

Success has many fathers and anyone would be hard-pressed to limit just one Democrat as critical to the success we have today. Senators BREAUX, BAUCUS, and KENNEDY have all been as unwavering as they have been untiring in their efforts to provide prescription drugs to our senior citizens. On our side of the aisle, Chairman GRASSLEY skillfully navigated this bill through the Finance Committee to a strong bipartisan vote. Senator NICKLES, the Budget chairman, is to be commended for ensuring full funding of the President's Medicare proposal in the budget and his tireless work to ensure the bill keeps faith with the President's original proposal and the future generations his proposal sought to protect. I look forward to continuing working with him to produce the best bill possible.

I want to say again the efforts of our colleagues, Senator CHUCK HAGEL and Senator JOHN ENSIGN, with their innovative proposal, which I hope will be thoroughly vetted in the course of this debate, are to be commended for their outstanding leadership on this issue. Combined, these efforts have produced a bill that will strengthen and improve Medicare and guarantee a prescription drug benefit. It will improve the quality of Medicare to guarantee its benefits for our parents and our children. It preserves traditional Medicare while allowing seniors to choose a benefit package that best fits their needs and gives them the same type of choices enjoyed by those of us in Congress and other Federal employees. It protects low-income seniors by giving them additional help in paying for prescription drugs. It protects all seniors from catastrophic drug costs. It addresses many of the problems associated with rural health care for our seniors on Medicare.

Debate on this bill will be difficult. Some will say it does too little. Others insist it does too much. Some will say the reforms go too far. Others will say the reforms do not go far enough. Where I stand is about where the President stands. He applauds the product but believes we need to do more reform, and I agree with that entirely. He believes in a fair competition between Government and the private sector to provide goods and services at the lowest costs, the private sector will win. I certainly agree with that, provided we craft this in a way that gets the private sector a chance.

He believes any reform of Medicare must begin with the infusion of private sector responsiveness and cost control. Again, I certainly agree.

The questions we share are: Will we achieve more reform? Will we ensure fair competition between the Government and the private sector? Will the reform we inject exceed the costs of the new benefit? That is what this debate is about. Today we begin to shoot with real bullets. This is no longer a ploy for the next election; this is about the next generation. This is not just about Medicare prescriptions; it is about

Medicare preservation. This is not just about our parents and our grandparents; it is about our children and our grandchildren. If we keep this in mind, I believe we can produce a product that preserves the social contract of Medicare with our parents, as well as our children.

I yield the floor.

#### RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

#### PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The ACTING PRESIDENT pro tempore. Under the previous order, the hour of 2 p.m. having arrived, the Senate will proceed to the consideration of S. 1 which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

The ACTING PRESIDENT pro tempore. The Senator from Nebraska.

Mr. HAGEL. Mr. President, I wish to acknowledge my colleague, the distinguished Republican assistant majority leader, for his remarks.

I see Senator KENNEDY in the Chamber.

Senator KENNEDY, thank you for your leadership.

I have a statement, and my understanding is that we will then rotate statements on both sides for the rest of the afternoon.

Over the next 2 weeks, the Senate will begin a historic effort to reform and strengthen Medicare. What we do here over the coming weeks will affect every American and future generations. Health care is a defining issue for our Nation. We must take the long view and recognize that if we do it right, the changes we make in health care, in the delivery of that care, will result in improved access to quality care and lower costs for Americans well into the future. This must be our objective.

The Senate Finance Committee bill represents a good solid beginning. The Senate Finance Committee, under the leadership of Chairman GRASSLEY and Ranking Minority Member BAUCUS, deserves great credit for its hard work and efforts in bringing the bill to the floor of the Senate. Over the next 2 weeks, the Senate will work with members to improve upon their bill.

Medicare is one of the two largest programs in the Federal Government. Today, Medicare covers over 40 million Americans, including 35 million over the age of 65 and nearly 6 million younger adults with permanent disabilities.

Medicare serves all eligible beneficiaries without regard to income or

medical history. It is projected to pay out \$269 billion in both Part A and Part B benefits this year. This accounts for 13 percent of the Federal budget and \$1 out of every \$5 spent in America on health care.

In 1965, when Medicare was created, only about half of America's seniors had health insurance and fewer than 25 percent had adequate hospitalization insurance. Now, because of Medicare, nearly all seniors have coverage. Medicare has been good for seniors and has become a dominant part of the U.S. health care system.

But Medicare does more for seniors than protect their health. Medicare improves their quality of life. Since Medicare was enacted, people are living longer and living better. Life in America has changed dramatically over the last 40 years, especially health care.

Medicine today addresses all conditions and diseases, with a special emphasis on preventive medicine and management of chronic conditions. This includes an emphasis on prescription drugs, diet, exercise, and lifestyle—health dynamics that were not given much consideration when Medicare was enacted in 1965.

Medical technology has exploded, and we have experienced a revolution in the development of new and effective pharmaceuticals. Outpatient treatment and prescription drugs have become mainstays of medical care, but the Medicare Program does not reflect these changes in health care. Like medicine itself, the Medicare Program must adjust and reform to address these new realities in health care delivery, consumer demand, and costs. Medicare is a 1960s model trying to operate in a 21st century world. Our goal in this debate is to bring this valuable program in line with today's health care needs in a responsible and sustainable program and prepare for the future.

As we look forward, we should also heed the lessons learned when Medicare was created. When Medicare was enacted in 1965, the Federal Government's lead actuary at the time projected that the hospital program, Medicare Part A, would grow to \$9 billion by 1990. But the program actually ended up costing more than \$66 billion by 1990. Even after adjusting for inflation and other factors, the cost of Medicare Part A in constant dollars was 165 percent higher than the official Government estimate according to the actuary who produced those numbers. In unadjusted dollars, actual costs were 639 percent above estimates.

A 1968 Tax Foundation study found that public spending on medical care had nearly doubled in just the first 3 years of Medicare. A recent example of these accelerating costs is that since 1999, drug prices have risen about 20 percent. The average cost of these life-saving pharmaceuticals will likely continue to increase, placing further pressure on seniors with fixed incomes.

In addition to the internal problem of the changing realities of health care,

Medicare is facing a looming external program. The largest generation in American history, the baby boomers, is aging. These Americans—over 75 million—will be added to the Medicare rolls over the next few years. The baby boom generation has changed and shaped every market in which it has ever participated. Medicare health care will be no exception. We have a responsibility to address this demographic pressure now or risk the system collapsing under its own weight in the future.

The task before us is immense but so is the opportunity. Although Congress has been working with health care professionals, we must continue to listen carefully to those who know most about health care. We need to assure the American people that the promises made to them will be kept and that seniors on Medicare today will not be forced to change or lose their benefits, but for the future enhancement and viability of Medicare, changes will be required. The American people must have confidence in the medical reform process, the process we use to reform Medicare. This is important because as we move forward, all Americans, especially seniors, must then have confidence in the results.

Facing these challenges will require difficult decisions. There will be no perfect solutions. There will always be imperfect solutions at the end of the day. At the same time, we must be responsible with our efforts. We are adding a costly new benefit to America's largest health entitlement program. In making decisions, we must not discount or minimize what we know has worked and what has not worked.

Much of the debate over the next 2 weeks will focus on prescription drugs. Medicare does not currently cover outpatient prescription drugs. Adding a responsible, sustainable, and meaningful drug benefit is a top priority for most in the Senate. Seniors are expecting to spend nearly \$1.9 trillion on drugs over the next 10 years. Clearly, the Federal Government simply cannot take on all of that expense. But seniors need help. They need help now. More than one-third of Medicare beneficiaries have no prescription drug coverage.

Mr. Joseph Antos of the American Enterprise Institute was quoted in the New York Times on Saturday as saying:

These seniors are the last people in America who are paying retail. When I turn 65, I'd hate to be the only one in the pharmacy line who's not in some kind of pain.

Also in Saturday's New York Times, Mr. Dana Goldman of the RAND Corporation, said:

What you really want to do is insure against very high expenditures. A catastrophic plan would be a cautious approach to sticking your toe in the water.

We should heed their advice as we move forward.

Any Medicare drug benefit must be sustainable. The benefit must deal with the realities that people are living

longer and better, and have higher health care expectations than ever before.

A new drug benefit should strengthen public/private partnerships that work. Any new drug benefit must pay particular attention to those in greatest need who have no options today, but this should not be at the exclusion of other seniors.

We must take care that we do not inadvertently stifle innovation in the private pharmaceutical, medical research, and healthcare sectors.

We know advances in research and medicine have been the critical factors in our increased lifespans, better health, and improved quality of life. The public/private relationship in these areas has been essential to that success.

The United States leads the world in medical innovation. Our actions over the next 2 weeks must not jeopardize that continued innovation but, rather strengthen it for the future.

The special healthcare needs of rural areas are of great importance to me and many of my colleagues. What we do in this body over the next 2 weeks should enhance rural healthcare as well as urban healthcare.

Tough choices and difficult decisions will have to be made. Not everyone will agree with the choices we make, but we owe it to the American people to face these challenges and produce a reformed Medicare program that will take America's seniors well into the 21st Century. That is doable, and I look forward to working with my colleagues in this important effort.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, let me begin by praising the chairman of the Senate Finance Committee, Senator CHUCK GRASSLEY, for his fine leadership and cooperative management of this bill. He has been very good. I know the folks in Iowa know that, but I want everybody else tuning in to know it as well. The chairman of the Senate Finance Committee, CHUCK GRASSLEY, has done a tremendous job. He deserves a lot of praise for this bill.

On that point, sometimes we fail to recognize just how historic some legislation is. This is truly a historic bill. This is not some garden variety piece of legislation that has come up and will pass in the Senate. This is a major expansion of Medicare—major. It is going to make a huge difference in the lives of many senior citizens in America. I again thank Senator GRASSLEY for his help putting this together.

I also thank many Senators who have helped bring us here today. Senator JOHN BREAU from Louisiana has been tireless in his effort on the Medicare Commission and other efforts to get prescription drug benefits and to try to reform Medicare. His work has been indispensable.

Senator OLYMPIA SNOWE from Maine, Senator HATCH from Utah, Senator

JEFFORDS from Vermont, have all contributed mightily to these efforts. It would take me a long time to go through all the efforts they have undertaken if I were to recite chapter and verse all they have done. It has been monumental.

Any discussion for the long struggle for improved health care in America would be absolutely incomplete without the mention of the longstanding effort of the Senator from Massachusetts, Mr. KENNEDY. Senator KENNEDY is on the floor. He is probably going to speak a little later. Without Senator KENNEDY and his efforts, I am not so sure we would be here today, on cusp of passing truly historic legislation.

We are here today to make a meaningful improvement in health care for our seniors. That is why we are here. We are here at last to bring prescription drug coverage to Medicare.

On July 30, the Nation will celebrate the 38th anniversary of the enactment of Medicare. Without exaggeration, Medicare is simply one of the most successful enterprises ever taken by a free people working through their government. Today we are about the business of making it even better.

Medicare took a long time in coming. Following the enactment of Social Security in 1933, progressives called unsuccessfully for a program of national health insurance. President Harry Truman repeatedly advocated national health insurance funded through payroll deductions, but as we know, his plan went nowhere. But the fact remains, retired Americans had a particularly difficult time getting health insurance in the private sector.

In 1951, planners at the Federal Security Agency, recognizing that difficulty, examined extending health insurance to this population. The idea slowly gained popularity in the 1950s.

Senator John Kennedy raised health care as a campaign issue in his successful 1960 Presidential campaign. Taking the reins of the Presidency from his fallen predecessor, President Lyndon Johnson spoke of moving, "not only toward the rich society and the powerful society, but upward toward the Great Society."

At the height of legislative action of President Johnson's Great Society in July 1965, Congress enacted Medicare into law in the Health Insurance for the Aged Act. With President Truman at his elbow, President Johnson signed the bill in Independence, MO. President Johnson at that time said, "No longer will older Americans be denied the healing miracle of modern medicine."

And President Truman told President Johnson, "You have made me a very happy man."

Since then, over the nearly four decades of its life, Medicare has improved the lives of over 100 million Americans. Medicare now provides health insurance coverage to more than 35 million seniors, virtually everyone aged 65 or older, and 6 million disabled enrollees for hospital or related care under the

Hospital Insurance Program. It covers nearly as many for doctors' services, outpatient hospital services, and other medical expenses under the Supplemental Medical Insurance Program.

Medicare has been a success. Health care expenses used to impoverish seniors. In conjunction with Social Security, Medicare has significantly reduced poverty among seniors. Despite progress on poverty among seniors, they are by no means an affluent group. From 2001 data, we can see that nearly two-thirds of Social Security beneficiaries rely on Social Security for most of their income. A third of beneficiaries rely on Social Security for 90 percent or more of their income. In 2001, the median income for all eligible households was \$19,000, and one-fifth have incomes under \$10,000; thus, vast numbers of America's seniors need Medicare and Social Security to keep out of poverty.

