there in the House? Hop on our bill instead of putting out a statement of principles. It is led by SHERROD BROWN of Ohio, but we have a number of Republican sponsors as well. Again, it is joint; it is not intended to be partisan. That is one way to lower the costs.

The pharmaceutical industry is not going to like it. Again, I ask my House Republican colleagues: Are you willing to buck them? Are you willing to say we are going to lower the costs and prevent the lawyers from fleecing the Hatch-Waxman Generic Act clean or not?

Today is a good little baby step on balance by my colleagues in the House, but they have a long way to go to convince the American people they really care about this issue.

TEACHING HOSPITALS

Mr. SCHUMER. Mr. President, I rise to address a related issue. I had come to join my colleague from New Jersey in addition to my colleague from Michigan on teaching hospitals. Like many of our precious resources, our teaching hospitals are concentrated in a few regions of the country. In fact, 50 percent of the residents trained in the US are educated in just seven States.

New York is home to nearly 10 percent of the Nation's teaching hospitals which train 15 percent of our Nation's new doctors—the single greatest percentage of any state.

And though we train them, they don't all stay in New York. They go to states where teaching hospitals are few and far between—like New Hampshire, Vermont, Montana, Delaware, and South Dakota—States that have fewer than 5 teaching hospitals each.

Twenty-two percent of the physicians practicing in both Vermont and New Hampshire—and nearly 20 percent of those in Delaware—were trained in New York. Five to 6 percent of the physicians practicing in South Dakota and Montana were trained in New York hospitals.

Even States that do have a significant number of teaching hospitals are dependent on New York for residents. Over 30 percent of Connecticut's physicians and 47 percent of New Jersey's were trained in New York teaching hospitals. Even 10 percent of those practicing in North Carolina hailed from New York originally.

In fact, there's not a State in the Nation that doesn't have at least a few doctors who were trained in New York institutions.

The concentration of medical education and research in New York State draws world-renowned physicians to train residents in an environment of state-of-the-art medical care and technology.

The State's teaching institutions also form the foundation of a powerful medical research industry, drawing 10 percent of the Nation's total National Institutes of Health grant funding.

But, like all our hospitals, our teaching hospitals are struggling. The Balanced Budget Act of 1997 was an important piece of legislation, but it cut funding for our Nation's hospitals by over $100 billion more than was originally intended, and our hospitals are still reeling from its effects.

Our teaching hospitals face another 15 percent cut in Medicare Indirect Medical Education, IME, payments this fall. This could mean almost $750 million to the teaching hospitals in New York.

This funding is a lifeline for our medical centers—it allows physicians to train in an environment of great technical sophistication where cutting edge biomedical research and breakthrough