With the nearly universal health insurance coverage and decreasing poverty achieved by Medicare and Social Security, seniors are also living longer. Before Social Security and Medicare, in 1930, for example, a 60-year-old had a life expectancy of 77 years of age. In the year 2000, 70 years later, a 65-year-old man could expect to live to 81 and a 65-year-old woman could expect to live to 84. Partly because of Medicare, more and more Americans are living into their late eighties and into their nineties.

Medicare has also improved the quality of seniors' lives. It has helped them to combat debilitating illnesses. It has helped them be free from pain. It has helped them to live fuller, better lives.

But the practice of medicine has also progressed since Congress set up the structure of Medicare. Prescription drugs have taken on a much greater role in maintaining health, replacing procedures, as has more prevention. Prescription drugs are just proportionately so much more important today than they were when Medicare was created.

The Congress that created Medicare did not envision that role of prescription drugs. Although former employers and other private insurance plans cover some seniors, about 10 million seniors have no prescription drug coverage at all.

Because seniors are not a wealthy group, for many this reality means a painful choice between filling their prescriptions and buying food.

I visited a community health center and talked to an internist—a doctor—the administrator of that health center. She told me she had to cut back on her medicine. She has to give up some of her medicine. Why? In order to pay for the medicines for her mother. Just think of it. A doctor who has to cut back on medicines for herself because they are so expensive and because her mother can't afford them. The doctor is sacrificing her health care to make sure her mother has prescription drug benefits. That is not an isolated inci-

dent. It is happening over and over again in America, and it is wrong.

Seniors should not have to choose among necessities in order to maintain their health. We can do something about that today.

To maintain Medicare's success, we must expand it to address the health care delivery structure that we have today. The bill that we bring to the floor would take a substantial step in that direction.

This bill would make available Medicare prescription drug insurance universally to all seniors. It maintains the important principle of universalism that has held together the remarkable social compact of Medicare and Social Security.

This bill would ensure that 44 percent of Medicare beneficiaries—those with the lowest incomes—would have truly affordable prescription drug coverage with minimal out-of-pocket costs. For these lower-income seniors with incomes up to 160 percent of the poverty level, co-payments would never exceed 20 percent of the cost of drugs.

Just think of that—never more than 20 percent.

This bill would make it so that an elderly retired couple in Great Falls, MT with an income of \$16,000 a year, would be able to buy their prescription drugs without ever having to pay more than 10 percent of the cost of the drugs.

This bill would thus ensure that those who have been least able to receive what President Johnson called "the healing miracle of modern medicine" would now be able to do so. Millions of people would have a better quality of life. Lives would be saved.

This bill would create a strong government fallback. Seniors would have access to at least two private plans for a prescription drug benefit or the government would provide a standard fallback plan. If there is no true competition, then traditional Medicare would provide a fallback.

Now some have raised fears that the competition that this bill seeks to foster would lead to the privatization of Medicare. This is not so. The Department of Health and Human Services would continue to oversee these plans. The plans would operate within tightly-controlled limits. This bill includes strong consumer protections.

This bill does not tilt the playing field. This bill does not make private plans a better deal than traditional Medicare.

But those of us who believe in traditional Medicare should not fear the entry of private options. For either they will work and make things better for beneficiaries, or traditional Medicare will still be there. It is another opportunity. Either private plans will deliver the efficiencies that their advocates on the other side of the aisle promise for them—in which case the beneficiaries who choose them will get more value for their contributions—or traditional Medicare will still be there.

Others have found fault with the costs that this bill would ask bene-

ficiaries to pay. Some have focused on what they call a break-even point—of a little more than a thousands dollars in drug spending—below which higher-income beneficiaries would spend more on the plan than they would receive in benefits. Yes, from a third to half of beneficiaries might spend more in a given year than they receive in benefits. But that means that from half to two-thirds will get more in benefits than they spend.

But it should not be surprising that some will pay more in premiums than they receive in benefits. That is the nature of insurance. We pay for insurance to protect against the risk of something that we hope will not happen. Most of us would be thankful if we do not encounter the ailments that require us to use our health insurance. Many would count that a blessing.

But this bill would provide a substantial subsidy for the health insurance need of Medicare beneficiaries. That is the nature of the cost of this bill. We as a society are choosing to make this insurance available at a substantial subsidy to all seniors.

For millions of Americans who are less fortunate, who have lower incomes and health needs, this bill will make a dramatic difference. For the 44 percent of Medicare beneficiaries with lower incomes, this plan would provide very affordable benefits. And remember that this lower-income population includes precisely the group most likely to be doing without prescription drug coverage today.

I acknowledge that some may have legitimate concerns with this bill. I note, in particular, that I and other drafters of the bill have become struck by CBO's high estimate of the percentage of beneficiaries whose former employers would drop their coverage, if Medicare started providing it. I would also like to find a way to make it so that seniors who were in a fallback plan could stay with that plan longer. I, for one, will look for opportunities during this process to address these concerns and improve the bill.

But this bill would create a \$400 billion expansion of a major entitlement program. Yes, we could have done more with more money. But this is a historic opportunity to make a fundamental change for the better, for millions of Americans.

In so doing, this bill would finally do something that the overwhelming majority of industrialized nations have already done; that is, provide prescription drug benefits to their seniors.

Medicare took a long in coming. But it came quickly when it did. Sometimes, the time is simply ripe.

The Health Insurance for the Aged took several decades to come to the Senate floor in 1965. But when the Senate took it up in 1965, it finished its debate in 4 days—July 6 through July 9 of 1965—and passed the bill with 68 votes.

Starting today, we will spend 2 weeks on this debate. And we should. And I look forward to a full and open airing of the issues.

But in the end, I also look forward to passage of this new benefit, with substantial support from both sides of the aisle.

The time was ripe in the summer of 1965, when Congress enacted the Health Insurance for the Aged Act and created Medicare. I believe that the time is ripe again, today.

The time is ripe for a new chapter in the successful story of Medicare. And we begin that chapter today.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I want to at the opening of this debate and discussion recognize the guiding lights of this legislation, Senator GRASSLEY and Senator BAUCUS, for bringing this legislation to the floor.

This legislation in one form or another has been before the Finance Committee for 5 to 6 years in recent times, actually going back to 1978 when legislation was introduced by myself, Senator Thurmond, and others at other times. But this is a major breakthrough, as was pointed out by the Senator from Kentucky. This legislation is going to lead to conference and eventually it will be signed by the President of the United States.

So this is good news for all the seniors of this country. It isn't all that all of us would like to have achieved. But, nonetheless, it is a solid downpayment.

I will take a few minutes of the Senate's time to indicate what I find to be the most compelling reasons for the legislation, and also discuss areas which I hope in the time we have to debate that the Senate will give some focus and attention to.

But we should not minimize the extraordinary work that has been done by the chairman, and the ranking member, Senator BAUCUS of Montana, in moving this legislation through the committee; and also other members of the committee. I also add to that the majority leader, Senator FRIST. Senator FRIST is a member of the Committee on Finance but he is also on the Committee on Health, Education, Labor, and Pensions. He brings a very unique background and experience in health care policy matters. Clearly, he has had a very important influence in the shaping of this legislation. All of us welcome his involvement in the health care debate. We have worked together on a number of the bioterrorism pieces of legislation and in other areas. I think we are fortunate to have his expertise in the Senate on health care matters. We are grateful for his involvement in this legislation.

I was here in the spring of 1994 when the Medicare legislation was defeated. It was defeated by a significant number—I think 15 or 18 votes—at that particular time. And then I was here again in 1995—about 10 months later—when again the Senate considered the legislation, and it passed overwhelmingly; and a number of those who voted against it actually voted in favor of it.

The principal intervening event between 1964 and 1965 was the 1964 election, where this was front and center in terms of President Johnson's election. It had been in the 1960 election, but in 1964, given the fact that Medicare had been defeated, it was a matter of enormous concern to seniors.

As has been appropriately pointed out, it isn't just the seniors who are interested in this legislation, it is generational because so many of those who are not seniors are involved in the quality of life for those who are seniors. They are the children and the grandchildren, and they care very deeply that their parents and grandparents are going to live in peace and security and dignity.

When we passed the Medicare proposal, we gave the assurances to our seniors that if they played by the rules, paid into the health care system, paid into the Medicare system, that their health care needs would be attended to. That was true with regard to hospitalization. It was true with regard to physician services. We did not anticipate the third leg of that stool of Medicare was going to be the prescription drugs. Only about 3 percent of the total private insurance company plans at that time had a prescription drug program. It was not included.

And now, if you look at the needs of our senior citizens, we ask ourselves, why didn't we have the foresight to see that need? And why haven't we taken action in order to remedy that loophole?

It has taken a long time, but we are finding a strong downpayment in meeting that obligation today. I have always believed that every day we fail to pass a prescription drug program we are violating our commitment, our promise, our guarantee to the elderly people in this country in that solemn promise we made when we passed Medicare: Pay into the system, and you will be assured that your health care needs will be attended to. So it has been a long time in coming.

There are those who have been strongly opposed to a prescription drug program for ideological reasons. They are strongly opposed to Medicare. You can go back and look and read the history of the debates on Medicare—both in the past and the statements made in recent times, and as recently as in the past few weeks—where we have found Members, primarily our friends on the other side of the aisle, who do not believe in Medicare and who never believed we ought to have a prescription drug program that was rooted in the Medicare system.

There are recent times most of us can remember where statements were made. There was the Speaker of the House who talked about the Medicare system, that they wanted to see the Medicare system wither on the vine, and so there was an ideological commitment that said: If we are ever going to pass a prescription drug program, it has to be rooted not in Medicare, but it

has to be rooted in the private sector, and we will do everything we can to make sure it is. We will provide all the financial incentives. We will effectively bribe individuals into the private sector or coerce them into the private sector and let the Medicare system wither over here.

If that was the program, there would not be anyone on this floor who would take stronger issue with it than I would, as one who has followed the Medicare system, believes in it deeply, and has seen the benefits it has provided to hundreds of thousands of the citizens of my own State of Massachusetts and around this country and knows the great sense of confidence our seniors have in this system and the Social Security system.

In fact, these are the men and women who brought us out of the Depression, who fought in the World Wars, who fought in Korea, who faced the challenge of nuclear terror and the dangers of the expansions of communism. They have sacrificed for their children and their grandchildren, and they are entitled, in the richest country in the world, to live in some security and dignity, and the lack of being able to get prescription drugs is denying them that opportunity. They believe in Social Security and the Medicare system. This legislation will give them the assurance that if that is their desire, they will be able to receive prescription drugs under Medicare. That is why I support this legislation. Those who believe it should be just a private system are not going to vote for this bill. They shouldn't vote for it because it isn't going to be a private system. We will have the opportunity to explain that in more detail.

I will take a moment to review some of the facts that are known to every senior citizen in this country. I think they are reflected on this chart I have in the Chamber.

First of all, let's look at what has happened in terms of the cost of the prescription drugs our seniors need.

The yellow on the chart shows the COLA for Medicare, Social Security. The blue shows the increased costs of prescription drugs over the same period of 1998, 1999, 2000, 2001, 2002, 2003, with the increased costs, respectively, being 10 percent, 19 percent, 16 percent, 15 percent, 14 percent, 13 percent. This all comes out of the income of individuals who effectively have fixed incomes, and this with a modest COLA.

You can see with these extraordinary escalations of costs what is happening to our seniors. Often on the floor we have seen and heard our good friend from Michigan, Senator STABENOW, who has provided great leadership—as have others—about the hard and harsh choices that are taking place in homes all over this country, where seniors are making choices between the prescription drugs which are vital to their health care and the food they need to eat, or in our part of the country, it is the heating so they can survive in the

winter, or in other parts of the country, it is the cooling to make life at least livable in the South.

There has been an extraordinary escalation and continuation of costs. We will have an opportunity during the debate and the discussion on this issue to consider legislation that has come out of our Human Resources Committee, out of the Health Committee, that was initiated by Senator McCain and Senator Schumer that we addressed last year on the floor of the Senate and which passed the Senate, which will help and assist generic drugs to come further forward. And, in the meantime, over the period of these past months, with a lot of hard work, there is legislation that now has very broad support, which was virtually unanimous out of our committee, with the support of Senator Gregg, myself, and others who are strongly behind it. I supported it last time. We are hopeful of doing something in the totality, not only in the area of coverage, but also in the areas of cost. We are not going to solve all of the problems in either area, but this kind of debate and discussion is going to include both the issues of coverage and the issues of cost.

Let me review very quickly where we are in terms of the coverage for our senior citizens. Of the 38 million seniors, we know 13 million lack any kind of quality drug coverage. They are effectively on their own. They buy at the top price. They do not really get any deduction, and they are virtually without any kind of coverage. Another 10 million have employer-sponsored coverage. Another 5 million have Medicare HMO, 2 million are under the Medigap, and 3 million are under Medicaid.

I believe when we used to debate this issue in years past, we would say the only group among these seniors that was really guaranteed affordable, dependable, reliable prescription drugs were the 3 million under Medicaid. That is not true any longer. Let's see what has happened.

There is a general kind of profile of where our seniors are with regard to the quality of their drug coverage. Let's take, No. 1, the employer-sponsored programs. This will raise an issue on one of the challenges this current bill is facing. But let's just review very quickly what has happened in terms of employer-sponsored coverage in recent times. If you go back to 1988, it was about 80 percent. In 1994, only 40 percent of all the retirees were included in the program. Look at this, as shown on the chart: Going down from 1994 to 2002, now it is about 22 percent, and falling rapidly.

The bottom is falling out in terms of the kinds of guarantees for the millions of Americans who have employer-sponsored plans. So we have one large group of Americans with nothing. We have another group that has employer-sponsored plans, but the total number of programs now providing these is dropping down, and employers who have them in many instances are drop-

ping them. So there is no guarantee for that group of Americans.

What about this other group of Americans, those with regard to the Medicare HMO? If you look at what is happening with regard to the Medicare HMO, you will find out the drug benefit is only offered as an option of the HMO. Thirty-four percent offer no drug coverage at all; more than 2 million Medicare beneficiaries lost their HMO coverage since 1999, so they are dropping. But this is the other insidious factor: 86 percent of HMOs limited the coverage to less than \$1,000 in 2003; 70 percent limited coverage to \$750 or less in 2003. So you can say on the one hand, some are covered with the employer-based system, but you can see that the system is at the point of collapse. Others say HMOs are offering coverage. But, they are dropping them on the first hand, and they are putting the blockage there to protect themselves, and that is, of course, a disaster for many other seniors.

We say we have the Medigap coverage that provides for 2 to 3 million. You all are familiar with the absolute explosion of the cost and increasing numbers. Both have dropped it.

This is the background. We find millions have no coverage. Even for those who have coverage there is uncertainty, even if they are employer based. If it is HMOs, we are finding increasing restrictions that make it unreliable. We have a whole population that is faced with a serious challenge and a serious need.

Now, what does this proposal do? How will our senior citizens under Medicare benefit under this program? What is basically the delivery mechanism that has been a key element in terms of trying to make sure we were going to give the assurances to our seniors that there will be somewhere, in any part of America, the guarantee that Medicare will be there but also permits the private plans, if they are in local areas, to be able to, if that is the desire at least, if they are going to meet the obligations? We will have a chance during the course of debate to review it. I know the ranking member and chairman have gone over in the markup those particular provisions that talk about the guarantees of the program and why the various kinds of conditions to make sure we are not going to have the excess charges and how we are going to have the standards and how we are going to have a good benefit package.

On the one hand, there is the traditional Medicare Program. The individual will be able to continue. The Government delivers the doctors, hospital, and other services. Then, in many areas, the individual will have a choice between two different private plans and a guaranteed fallback of the Medicare system, if the private plans are not successful. So there is the guarantee there. And in the cases where there is the Medicare Advantage and the private plans, you will have the

PPOs and the local HMOs that will be able to submit the plans. We will have the guarantee on the one hand through the Medicare system, and the opportunity on the other. We will have an opportunity to go through it in greater detail.

Let me mention, for those who are watching this broadcast, what this can really mean to individuals. We know the average cost for seniors is \$2,300. That is the average cost per year. As we have pointed out, and it has been mentioned earlier, the elderly are going to spend \$1.7 trillion, \$1.8 trillion over the next 10 years on drugs. This is only \$400 billion, 24 or 25 percent. So we know there are large gaps. This will not be everything for everybody, but it is going to provide important coverage to about 35 to 40 percent of our elderly under Medicare, those of the lowest income who are in desperate need, and also be sensitive to those with catastrophic kinds of health needs. And it also provides some important relief for those in the middle, although not all of what we would like because individuals will for a period of time fail to get the coverage, the area that we call the donut, and then pick up coverage later on.

But let me use the example of a typical income which would be about \$15,000 for a senior. This is the chart that will indicate what the savings would be. The typical one is \$15,000. The typical prescription drug cost would be \$2,300. The premium would be \$420. Their cost sharing would be \$1,250. They would save \$600 in this program. I wish it was a good deal more, but that is \$600 over the cost of the year.

Take that same individual, \$15,000, they have \$10,000 in health care costs. They would spend \$400, and they would save \$5,462 under the bill. This is a dramatic savings for those on the upper end, and let me tell you what it would be on the lower end.

Let's take an individual with \$15,000 income who might have expenses at the lower level. I will have a chart for this. I am sorry I don't have it. What we are trying to do with each example is to give individuals who might be watching some idea as to what would happen to them. Say a senior with an income of \$9,000 and they currently have monthly drug bills of \$500. They would, under this bill, pay a total of \$15 and have \$484 in savings. Low-income people who have drug bills of \$500 would have \$484 of savings. If they are \$12,000, they would have \$468 in savings, if they spend \$500. And if they are \$13,500, which is the 160 percent of poverty on this thing, and had \$500 a month, they would save themselves \$416.

So we see for the very needy it is a very important benefit. For those who will be facing catastrophic drug costs, it is a great help. For those in the middle, it is some help but not all the help we would like to see, or that they deserve.

Beyond this, one of the other features I find enormously appealing is

what they call the card, the discount card that seniors will be issued. It is called the prescription card. It will be issued next January. Basically, what that will do, for approximately 5 million low-income seniors, if this bill gets passed and signed into law, basically, again, the 5 million low-income seniors, they will be able to get a card for \$25 and be guaranteed up to \$600 at their pharmacy. If they don't spend it all the first year, say only \$400, the remaining \$200 will kick over for the next year. That will begin immediately.

This legislation will take time. It will take 2 years before they are able to set up the various kinds of structures which I outlined earlier to achieve it.

There are important areas I am hopeful we can address in this area. This is \$400 billion. It is a lot of resources. But we have also seen where this Senate has passed tax cuts for \$2.3 trillion. This is \$400 billion. So it does seem to me we ought to be able to find some way to help middle-income seniors more than we have by providing additional resources to this particular proposal. An effort certainly will be focused on that.

There is a second area which is of central concern. That is the retirees. The way this legislation has been constructed, there may be those companies that feel that rather than continue to provide coverage for retirees, this will be a way to drop them off and have them picked up under this program rather than meeting their obligations and their responsibilities under the agreements which they have had and committed themselves to over time.

We believe that is an area that needs focus and addressing during the course of the debate. You cannot get away from the fact that this legislation is, as Senator BAUCUS has pointed out, major legislation in terms of the unfinished business and in terms of Medicare, particularly in the area of prescription drugs. Many of us believe this is the life sciences century, where we have seen breakthroughs that are coming, like the mapping and sequencing of the human genome which has permitted us to be able to screen and inform people who might have a predisposition in terms of breast cancer, for example. We are considering legislation to make sure people will not be discriminated against in terms of employment and getting medical insurance because of these kinds of indications. But we are able to find out through the work on the human genome so much about the types of illnesses that people have proclivities to develop.

So we are in the century of the life sciences and breakthroughs. We have doubled our basic commitment in terms of basic research. We are seeing the breakthroughs in these extraordinary kinds of developments of pharmaceutical drugs that can be lifesaving and can relieve the most challenging and difficult illnesses and diseases that

we face in the country and around the world. We are going to face a challenge about how we are going to get the best of those prescription drugs into the homes of people who need them. That will be a challenge. That will be a challenge for us here as a matter of national priority, I believe.

A defining aspect of our humanity and decency is whether we are prepared as a nation to make it a priority to be able to do that. This is a downpayment on that commitment. That is why this legislation is of essential importance and consequence and why I look forward to the next days in terms of the debate and discussion that we can move this process forward and move to making sure we are meeting the challenges that our seniors are facing in all parts of the country.

I yield the floor and suggest the absence of a quorum.

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

The assistant legislative clerk proceeded to call the roll.

Mr. THOMAS. 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. THOMAS. Mr. President, I am pleased we now have gotten to the floor with this bill. Certainly, most everyone agrees that this may be one of the most important issues that we will undertake this year. Along with that, of course—which I guess is not unusual—it will be one of the most difficult. I think there is a strong feeling that this needs to be done. I believe that will drive us. We certainly have had a good deal of support from the administration, from the President, and from Secretary Thompson. So we have an opportunity to move forward.

This is a very difficult issue. It is one that is hard to deal with, to make sure that everybody is treated properly. It is hard to deal with in terms of costs. It is also hard to deal with in terms of different parts of the country and how you have a delivery system that fits everywhere. It will be a challenge, but I believe we have no greater domestic challenge than reforming Medicare and providing seniors with access to prescription drugs. We will hear a great deal of the same sort of conversation during this week. We will also find that there are different ideas about how this is done.

The committee approved a prescription drug bill last Thursday night after an all-day markup, which was interesting—by a substantial bipartisan majority, which is very good. So it is a promise that most of us have made to take a look at Medicare and to be able to strengthen it. It has been mentioned that it is more than 30 years old and hasn't been changed a great deal. The greatest change that has come about is in pharmaceuticals, which has become one of the most expensive aspects of health care and has not been covered under Medicare in the past.

So I think we have two things we are seeking to do, and I hope we don't lose sight of them. One is to make the Medicare delivery system work better. Second is to include a reasonable access to pharmaceutical drugs. The program we have had has been difficult in a number of ways. We have had more and more providers that will not provide care under Medicare because the fees have not been equal to what they get in the private sector, and therefore access is not available. That is a difficult issue, particularly in rural areas where there are not a lot of providers. So we have to make sure we have a plan that puts this kind of program basically in competition with the private health care sector. The program has been inefficient and, no doubt, we need to change some things, particularly with respect to chronic illness.

A relatively small percentage of the elderly use a very high percentage of the total expenditure. So it has to be oriented somewhat toward dealing with those things that we know are the most expensive, and this cannot be done without some special attention to those things. These are the people who need the most expensive drugs. We ought to have a plan in which seniors could choose what fits them best.

We will be continuing to have the general plan that is in place now. If people find they want to stay with it, they will be able to do that. Nobody will be forced to change—at least in the near future. But there will be another plan, an alternative. We have felt that we could follow the plan that is used by Federal employees, generally, as an option. That would be one where there would be a plan laid forth, where we would have different sorts of insurance coverage, and providers will bid on doing that job. Maybe we would take the lowest bids—maybe the three lowest bids, or whatever. It would be a little different—sort of a PPO program, preferred provider program. Some say if you have a PPO, it won't cover everybody. In Wyoming, there are not formal PPOs, but we still have coverage for Federal employees, and there will be an arrangement made so where they are without a form of specific PPOs, they will still be available in the private sector. So I think that is, indeed, the way it ought to be. If we follow that plan, I think it would be one that we can really make available.

One of the things we have been working on—and I happen to be chairman of the Rural Health Caucus—there has always been a considerable amount of difference in the health care programs between urban areas and rural areas. One of the things is, there has not been equity in payments. Payments in urban areas have been higher than in rural areas. They have thought the costs are not as high in rural areas. In fact, because of lower volume, they may be higher in rural areas than in urban areas.

I had an experience recently where an MRI in one town costs almost 50

percent more than the larger city simply because they didn't have the volume. This bill, by the way, has that sort of remedy in it so that we will have urban areas and rural areas that will have equity in the way they are handled. We hope we can do that.

Some have a concern about small counties. We have a situation now in Medicare where we deal with each county to determine the price of service. Here we will have 10 regions over the whole country, so it will be a broader base, which is the basis for insurance, to spread that over a broader number of people so that there is better equity for everyone. I think a lot of provisions in this bill will be much more advantageous for users than what we have had in the past.

We will all be talking about this bill in more detail. I hope we can make some changes and we can remember the objectives. There are so many details involved with Medicare and with health care, as a matter of fact, that I think we have to focus on what it is we are seeking to do and to stay with that.

I hope we can develop a vision of what we want this to be when we are through and try and stay within the parameters of that vision. The objectives will be to strengthen Medicare and provide accessible pharmaceuticals.

There are, as we go about our work, lots of issues involved in health care, many of them beyond Medicare. We have to deal with those issues at another time. I hope we do not try to remedy all problems in health care and get it confused with this program, which is a specific program. For instance, we had some amendments having to do with refugees and legal immigrants. That is an issue, and it is a tough issue, but it is not part of Medicare and we ought to separate those issues so we keep it that way. I hope we maintain our focus so unrelated issues do not become wrapped up in this bill.

We also need to be conscious of spending. We have a budget of \$400 billion, an amazing amount of money. But when we compare it to health care costs, it is not huge. I did not think I would ever say \$400 billion is not huge. Cost is something, and we have to do something that is efficient. Money is not endless, particularly when it relies largely on what you and I pay in every month. If we have total expenditures that continue out of control, we have to do something different as to how they are paid. We should keep that in mind.

One of the keys—even though we should recognize the needs of low-income people certainly, and that is in the plan and we should do that, as opposed to higher income people—I think it is important everyone who is a beneficiary have some responsibility. When we have a program paying for all of the health care, we get overutilization, without exception. So there has to be some first dollar payment in this program, even though it can be very small, I believe.

We need to take advantage of the opportunity with the volume of pharmaceuticals we will be using, for example, to hold down the costs somewhat. Health care has been going up almost 13 percent a year, which is much higher than almost every other activity. Part of it is because times change and we are doing things so people are healthier, and people are living longer partly because of that. Nevertheless, if you start adding up 13 percent a year on these costs, it would be an almost unmanageable program over time.

I already mentioned this will serve all eligible seniors, whether they are rural or urban. I am hopeful as we go through this very complicated and difficult program. I am very pleased, particularly serving on the committee of jurisdiction, to have been involved in this debate and to see we are as far along as we are, and I am very confident we are going to come out with a package. That, of course, is our responsibility and what we ought to do. As we do that, I hope we have a vision of where we want to be when it is over and take a look at the issues we do in the interim and see if they are going to contribute to providing that program we envision for the future. It is one that ought to strengthen the program. It is one that ought to be available to people all over the country. It is one that ought to recognize the special needs, particularly of very low-income people. It is one that ought to give choice of different kinds of programs so you can choose something that fits you.

I think we have to have a program that does not have runaway spending so that it destroys the whole program over time and that we also recognize related programs, whether it be VA or retirement. These had to be fit in so we could have a total package.

I am looking forward to 2 weeks of considerable debate. I think with all these various issues, we will, frankly, have hundreds of amendments, most of which will be dealt with, and that is good. But as we look at all these different issues, I suggest to my friends in the Senate that we try to focus on what we want the result to be and measure these amendments against that.

I am looking forward to the debate. I am sure most of us are. I think we can come up with a program that will be much better and provide services for the needy better than we have in the past.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. HATCH. 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. HATCH. Mr. President, I rise to express my strong support for S. 1, the

Prescription Drug and Medicare Improvement Act of 2003. Medicare beneficiaries have been waiting decades for a comprehensive and permanent prescription drug benefit. Debate on this legislation is truly a landmark occasion for America's seniors, the disabled, and the United States of America, including our own Senate. I congratulate both the Senate Finance Committee Chairman, Senator GRASSLEY, and the ranking member, Senator BAUCUS, on a job well done. Both of them worked well together. It has been bipartisan. They have done everything they possibly can to bring people together so that we can pass a bill out of the Senate, and they both deserve a lot of credit.

Both of them have been able to put together a Medicare prescription drug bill that not only has bipartisan support but was also approved by the Senate Finance Committee, both remarkable feats. I am so proud of both of them.

The majority leader, BILL FRIST, also deserves credit for his commitment to this issue. He is to be congratulated not only for his behind-the-scenes efforts to move this bill forward but also for his vision in developing with Senator BREAUX the model upon which many of the improvements in this bill are based. Of course, Senator BREAUX deserves a great deal of credit. He has consistently fought to try and get a prescription drug benefit bill, and of course was a member of the tripartisan group in the last Congress.

Finally, I would be remiss unless I recognized the central role the President played in this matter by insisting that Medicare drug coverage must be a top domestic priority. Many believed it could not be done, especially in this, a non-election year.

President Bush's persistence, his commitment, and, indeed, his leadership on this issue will prove those naysayers wrong.

At last, we will provide senior and disabled citizens across the country with the prescription drug coverage they need.

In fact, prescription drug coverage for Medicare beneficiaries has been one of my top priorities, as well, and think everyone knows.

I was the principal cosponsor with then-Chairman Bill Roth of the 1997 legislation creating the Bipartisan Medicare Commission.

That commission, as my colleagues are aware, was charged with making recommendations on how to improve the current Medicare program.

And although commission members were unable to report a recommendation due to the "super-majority" vote requirement, the work they did laid the groundwork for efforts to improve Medicare by including the private competition that could provide prescription drug coverage.

Through their leadership on the commission, my friend and colleague, Senator JOHN BREAUX, and our House colleague, Ways and Means Committee

Chairman BILL THOMAS, were instrumental in laying the groundwork for Medicare prescription drug legislation.

More recently, I worked closely with Chairman GRASSLEY, Senator SNOWE, Senator BREAUX, and Senator JEFFORDS in an effort to develop a centrist, Medicare prescription drug bill that the Congress could adopt free from partisan politics. This was an 18-month effort.

We called our effort "tripartisan," because Senators participated from the Democratic, Republican and Independent parties.

I took great pride in our effort, which I believe would have passed the Senate but for election-year maneuvering.

The goal of the tripartisan legislation was to provide all Medicare beneficiaries with quality drug coverage through private health plans. In addition, the tripartisan bill gave seniors and the disabled a choice in health coverage: They could have traditional Medicare, a Medicare+Choice plan or a new enhanced Medicare plan.

It was truly a labor of love. We are proud of that effort and the fact that it laid the foundation for S. 1, the Prescription Drug and Medicare Improvement Act of 2003, which we are considering today.

I predict that S. 1 will not only pass by the Senate by the end of the month, it will be signed into law at the end of the summer. What a difference a year makes.

S. 1 builds on several important foundations we laid in the tripartisan initiative.

And, in many ways, it is far superior to our tripartisan initiative.

It offers beneficiaries a meaningful and reliable drug benefit through the private sector with reasonable and fair cost-sharing. Beneficiaries will have the ability to obtain the drugs of their choice without Government interference and with better coverage choices.

In contrast to last year's bill, the measure we have before us today provides beneficiaries with several choices: A stand-alone drug benefit, a drug benefit through a Preferred Provider Option, PPO, or a drug benefit through an HMO.

Those who do have drug coverage will have the choice of remaining in the existing plans or choosing a Medicare prescription drug benefit. S. 1 also offers beneficiaries a temporary drug discount card available to seniors no later than January 1, 2004. This drug card would be in operation until the Medicare prescription drug benefit is fully implemented.

In sum, S. 1 offers additional assistance to those who cannot afford to purchase their prescriptions.

In a country as prosperous as ours, we can no longer tolerate situations where seniors have to split their pills in half or cannot fill necessary prescriptions because they do not have the money.

A land as great as ours owes it to needy seniors and disabled to help

these individuals who many times cannot help themselves.

Another important point is that S. 1 also ensures access to drug benefits for beneficiaries who live in rural areas. This is a must-do for my home State of Utah. S. 1 provides reliable coverage everywhere in America. Wherever there is Medicare coverage, there will be Medicare prescription drug coverage.

In addition, this bill includes important consumer protections. Every plan offered to Medicare beneficiaries will have to be certified by the Federal Government.

A key point is that S. 1 recognizes the role of employers in providing their retirees with health coverage. Let me make it perfectly clear that the intent of this plan is not to disrupt that important relationship between employers and their retirees. We should encourage employers to continue to offer retiree health coverage.

Finally, I must note that this legislation does nothing to dismantle or weaken the traditional Medicare program. The bill offers beneficiaries more coverage options, and does nothing to disrupt the existing physician-patient relationship. That is a fundamental principle that was very important to me as I worked with committee members to draft this legislation.

At this point, I would like to take some time to go into the details of the principles I have just outlined. First, and most important, this legislation provides beneficiaries with more coverage choices.

Let me emphasize, S. 1 does not, I repeat, does not, take anything away from Medicare beneficiaries. If beneficiaries like what they have, they may keep their current coverage. However, if they want coverage similar to private health insurance, S. 1 offers them this choice.

Those remaining in traditional Medicare will be able to receive prescription drug coverage equal to that received by beneficiaries who elect to receive their prescription drug coverage through the new MedicareAdvantage program. MedicareAdvantage is the new name for the current Medicare+Choice program, also known as Medicare Part C.

As my colleagues are aware, today we have Medicare Part A, which is for hospitalizations, and Part B, which is for outpatient and physician coverage.

This legislation will then add Part C, for Medicare Advantage. And, beginning on January 1, 2006, a Medicare prescription drug benefit will be established under a new program which will be codified as Part D of Medicare.

Beneficiaries will have the choice of either adding a new stand-alone drug plan to their current coverage, delivered through fee-for-service reimbursement or they may participate in a program which integrates their basic medical coverage with added pharmaceutical benefits through either a health maintenance organization, HMO, or a preferred provider organization, PPO.

There will be a new Center for Medicare Choices established at the Department of Health and Human Services, with an administrator who will oversee both the new drug plan under Medicare Part D and the new MedicareAdvantage program under Medicare Part C.

To operate the prescription drug plan, the Administrator will create at least 10 regions throughout the country, which must be at least the size of a state. States will not be allowed to be divided among regions.

Private-sector entities will bid to provide coverage. For PPOs, they will contract to provide the entire spectrum of Medicare services, including drug coverage, for the region. For HMOs, they will contract to provide Medicare services, including drugs, for a county.

If a beneficiary elects to remain in the traditional Medicare program, he or she may receive pharmaceutical assistance through a new add-on program which will be administered by a private insurer who has been certified by the government to provide coverage in that region. Many have been concerned that in some areas of the country there will not be private sector entities that wish to provide this new coverage. I share that concern, especially after my own State's experience with Medicare+Choice program.

For this reason, we worked very hard to make certain that there was a safety net, a "fall-back" plan that would provide seniors with the coverage they need if no private sector plans came forward.

I will discuss how the fall-back operates in a few minutes, but I did want to assure my constituents that there will be safety net if it is needed.

Another assurance this bill provides to our constituents is that beneficiaries will be allowed to change plans on an annual basis. We do not want any beneficiary to feel that he or she is locked into a program that is not a good fit. So, I have insisted that the flexibility to change plans was present in the bill, and I am pleased it was included.

As I mentioned earlier, one important principle of our plan is that beneficiaries who continue in traditional Medicare or those who enter a new integrated plan should have the same level of coverage.

So beneficiaries can either purchase standard coverage from an insurer or they will have the benefit of participating in a new HMO or PPO plan that includes pharmaceutical coverage valued at the equivalent amount of the subsidy the government is providing for the stand-alone plan.

In 2006, standard coverage would have a \$275 annual deductible. For spending over the deductible up to \$4,500, beneficiaries would pay one half, and the government the other half.

Eighty-eight percent of Medicare beneficiaries will not reach this limit of \$4500 in 2006.

Even so, the plan envisions generous subsidies for beneficiaries who cannot afford their drug coverage, in this case those with incomes less than 160 percent of the federal poverty level.

However, for those with incomes at the above 160 percent of the federal poverty level, there would be no government subsidy for out-of-pocket expenditures once drug costs in total reach \$4,500, of which the government would have paid roughly half once the deductible was satisfied.

As a protection against extremely high drug costs, which can prove catastrophic to a beneficiary, we have included a provision limiting a beneficiary's spending to 10 percent of costs once their out-of-pocket expenditures for drugs reaches \$3,700.

We want this program to be as affordable as possible for beneficiaries. Indeed, the committee was torn.

We needed to make certain that the program is affordable to Federal taxpayers and does not exceed the \$400 billion we have planned for in our budget.

On the other hand, we wanted the coverage to be meaningful and really help seniors and disabled who need assistance.

This is one reason the bill contemplates an affordable, national average premium for pharmaceutical assistance of \$35 per month. I know this can be very confusing—even for those of us who drafted the bill—so I want to take this opportunity to explain the standard drug plan and the actuarial equivalent drug plan—the two types of drug plans that will be offered to Medicare beneficiaries.

First, both the standard drug plans and the actuarial equivalent drug plans would have the same deductible.

Second, beneficiary out-of-pocket expenditures would be the same in both the standard and actuarial equivalent plans.

Both the stand-alone drug plan and the MedicareAdvantage PPO plan could offer beneficiaries standard coverage that is described in the statute, or they can offer differing coverage as long as certain provisions are met: The actuarial value of the prescription drug plan would have to be at least equal to the actuarial value of the standard plan; and the coverage would be designed to cover the same percentage of costs up to the initial benefit limit as that provided under the standard plan. Again, the limits on beneficiary out-of-pocket expenses and annual deductibles would be the same in both the standard plan and the actuarial equivalent plan.

Finally, actuarially-equivalent plans would be allowed to vary the monthly beneficiary premium and the beneficiary copayments. In addition, if these plans wanted to offer additional benefits to seniors, they may do so and the beneficiary would be responsible for paying additional costs.

In sum, a beneficiary is permitted to choose a drug plan that best suits his or her health care needs.

In S. 1, we are offering seniors choice in drug coverage. Medicare beneficiaries may stay in traditional Medicare fee-for-service and receive their drug plan through a stand-alone drug plan. Or, they may receive their drug coverage through the new MedicareAdvantage program either through an HMO or the new PPO option.

The plans offered through MedicareAdvantage are integrated health plans which means these plans are similar to private health insurance which combines health and drug benefits in one insurance plan. In order to encourage plans to participate as stand-alone drug plans, interested entities would submit bids to the administrator. This bid would include information on benefits, the actuarial value of the prescription drug coverage, the service area for the plan, and the monthly premium.

Plans could submit bids to provide coverage for a specific region, as established by the Administrator, or the entire area covered by Medicare. Plans could also submit bids for more than one region and they may also bid nationally.

A plan would not be accepted by the Secretary unless the premium, for both standard coverage and for any additional benefits, accurately reflected the actuarial value of the benefits.

The administrator will work with bidding plans so a region will have at least with two stand-alone drug plans that will offer prescription drug coverage to Medicare beneficiaries in an area. These contracts would be awarded for 2 years. Finally, the stand-alone drug plans would be required to accept some level risk.

If only one plan, or even no plans, are unwilling to offer stand-alone prescription drug coverage within a region, the Administrator will enter into an annual contract with an entity to provide a prescription drug fallback plan. This fallback plan, which would be given a 1 year contract, would offer Medicare beneficiaries the standard drug plan.

We have designed this fallback plan to ensure that seniors will have prescription drug coverage across the country. In addition, seniors could be offered prescription drug coverage through a MedicareAdvantage HMO or PPO.

During the Finance Committee mark-up, an amendment was offered that would have given the fallback plan a two-year contract instead of a one-year contract.

While I am sympathetic to some of the concerns raised about the administrative difficulties surrounding choosing a fallback plan within a few months, I do not believe that a 2-year fallback plan is the solution.

I believe that having a two-year fallback plan makes it even more difficult to encourage other private plans to bid in a region. As a result, a two-year fallback plan could prevent a private plan from ever wanting to enter the region

and beneficiaries are left with a fallback plan that does not offer much flexibility. Therefore, I would strongly oppose such an amendment.

With regard to the low-income, I believe that we should provide additional assistance to the low-income Medicare beneficiaries when it comes to prescription drug coverage. S. 1 provides additional subsidies for drug coverage for Medicare beneficiaries under 160% of the federal poverty level, individuals with income limits of \$14,368 for individuals and \$19,360 for couples.

Let's face it, these beneficiaries, in many cases, are struggling with their bills and are barely making ends meet. These are the individuals who are deciding between paying the rent and paying for food. This population makes up 37.4 percent of Medicare beneficiaries.

S. 1 continues to provide drug coverage for the dual eligible population, those who are currently eligible for both Medicare and Medicaid, through the Medicaid program.

Dual eligibles have incomes that are below 74 percent of the Federal poverty level—annual income limits are \$6,555 for individuals and \$8,848 for couples.

During the Committee's consideration of S. 1, I authored a provision that would reward states that already provide both Medicare and Medicaid coverage for low income individuals between 74 percent and 100 percent of the Federal poverty level.

For the 19 States that have expanded their Medicaid coverage to these seniors, the Federal Government would pay for the Medicare Part A cost-sharing of these beneficiaries. The provision is important because it gives incentives to States that expand their dual eligible programs.

This legislation provides these beneficiaries who are below 160 percent of poverty with additional subsidies for their drug coverage.

There are some who are concerned about the Federal Government heavily subsidizing this population because drug coverage is so expensive. In my opinion, providing additional assistance to these lower-income beneficiaries is the right thing to do. End of story.

With regard to the comprehensive drug program, some have expressed concern that the program will not begin until January 1, 2006. I understand the concerns of those who advocate for immediate coverage for seniors. That's why we created the Medicare Prescription Drug Discount Card available to Medicare beneficiaries no later than January 1, 2004 and would provide discounts up to 25 percent on their prescription drugs.

Medicare beneficiaries would be charged an annual enrollment fee of \$25 and could only be enrolled in one endorsed card program. The prescription drug card program would continue to operate for at least 6 months after the implementation of the Medicare Prescription Drug Benefit Plan.

At the beginning of 2004 and 2005, low-income beneficiaries under 135 percent of poverty would be given \$600 per year for their drug expenses. These beneficiaries would be permitted to carry any left-over money from year to year. Additionally, spouses may share their drug cards.

I worked very hard to make certain that our new plan does not disadvantage rural areas such as my home state of Utah. The bill before us provides assurances that any Medicare beneficiary, regardless of where he or she lives, will have access to prescription drug coverage.

For example, the legislation requires that at least two stand-alone drug plans would be offered to Medicare beneficiaries in each region. And, if only one plan, or worst case scenario, no plans, bid to offer stand-alone coverage, there will be a fallback plan to provide prescription drug coverage. No beneficiary, regardless of where he or she lives, would be without prescription drug coverage.

In addition, for those living in rural areas, the MedicareAdvantage plans will offer beneficiaries a maximum of three PPO plans per region. If PPOs decide not to bid in a specific area, these beneficiaries still will have coverage through traditional Medicare and will also have optional prescription drug coverage.

S. 1 also gives the Secretary of Health and Human Services the discretion to make adjustments in geographic regions so there will not be a large discrepancy in Medicare prescription drug premiums across the country.

However, our first and foremost goal in S. 1 is to provide drug coverage to those who currently have no coverage. We need to help beneficiaries first, but we also need to continue our work with the employer community to ensure that they will continue to offer retiree health benefits.

Finally, I want to take a minute to talk about traditional Medicare and why I believe that the PPO option under the MedicareAdvantage program is the better choice.

Most will agree that the current Medicare program is an archaic system that still looks very much like the program when it was created in 1965. Do any of you remember what was popular in 1965? Most of you probably do not but, unfortunately, I do.

What we are trying to do in S. 1 is provide seniors with the same health choices available to those under 65 today, and not offer them only health choices that were available in 1965! While most seniors are comfortable with the current Medicare coverage, traditional Medicare is outdated in several ways. Besides not offering seniors prescription drug coverage, it does not provide protections for the sickest beneficiaries. To me, that is a major flaw of the program. Most drug plans offer catastrophic coverage for seniors once they spend a certain amount of

money for their health care costs. Not traditional Medicare. Medicare requires the sickest seniors to continue to pay for their health coverage out of pocket without assistance.

In addition, beneficiaries currently receive their coverage through Medicare Part A, which covers hospital expenses, and Medicare Part B, which covers providers' expenses, such as physicians. There are deductibles for Medicare Part A, which is \$840 in 2003, per spell of illness.

Simply put, this means that a beneficiary who is admitted to the hospital for different illnesses ends up paying this hospital deductible more than once per year. The Medicare Part A program also has copayments and other beneficiary cost-sharing that could be very expensive. On top of it, beneficiaries also must pay a \$100 annual deductible for Medicare Part B, along with beneficiary copayments for these services.

The bottom line? Medicare beneficiaries are paying two different deductibles each year for different health services. How fair is that to seniors? And why should seniors be the only ones who have to adhere to such a crazy system?

Private health insurance does not operate like this. Those under 65 do not have to pay arbitrary copayments and deductibles. They have prescription drug coverage in many cases. And they typically do not have to pay extra money out of pocket if they are seriously ill.

I believe that Medicare beneficiaries should have those same choices and that's why we created the MedicareAdvantage program in S. 1.

MedicareAdvantage improves the choices offered to beneficiaries. They would have their choice of coverage in MedicareAdvantage through HMOs, the same Medicare+Choice plans many have been offered or the new preferred provider organization, better known as PPOs.

MedicareAdvantage PPOs would have a network of providers that will agree to offer Medicare beneficiaries coverage for benefits in the traditional Medicare program. Through this PPO system, beneficiaries will be able to see their same doctors, and go to the same hospitals.

If these medical providers are in the PPO network, the beneficiaries will pay the standard coverage for participating network providers. If they do not participate in the PPO network, seniors will pay more to see them. The important point is that, through PPOs, beneficiaries would still be able to see the doctor of their choice.

Similar to the regions created for the Medicare prescription drug benefit, S.1 also creates 10 regions for PPO coverage. To make things simpler, the secretary of Health and Human Services would be allowed to use the same regions as the ones established for the prescription drug program.

Again, these regions must include at least one State—and parts of one State

could not be divided up into separate regions. A maximum of three PPO plans per region would be offered to Medicare beneficiaries. The HHS Secretary would calculate what the benchmark payment from the federal government would be for these new PPOs. This benchmark would be based on the higher payment of traditional Medicare FFS or the Medicare+Choice payment for the specific region.

The MedicareAdvantage PPO will provide beneficiaries with the health coverage that is similar to private health insurance. Instead of the crazy patchwork of deductibles and copayments imposed on beneficiaries in traditional Medicare, it would offer them a combined deductible, instead of separate deductibles like traditional Medicare.

MedicareAdvantage PPOs will offer beneficiaries with catastrophic health coverage. If beneficiaries choose the PPO option, they will not longer be completely responsible for bills associated with catastrophic illnesses. The PPO plans would determine appropriate levels of beneficiary cost-sharing—deductibles, catastrophic limits and copayments, not the federal government.

In addition, plans under the MedicareAdvantage program will provide beneficiaries with coordination of care.

It is unfortunate that the traditional Medicare program does not have any disease management or chronic care management programs available for all Medicare beneficiaries. This is something many of us had hoped to improve for years.

Under S. 1, MedicareAdvantage plans will create disease management programs and, in my opinion, do a much better job of monitoring the health care needs of individual Medicare beneficiaries than traditional Medicare.

In the worst case scenario, if PPO plans do not offer coverage for a specific region, the Medicare beneficiary would have traditional Medicare coverage along with a prescription drug benefit. Seniors will always have health insurance coverage and the option of prescription drug coverage as well.

Before I close, I want to address one of other important priority of mine.

Although we have worked for several years to pass a Medicare prescription benefit in the Senate, we have worked just as long to pass a Medicare regulatory reform bill.

That is why I am delighted that the "Prescription Drug and Medicare Improvement Act of 2003" includes "The Medicare Education, Regulatory Reform and Contracting Improvement Act" a bill that I am introducing this year in the Senate. This bill is called MERCI [mercy] because it provides regulatory relief for Medicare providers and improved services for beneficiaries.

Medicare's antiquated regulations—three times longer than the U.S. tax

code—prevent providers from delivering health care efficiently and beneficiaries from receiving the care they need.

Secretary Thompson has said, “Patients and providers alike are fed up with excessive and complex paperwork. Rules are constantly changing. Complexity is overloading the system, criminalizing honest mistakes and driving doctors, nurses, and other health care professionals out of the program.”

Failure or just the perception of failure to follow Medicare’s needlessly complex rules can result in audits, withholding of payments, and crippling of a physicians’ practice. Furthermore, obsolete restrictions on Medicare contracting authority impose burdens and inefficiencies on contractors, taxpayers, providers and beneficiaries.

This bill improves the Medicare program for beneficiaries and provides by clarifying regulations, rewarding quality and by enhancing services.

The bill decreases waste, fraud and abuse in Medicare in ways that are just and fair for beneficiaries, contractors, and providers by eliminating retroactive application of regulatory changes, and by expediting the appeals processes for beneficiaries, providers, and suppliers of Medicare services.

It improves communication between HHS and both Medicare providers and beneficiaries by enhancing central toll-free telephone services and providing for provider and beneficiary ombudsmen. It increases competition, improves service and reduces costs by providing for a competitive bidding process for Medicare contractors that takes into account performance quality, price and other factors that are important to beneficiaries.

And, it decreases Medicare billing and claims payment errors by improving education and training programs for Medicare providers and at the same time creates an expedited appeals process for Medicare claim denials.

These provisions will improve the delivery of health care services to Medicare beneficiaries by enhancing the efficiency of the program for all concerned.

It is high time that we made Medicare more user-friendly. I want to thank my colleagues Senators Grassley and Baucus for working with me on these provisions.

In conclusion, I believe that this will assist all Medicare beneficiaries, especially those without prescription drug coverage, by providing them with a choice of quality prescription drug coverage and a choice of quality health coverage. Passing this legislation is the right thing to do for our seniors.

It is remarkable to me that close to a year ago, we were having the same debate on the Senate floor.

Last year’s outcome was a major disappointment to me and my tripartisan colleagues. At the time, I honestly believed that last year was our final chance to make improvements to the Medicare program for a long time.

But here we are, almost a year later, debating this important issue once again. Thankfully, we have a Finance Committee chairman who has been able to guide this legislation through the Senate in a timely manner. Thankfully, we have a President who made Medicare prescription drug coverage for seniors one of his top priorities.

This year is different than 2002.

This year, we have accomplished what we could not accomplish last year.—We have put partisan politics aside and written a bill that is truly bipartisan.

And because of this bipartisan effort, I believe a Medicare prescription drug benefit will become a reality for Medicare beneficiaries across the country. The wait for Medicare prescription drug coverage will soon be over thanks to the hard work of the Senate Finance Committee, especially Senator GRASSLEY, Senator BAUCUS, Senator SNOWE, Senator BREAU and Senator JEFFORDS.

This is a historic time for the United States Senate.

I notice my esteemed colleague who has done so much in the field of health care in the House, and who has started anew here in the Senate in many ways, is here to speak.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, before he leaves the floor, I just want to commend the distinguished Senator from Utah on all his extraordinary work in the health care field. If you look at what the Senator from Utah has achieved in the S-CHIP area, his work that led to the Hatch-Waxman legislation, and what he has done on a whole host of health care issues, the senior Senator from Utah has made an extraordinary contribution.

As we begin this discussion on Medicare reform, I commend the Senator from Utah on an excellent statement. I think the Senate will have another success over the next few weeks. After the Senator’s success on S-CHIP, Hatch-Waxman, community health centers, and other areas, there will be yet another significant milestone the Senator from Utah will have helped to achieve in the health care area. He and I are working on a variety of initiatives now. I commend the Senator on an excellent statement and wish to associate myself with his remarks.

Mr. HATCH. Mr. President, I thank my colleague. He is a definite leader in health care. I enjoy working with him and appreciate his kind remarks.

Mr. WYDEN. Mr. President, a Congress that can find hundreds of billions of dollars in money for tax cuts and the money to rebuild a foreign country must find a way to make Medicare work better for the Nation’s vulnerable senior citizens. That is what the next two weeks are all about, and they are historic weeks for the Senate.

Updating Medicare is an issue I have felt very strongly about for several

decades because my public service career began in the early 1970s, when I served as codirector of the Oregon Gray Panthers and ran the Oregon Legal Services Program for the elderly. Back then, the old saw was that Medicare was just half a loaf. Of course, from its beginning, Medicare did not cover eyeglasses, hearing aids, dental care, and a host of services that are so important to vulnerable older people. But of particular concern, even then, was the fact that medicine, in so many instances, was both unaffordable and inaccessible. Now the Senate has an opportunity to do something about that in providing a real measure of relief for the Nation’s older people. I believe over the next couple of weeks what the country is going to ask is not what a particular philosophical approach of a Senator was, but whether that Senator was part of an effort to find the common ground in finally getting real results for the Nation’s older people.

Senator OLYMPIA SNOWE and I offered the first bipartisan amendment to the budget resolution to fund a Medicare prescription drug program back in 1999. We followed that action up by introducing the first bipartisan proposal called SPICE, the Senior Prescription Insurance Coverage Equity Act. I am very proud to be able to stand on the floor today and say that because of the dedication of members of the Finance Committee, the leadership of both sides, many of the provisions Senator SNOWE and I have been advocating for a number of years have been included in the legislation the Senate will vote on over the next couple of weeks.

We were concerned then that traditional Medicare not be skimpy, that it be a good benefit package, and that it would be affordable for older people. Suffice it to say, under the legislation the Senate will be considering, traditional Medicare will survive. The millions of seniors who want to take that program will be able to do so. Traditional Medicare will not wither. It will not vanish as a result of being underfunded or having provisions that would make it less attractive for seniors to choose.

A number of important consumer protection provisions are included in this legislation, something I think is absolutely critical if you are going to allow private plans to play a bigger role in delivering this benefit.

I have had a great interest in this area since the distinguished minority leader, Senator DASCHLE, and I wrote a Medigap law a number of years ago which eliminated a lot of the unscrupulous practices that were taking place in the insurance market designed to supplement Medicare. Now there are standardized benefit packages for these Medigap supplements, and a lot of the abusive activity that used to go on, that used to exploit older people, has been eliminated.

Many of the consumer protections in this legislation have been borrowed from the Medicare Choice Program,

really building on what Senator DASCHLE and I wrote into the Medigap law years ago, and are a significant step in the right direction.

I think there are also important steps included in this legislation to make medicine more affordable to the Nation's older people. It seems to me by giving seniors more choices, you make it possible for seniors to have the opportunity to get medicine that is more affordable because for a private plan to attract a senior subscriber, that private plan is going to have deliver medicine in an affordable way. So there will be a concrete incentive to actually hold down the cost of medicine because those private plans will not be in a position to make money, they will not be in a position to be profitable if they cannot attract seniors by keeping down the cost of medicine.

So it is important that this legislation be enacted. I have always felt Government really comes down to people, and it comes down to those who tell us exactly what their experience has been with health care and various other areas of Government.

What has really colored my judgment on this issue are the accounts I have heard from seniors, many of them going back to my days with the Gray Panthers. Not long ago a woman from my hometown of Portland, with \$806 in monthly income, had prescription drug bills totaling \$150 a month, and she got no help from Medicare whatsoever. My staff and I inquired about how she was able to get by, and her answer was just heartbreaking. She said: I just do without, and I pray.

I do not think that is good enough. As I said earlier, I think a country and a Congress that can find hundreds of billions of dollars for tax cuts and a hundred billion dollars or so to rebuild a foreign country can do better by seniors on Medicare. So this legislation provides an opportunity to do that.

I think there are a number of important issues for the Senate to zero in on as we begin this debate, the first of which is the cost. A number of Senators have said this legislation is costly and it will be difficult to finance in the years ahead. What I would say, Mr. President and colleagues, is this country cannot afford not to cover this vital service for older people.

Not very long ago a physician in Hillsboro, OR, wrote me and said he put a senior citizen in the hospital for something like six weeks because that person could not afford their medicine on an outpatient basis. That is pretty bizarre by anybody's standards. If a senior is hospitalized, they get their medicine covered under part A of the Medicare program. But, of course, if the senior faces a serious health problem and is not hospitalized, they have to resort to outpatient services, and Medicare part B historically has not picked up the bill for drugs.

So what we saw in Hillsboro, OR, not long ago is that it costs thousands and

thousands of dollars for a senior to be hospitalized in order to get the Medicare benefit. It would have cost a small fraction of that if the drugs were covered on an outpatient basis.

When seniors and others wonder about the cost of this benefit, and for Senators who are asking if the Nation can afford prescription drug relief for older people, my message is, America cannot afford not to do this. America cannot afford inaction and having older people hospitalized, facing serious health problems simply because they are not able to get medicine in a cost-effective kind of way.

Second, as we look at this issue, we ought to understand that older people are getting hit by a double whammy when they try to afford their medicine. First, Medicare does not cover their purchases. But secondly, the older people of this Nation are subsidizing those who do have bargaining power, the health plans and big buyers who are using bargaining power to knock the price down. What we have been trying to do, going back to the days when Senator SNOWE and I introduced the SPICE legislation, is give seniors some bargaining power, a chance to be on a level playing field with the big buyers, with the HMOs, with those who have bargaining clout. This legislation puts seniors on a more level playing field so that they are able to better afford their medicine and that is a step in the right direction.

There are going to be a number of issues that will come up in the course of the debate. One that my State feels very strongly about is the fact that Medicare's payment system penalizes those who have been efficient. Historically, States such as Oregon that have been innovative in the health care area have taken concrete steps to hold costs down. You would think the Federal Government would reward them. You would think the Federal Government would give them a break for stressing cost containment. The reality has been just the opposite. The Medicare Program has penalized States for holding costs down.

This legislation doesn't do as much as I would like it to do to remove the penalties against those who have been efficient, and I am hopeful that as we consider the legislation more can be done in that area.

It does take significant steps to address the question of rural health care, something that has been particularly important to me. Senator SMITH and I have included it in our bipartisan agenda for the State of Oregon. All who represent States like ours know that States that are largely rural find it extremely hard for seniors to get the care they need. Very often they don't have hospitals or doctors in close proximity and clearly need extra help in order to ensure that our rural communities survive. The fact is, without rural health care, you cannot have rural life. I am not prepared to sit by and let rural communities become sacrifice zones.

That is why the provisions in this legislation to provide better reimbursement for rural health care are heartening.

The provisions in the legislation for rural health take strong steps forward. It would adjust hospital payments to account for the higher costs associated with low-volume hospitals. It makes changes to what is known as the "swing bed concept" which will help critical-access hospitals, and it creates a floor for geographic payments for physicians and offers improvements for rural health clinic reimbursement.

More needs to be done to assure that provider reimbursement is adequate. Better reimbursements obviously keep more qualified doctors and other providers in the Medicare system. That, of course, provides more choice and better care for the Nation's older people.

I have been involved in a number of efforts with respect to trying to help seniors with their prescription drugs over the years. I have been involved in measures to expand access for generic drug coverage. I have been involved in efforts to give more bargaining power to public programs, particularly the Medicaid Program, and the program for the Veterans Administration. I have believed, even most recently with the drug Taxol, which is the largest and biggest selling cancer drug in history, that the Government has to do a better job of striking a balance between the need to get drugs to market quickly and be sensitive to making sure that the interests of taxpayers are protected.

But all of those steps together, which have been of some help in terms of making medicine more affordable for older people, do not rival what the Congress is facing now in terms of modernizing the Medicare Program and providing concrete relief to the millions of the country's elderly who are watching now and urging the Congress, after years of partisan action, to actually produce results and address their drug costs.

The fact is, Medicare reform isn't easy. No Senator walks away with everything he or she wants. But there is a chance now to make sure seniors don't walk away empty handed. It is not going to be inexpensive. There will be some who want to spend more. Certainly, I have believed the key issue for all these years has been to try to find the common ground, to act on a bipartisan basis—Senators BAUCUS and GRASSLEY have done that—and we must not let this legislation go by the wayside once more.

For my part, I will do anything over the next couple weeks to build the bridges that are necessary to make health care more accessible and more affordable for the Nation's older people. This is the issue I care the most about, the question of making health care more affordable and more accessible. We have the most talented, dedicated, and caring health care providers on Earth. They deserve a Congress that

does a better job of setting in place the governmental policies that allow them to deliver the best and most affordable health care that is possible. This has been my goal since I came to the Congress. This is the issue that has been most important to me throughout my years in public service.

More than 25 years ago, when I was codirector of the Oregon Grey Panthers, we were talking then about what it would take to modernize the program, to turn that program that began as just half a loaf into a program that would deliver the best possible services to the Nation's older people. You cannot do that without covering prescription drugs for vulnerable elderly. This is an opportunity, if not to do everything that needs to be done, to take substantial steps in the right direction.

I urge my colleagues over the next couple of weeks to work together on a bipartisan basis to finally accomplish the reforms that are necessary.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, I rise to address this historic opportunity for strengthening Medicare and providing prescription drug benefits for our seniors. I am pleased that as a member of the Finance Committee I was able to participate in the construction of the legislation which is before us now and to be able to speak to this historic legislation on the first day we are considering it.

My understanding is that as of Wednesday we will be able to begin offering amendments to the legislation, and I know it is the leader's intention that we complete it before the end of the following week so that the bill can be merged with the House bill which should be adopted at roughly the same time. We can go to a conference committee, iron out whatever differences we have, and get this bill to the President as soon as possible. It is the President who has led on this initiative and who has promised the American people that we are going to provide both a new prescription drug benefit for America's seniors and a strengthening of Medicare so that we know that this program can continue on into the long-distant future and not be troubled by financial problems that we can see on the very short-term horizon.

So this Medicare reform legislation, S. 1, that is before us now offers us a historic opportunity, one I think we must be very careful not to squander. In that regard, let me discuss, first of all, the problems we are going to be trying to deal with here, the way the Finance Committee bill attempts to deal with them, and then I will conclude with some concerns I have about some changes I believe we are going to need to make to ensure this will work for the benefit of our Nation's seniors.

First, let me discuss the need. There are a couple of key things to keep in mind here. Just as with the Social Security system, of which Medicare is ac-

tually a part, Medicare cannot continue to pay the benefits we have promised America's seniors, primarily because of the good news that America's seniors are living longer, and we are finding more and more ways to treat their diseases and illnesses, all of which, of course, costs money. But we should not consider that bad news. In fact, we consider it a very fortunate dilemma that we face, in which we are not only able to prolong life but enhance the quality of life for our seniors. That is the reason we want to deal with this problem now.

But as seniors are living longer, this is going to provide a greater financial burden on taxpayers, and we find that the number of taxpayers paying for it is actually decreasing in relative size. Therefore, we see a financial insolvency for Medicare not too far down the road. In fact, by the year 2026, the system will be, technically, out of balance. By 2012 or 2013, we are going to have to begin paying out of the trust fund for Medicare, which means that the general fund is going to have to be tapped to help to pay for the Medicare funding and the hospital insurance program is going to be in debt. The long-term costs for Medicare are staggering when you stop and think about it, although, again, this can be looked at as good news since we are finding ways to treat our illnesses. And while it costs money, it still preserves our quality and length of life. Therefore, we should be happy for this condition. But it will cost money.

To give you an idea, over the next 75 years, the average deficit of the hospital insurance program is 2.4 percent of taxable payroll, which is 71 percent greater than the projected funds coming into the program over the same period. So we have a huge deficit we are going to face in how to fund our Medicare commitments to seniors.

In addition, when Medicare was created in 1965, it was a very different program than Americans have become accustomed to now. For one thing, it didn't have a drug benefit. We are all committed, I think, to the proposition that we have to add a drug benefit to Medicare, among other things, because now, unlike in 1965, treating through prescription drugs, through medication, has become really the preferred option in most cases. We no longer need acute surgical care, for example, to treat many situations. We are able to control the illnesses through the use of medications. Isn't that a much more humane and satisfying way to treat diseases than through some intrusive kind of treatment, such as surgery?

So medical advances have permitted us to accomplish a great goal. We are going to have to add this benefit to Medicare, however, if we are to achieve the degree of success we would like to achieve. Nobody who has health insurance in the private sector has a structure like Medicare does today. For example, in the private sector, you usually only have one deductible for your

insurance. And then your copayment—if it is for drugs or some other kind of benefit—is usually at the front end of most of those services. Most of the time in the private sector, people have catastrophic insurance coverage. In other words, you will pay a deductible and there will be some copayment for the other services you derive along the way. But if your illness is so severe as to cause huge medical costs, that catastrophic care is paid for with your private sector insurance premium. Not so with Medicare.

With Medicare, it is almost exactly the opposite. There are two deductibles, one for part A and one for part B, for hospital stays and physician services. It is especially complicated for hospital stays. And you have high copayments under Medicare that are toward the back end of the coverage. You have no catastrophic coverage at all, as a result of which seniors have had to go through a distribution of Medigap insurance, private sector coverage, coverage sometimes from their employer, and the Government's Medicare Program and, in some cases, some even do without. There is no drug benefit today as a part of Medicare.

So all of this has to be dealt with. Clearly, we cannot continue to work with a program that is not going to be able to treat our senior citizens as we have moved into the 21st century, which is the historic opportunity we are presented with. The first way to respond to that is to add a drug benefit to Medicare. Clearly, as I said, we are all committed to doing that.

S. 1 provides a generous universal benefit for prescription drugs. I think, given our budget constraints, the bill put together by the chairman and ranking member of the Finance Committee is a very good start to providing that kind of universal benefit of covered pharmaceuticals.

Now, importantly, the way the bill is constructed, no senior will have to leave the traditional Medicare. The first option is you can stay right where you are, and there is a drug benefit added to traditional Medicare. It will have the same actuarial value as the drug benefit added to the alternative choices that will also be provided now. For those who are satisfied with Medicare, except they would like to have a drug benefit, that is precisely what will be available to them. For those who would like to or are used to having a private sector insurance plan, that option or alternative will be available as well. You don't have to choose it, but if you do choose it, it will have a drug benefit with the same actuarial value as that provided or added to the traditional Medicare. But it will also have a variety of other kinds of options.

For example, you will probably have just one premium, one deductible, and copayment then for some of the services at the front end. There will probably be catastrophic coverage at the back end. In other words, you will be

protected against the very large medical expenses you may face. That catastrophic coverage will be part of the premium and part of the subsidized care from the Government.

This new option that is being provided is primarily being structured like the preferred provider organizations, or PPOs, which currently serve a lot of our population in the private sector today. If you are part of an employer-based insurance plan, for example, chances are you are enrolled in a PPO, or preferred provider organization. What is this? It is an insurance plan that pays you benefits with a premium, deductibles, and copays, as I said. There is provided a list of physicians you can go to, including specialists, generalists, and so on. Ordinarily, you can even go to a physician not on the list, but you may have to pay a little bit more for the coverage. In other words, the insurance will pay up to a certain amount and you may have to pay the difference. It is your choice. If you want to do that, you can. If you don't want to, you don't have to do that. That is what a lot of us are used to.

There is a third kind of insurance, called the HMO, or managed care. Some people are very happy with the Medicare version of that. It is called Medicare+Choice. That is only available in certain parts of the country. We are not touching that. If you are happy with Medicare+Choice and you are in that, you will be able to continue to participate in that. As a matter of fact, it is hoped there will be more of those kinds of plans operating as a result of the private insurance option that will be made available. But nobody has to participate in that if they don't want to.

The drug benefit that will be provided will have the same actuarial value as that of the PPOs and of traditional Medicare. Think of it in terms of traditional Medicare on one hand, plus a drug benefit and this new option of PPOs on the other hand. It, too, will have the same actuarial value drug benefit.

On the PPO, however, there will be more integrated care. In other words, there will be a group of physicians who are taking care of you and they may have you do more preventive care, more tests. It would be to their benefit to not have to pay a lot of money for your heart attack, for example, so they want to keep you healthy and not get that heart attack. It enables you to take care of yourself in such a way that, hopefully, you will not have the heart attack. Under traditional care, you may not go to the doctor until you are really sick, at which point, of course, then are you not only going to be in trouble but there will be higher bills to pay.

The idea of PPOs is maybe to reduce the overall cost of providing the care by taking care of you better so, of course, you will be more healthy, which is to the benefit of everybody.

It is not going to work out that way for everybody, but at least the alternative or the option is there. Therefore, if you decide this is a better option for you, you will be able to participate in the PPO.

I identified the need briefly, and I went into some description of the alternative plans provided in this legislation. Let me turn now to the one concern I have because I think we all want to make sure that if we are going to provide an alternative, it works.

If we are really going to strengthen Medicare so people will have options or have choices, we expect those choices to provide better care, perhaps for a lesser amount of money, perhaps not, but better care should be the primary goal here. If we are going to attract people to enroll in that option, then we have to make sure it works.

One of the concerns some of us have is that the way the bill is structured currently, it is less likely to succeed than it would if it were as the President originally proposed it. Let me go into a bit more detail what I am talking about.

One of the problems with Medicare today is that we have price controls on the health care providers. The Government decides exactly how much it is going to reimburse doctors, for example, and that is how much they get reimbursed. The problem with that is we are trying to control costs, and so the Government keeps ratcheting down what we pay the doctors until we find the doctors are deciding not to treat Medicare patients anymore, until they decide they just cannot afford to continue to be part of Medicare.

At this point, because we want to make sure seniors have plenty of health care providers available to take care of them—and, frankly, we do not want to put any of the health care providers out of business, obviously—then all of a sudden we are going to pay more to allow them to stay in operation, and that costs a lot of money. We put that back into the system. Then we begin to ratchet down what we pay again. It is the traditional problem of price controls.

Nobody knows better than the market what the price of a good or service ought to be, but some bureaucrats, the idea goes, know better than the market. Whenever it is tempting for us to think that, we ought to look to history for a lesson. Price controls never work.

Think of it in the way earthquakes occur. We have the great tectonic plates of the country, and they are constantly under stress. We may go for quite a long time without an earthquake, but if we have those tectonic plates stressing, all of a sudden, it is going to get to the point where they just cannot stand to be together anymore, and they are going to move. That creates an earthquake.

It is a lot like that when it comes to price controls. We may be able to keep the lid on prices for a while, but the inevitable pressure will increase to the

point that eventually something has to give. One thing that can give is that we no longer have the providers willing to provide the service because they are not getting paid enough to stay in business. Therefore, we have a little revolution on our hands where people say: Look, they are all leaving the practice. We want to be cared for; can't you pay them more money? The Government says: OK, we will do that. We provide the money. What have we saved?

It would have been much simpler to have allowed the market to work along the way so that the providers could be reimbursed what they need to stay in practice, the beneficiaries of care continue to be provided that care, and we have a more stable financial situation as well.

Price controls simply do not work, and they have not worked in Medicare where we have tried to control the prices of the providers.

What makes us think that controlling the prices of the PPOs is going to be any more successful? It clearly is not going to be, and yet that is, in effect, what we have in this bill.

We have said we want to provide a private sector option, and then we place price controls on how much we are going to pay the providers. Some people say we might as well just stick with the current system of price controls on the providers. If we are going to provide a real private sector alternative, then do not turn around and cap the prices we are going to pay.

The Government has a legitimate obligation to keep prices down, and I will get to that in a moment. But by the same token, we have an obligation to provide high-quality health care. If we are going to make the decision to provide an alternative to traditional Medicare, one which provides choices for people and relies upon the private sector to design plans that best meet the needs of different seniors all over this country, then we need to let those plans work.

The way the administration designed it was that in deciding which PPOs would be allowed to provide the services, they would simply allow a competitive bid process. The plan is to have approximately 10 regions in the United States, to have the country divided; 50 States divided into 10 regions. Think of it as roughly 5 States per region, although that is not exactly how it will work out.

In each region, if you are an insurance company and you want to provide this alternative to Medicare, you would bid and the three companies that provided the lowest bids would have the opportunity to provide this care. They would then be reimbursed by the Government at the level of the middle bid.

In other words, if you had \$10,000 for the top bid and \$9,000 for the middle bid and \$8,000 for the third bid, then all three companies would be reimbursed at the \$9,000 per patient level, speaking hypothetically, of course. That competitive bidding process would enable

the insurance companies to figure out how much money they need to make to stay in business, but also how little they can charge in order to get the business.

It is the same process that any company undergoes. For example, a construction company wanting to build a highway bids on the highway. If they bid too high, they are not going to get the job. If they bid too low, they are not going to be able to pay all their workers and make a go of it. So they have to calculate what it is going to take to stay in business, to make a little profit, and still get the business. That is what encourages them to be careful with how they spend their money—to be economical, frugal, and thoughtful with what they do, and keep the customer happy.

The same thing happens with insurance companies. When the Government comes along and says, We are not going to take the three lowest bids, we are going to put a cap on how much you can bid, they have totally distorted the process. So if the Government came along and said, for example, that \$10,000, \$9,000 and \$8,000, no, we are not going to do that, we are going to say no company can bid more than \$8,000, what is that going to do? The company that bid \$10,000 is going to say: We cannot make any money at that; we cannot even serve the patients; and we are not going to try to fool anybody and go into debt. So we are not going to bid.

The company that bid \$9,000 is going to say: I do not know if I can make it work. We had better not bid for the same reasons.

The company that bid \$8,000 is going to say: We can make a go; the Government says we cannot bid more than \$8,000; we are going to bid that. What kind of choice do the consumers have? One company.

What if the Government decides it knows best and the bureaucrats decide to set the level at \$7,000? Then how many companies are going to bid? This is precisely the problem the Congressional Budget Office identified.

The Congressional Budget Office said when you set the bid at the Medicare payment level, which is the way the bill is constructed, that is what the level is going to be, you may end up with nobody bidding. Do you know what the Congressional Budget Office says the participation rate is going to be under the bill? Two percent. Effectively nobody is going to bid. Nobody is going to be able to participate because the Medicare level—remember the price control level I talked about before—that level is going to be the level set under the bill.

What they are saying is almost nobody is going to be able to work under that artificial capped rate. So only 2 percent of the people are going to participate in these plans. The plans are not going to be able to provide a robust enough benefit, a benefit that attracts people into the plan. What are the plans going to do? Obviously, they are

not going to participate. What kind of option have we created?

There are some on the far left, I suppose, who will say that is great; that proves the only thing that works is a Government, one-size-fits-all medical benefit, and we can finally get to the single-payer system some wanted to do all along. Those, on the other hand, who want to see the private market system work, will say: No, let's try to adjust the bill; it will not take a huge adjustment, to be sure it can actually work. The way we would adjust it is we would simply substitute this Medicare capped rate, the price control rate, for that which the President originally proposed; mainly, take the three lowest bids. The bids still have to be low enough to get the business, so there is still a big incentive to keep the cost down, but at least you know you are going to get some people bidding.

The estimate in this instance is the participation would be somewhere between 30, 40, or maybe even more than 40, 48 percent, something like that, 43 percent. That is a lot more people participating in the plan. It at least would have a chance to work then.

It seems to me, if we are dealing between estimates of 2 percent on one hand and over 40 percent on the other hand, that is too big a difference for us to be rushing to pass this bill.

Nobody knows for sure what the answer is. Will it be 2 percent? Will it be 40 percent? If we are dealing with that kind of uncertainty, it seems to me we should not be rolling the dice, especially since what is at stake is the quality of health care for our senior citizens. We ought to take our time and do it right.

As I said, fortunately we have the answer in front of us. It is what the President originally proposed, take the three lowest bids and then use the middle of those three bids. We could easily substitute that for what is in the bill today. If I had my druthers, we would even go one step further.

Those of us who say what we are providing for our seniors is very much like what Members of Congress get in health care are almost right but not quite. Under the FEHBP, the Federal Employees Health Benefits Plan, all of us, plus the other 10 million Federal employees, get a chance to enroll in one of several PPOs.

Do the PPOs that provide the care for Federal employees, including Members of Congress, have price caps on them? No. Do they even have to take the three lowest bids? No. Whatever companies would like to bid that will offer the benefits that the Government promises to its employees, if they are qualified companies and they offer the benefits, it does not matter what they bid; they get to offer those benefits to the employees.

Now, if they bid way too high, they can still bid and they can still offer the plan, but none of us are going to join because it will cost too much money. So they still have to be reasonable. But

if they want to participate at a rate higher than some of the other plans, they can try. If they can sell their product, then who is hurt? Not so with Medicare. What the President has said is in order to keep the costs down, we are going to take the three lowest bids. Well, that is not as good as what the Federal employees have, but we believe it is a system that can be made to work. What cannot work is to go to the lowest common denominator, and that is the Medicare artificially controlled, capped price control rate that CBO says will not work. That is the change we are working with the chairman and the ranking member of the committee and the administration to effectuate in this legislation. We have to get the score from the Congressional Budget Office; that is to say, they have to tell us how much the two different versions would cost so that we would know and be able to fold that into the \$400 billion budgeted amount with which we have to work. It is my hope over the next few days that we will be able to do that and be able to offer an amendment that can be supported by all of us that would permit a more plausible scenario for the preferred provider organizations to succeed so that we can honestly say to our seniors they have two legitimate options.

They can stay in traditional Medicare or there is a good PPO option, their choice, and have some confidence that the PPO option will actually work and will be a good option for them.

I am going to close with this thought: Whenever there is a third party paying for something that is near and dear to you, you have to be very careful because that third party is going to have a dual loyalty. If it is an employer or the Federal Government, let's say, and they are buying your health insurance, they want to take care of you, your employer wants you to be happy and healthy, and in a plan like Medicare, the Government certainly wants to take care of the senior citizens, but there is another motivating factor for either the employer or the Government. What is it? It is, how much does it cost me? The employer can only afford to pay so much for the health care of his or her employees. The Government, because it is taxpayer money, can only afford to pay so much for the care it provides to senior citizens under Medicare. So you always have to ask the question: If I am relying upon my employer's provided insurance or the Government's provided insurance, am I getting the best quality care I can get? Reasonably. Am I getting affordable, high quality care? It is a question you should always be asking because when a third party pays, there are mixed loyalties.

If I am paying for it all out of my own pocket, and I can afford to do that, then I am going to pay for good care for me and my family. But if I am paying for a complete stranger's care just ask yourself: Do I care quite as much? Am I going to be quite as concerned

about the quality of care or am I going to be at least equally motivated by how much it costs?

Being concerned about saving money, am I going to maybe skimp and save a little bit? What is the result of that skimping and saving? Is it going to be a lower quality care?

When we set a price and say you can only bid so much, what is the potential effect of that? It is lower quality care. That is the tradeoff we have to be very careful of. We are buying care for senior citizens and we have to be very careful that in our concern about wasting taxpayer dollars and being able to afford this quality care, that quality does not suffer as a result.

I submit the best way to do that, when the third party, the Government, is paying for the bulk of this care, is not to set a price cap because the inevitable result will be the ratcheting down of the prices and very uneven, if not poorer, quality care but, rather to allow the insurance companies to bid what they think they have to to win the contract but enough to provide high-quality care.

Will that cost less than traditional Medicare? A lot of people at CMS, the Government-run Medicare system, think it will be actually less than traditional Medicare. Will it be more than traditional Medicare? It might be. CBO thinks it will be more. The experts are not sure. I suggest that actually there is no one answer. It will depend upon how things evolve. So we cannot know for sure one way or the other.

So why should bureaucrats or Senators think we are so smart as to be able to predict this in advance when, again, one Government agency says 2 percent and another one says over 40 percent? Clearly, the experts are in disagreement. Why would we be so arrogant as to think we know best and can set those prices? Let the market work and determine what can be bid for companies to stay in business but provide high-quality care. Then let the customer, the consumer, the seniors, decide are they getting their money's worth or not. If they think this is a good deal for them, they will choose that option. If they think it is not, they always have the traditional Medicare option to stick with. So it is the best of all worlds.

That is what this is all about, not trying to shoehorn everybody into a one-size-fits-all plan. Regions of the country are different. Urban versus rural is different. The needs of seniors are different. There are so many different factors that we should not presume to know best. We need to be willing to spend what it takes for high-quality care. The only way we are going to know what that amount is, is to let the market work, not to impose an artificial control on it. That is why I think we are going to have to make a change in this bill.

Fortunately, it is a relatively modest change, but I think it is a critical change because it could mean the dif-

ference between a successful Medicare Program and one which is not, and we will have missed a historic opportunity to strengthen Medicare if we fail to address these kinds of issues in the legislation that we are dealing with over the course of the next 2 weeks.

I thank the chairman and ranking member of the Finance Committee for their hard work, the administration for the work it has put in, my colleagues who have worked a lot on this, and I am hoping over the next several days we will be able to come together in a bipartisan way to craft a plan that truly provides new drug benefits for our seniors, choices that they will like and appreciate, and a private sector alternative that has a chance at working.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, today the Senate begins a truly historic debate on landmark legislation that will make affordable, comprehensive prescription drug benefits available to our Nation's seniors as well as to people with disabilities who receive Medicare benefits. This legislation is long overdue, but I am confident the Senate will, in fact, approve it before the Fourth of July. That is good news for our Nation's seniors.

The Prescription Drug and Medicare Improvement Act that the Finance Committee approved last week represents the most significant expansion of the Medicare Program in its 38-year history. I commend the chairman, the ranking member, and the other members of the Finance Committee, including my senior colleague, Senator SNOWE, for their hard work in devising and developing this important package.

We now have an unprecedented opportunity to make the improvements necessary to ensure that the Medicare Program can provide peace of mind to our Nation's seniors and true health security, not only to the 40 million American seniors who rely on Medicare today but to future generations as well. We want a strong Medicare Program that meets the needs of our grandparents, our parents, and our children's generation.

With recent advances in research, prescription drugs can become literally a lifeline for patients whose drug regimen protects them from becoming sicker. Prescription drugs reduce the need to treat serious illness through hospitalization and surgery. Soaring prescription drug costs, however, have placed a tremendous financial burden on millions of our seniors who must pay for these necessary drugs out of their own pockets. Monthly drug bills of \$300, \$400, or even \$500 are not at all uncommon for older seniors living on limited incomes.

For example, Emery Jensen of Gorham, ME, has an annual drug bill of about \$4,600. That is about one-quarter of the entire income he and his wife receive from Social Security. Another

constituent from coastal Maine sent me a 2-page list of the medications her husband took over an 8-month period before he died. The total cost: Nearly \$4,000. More and more, I am hearing disturbing accounts of older Americans who are running up huge high-interest credit card bills in order to buy medicine they could not otherwise afford. Even more alarming are the accounts of patients who are either skipping doses to stretch out their prescriptions or forced to choose between paying the bills or buying the pills that keep them healthy.

I will never forget an elderly woman coming up to me in the grocery store in Bangor and saying to me she was only able to get half the number of pills her doctor had prescribed because otherwise she would not be able to buy the food she needed. No senior in our country should be forced to choose between putting food on their table and buying the pills they need to remain healthy.

It is critical we bring Medicare into line with most private sector insurance plans and expand the program to include coverage for prescription drugs. The legislation before the Senate today will make prescription drug coverage a permanent part of Medicare. This is an important improvement over previous versions of this bill which had sunset dates which would have created tremendous anxiety for our seniors on whether this would be only a temporary program.

This bill will make this coverage permanently part of Medicare. It provides a comprehensive prescription drug benefit that will be available to all seniors in Medicare, regardless of where they live. Moreover, that benefit will be equal for everyone, both for those who choose to stay in the traditional program as well as for those seniors who elect one of the new programs, the new plan options available in the Medicare Advantage Program which is modeled after the Federal Employees Health Benefits Program.

Beginning in 2006, seniors will be able to get comprehensive prescription drug coverage, including both upfront and catastrophic protection, for \$35 a month premium. Moreover, low-income seniors will receive generous subsidies and get additional protections and assistance. The more than 9 million seniors nationwide, including 60,000 seniors living in Maine, who have incomes below 135 percent of the poverty level will not have to pay any premium to secure coverage. That 135 percent of poverty equals \$12,120 for a single person and \$16,360 for a couple. It is important we provide that extra assistance for these very low income elderly people who would be hard pressed even to afford that \$35 a month. Unfortunately, this is not going to happen overnight. It will take some time for this new benefit to come online.

To provide some interim assistance, starting next year seniors will get prescription drug discount cards that will

save them between 15 and 25 percent on each drug purchase. Lower income seniors will receive a benefit of \$600 on top of that starting next year.

There are also some other significant features in this bill. Medicare's reimbursement systems have historically tended to favor large urban areas and failed to take into account the needs of more rural States. This simply is not fair to States such as New Hampshire, which the Presiding Officer represents so ably, or my home State of Maine.

Ironically, Maine's low payment rates are also the result of its long history of providing cost effective high-quality care. We have a strange system where, if you delivered care in a low-cost manner, the formula actually penalizes you for doing so. In the early 1980s, lower than average costs in Maine were used to justify lower Medicare payments to doctors and hospitals. Since then, Medicare's payment policies have only served to widen the gap between low- and high-cost States.

This is an issue on which I have been working my entire time in the Senate. I remember in the previous administration meeting with the head of what was then called the Health Care Financing Administration and her telling me that in fact the State of Maine ranked dead last in Medicare reimbursements. Since that time, I have worked hard to improve the reimbursements to Maine, and now we are up to about 46, but that still represents a tremendous inequity.

I am, therefore, particularly pleased the legislation before the Senate takes steps to strengthen the health care safety net by increasing Medicare payments to physicians and hospitals in rural States such as Maine to help even out the reimbursement and eliminate the inequities that have hurt rural States.

According to the American Hospital Association, the provisions in this bill will increase Medicare payments to hospitals in Maine by approximately \$63 million over the next 10 years. That is a step in the right direction. It will be particularly helpful for our small community hospitals which are struggling to make ends meet. Those same hospitals tend to serve a population that is older, poorer, and sicker, so they particularly suffer when Medicare reimbursements are unfair because they simply do not cover the cost of treating this older, poorer, sicker population.

This legislation also restores funding to some extent for home health. That benefit has been cut far more deeply and abruptly than any benefit in the history of the Medicare Program. Earlier this month, 54 Senators, at my request, joined me in sending a letter to the chairman and the ranking member of the Finance Committee asking that they avoid any further cuts in home health care and extend the additional payment for home health services in rural areas that expired on April 1 of this year.

I am pleased the legislation before the Senate does provide for a full infla-

tion update for home health agencies and also extends the rural add-on that is vital to sustaining home health care in rural areas of our country. Surveys have shown the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly because of the extra travel time required to cover long distances between patients, higher transportation expenses, and other factors.

While I am disappointed the Finance Committee reduced the add-on payment from 10 percent to 5 percent, at least it has been extended, and that will help to ensure that Medicare patients in rural areas continue to have access to home health care services.

The Prescription Drug and Medicare Improvement Act was approved by the Finance Committee by a strong 16 to 5 bipartisan vote. I think that bodes very well for the future of this legislation. At long last, this legislation holds out real hope to our seniors that they will finally receive an affordable, comprehensive Medicare prescription drug benefit.

Since the cost of providing a meaningful drug benefit will only increase as time passes, it is imperative that we act now. I am pleased the majority leader has scheduled this legislation and set a goal of its passage before we adjourn for the July 4 recess.

Our senior citizens deserve no less from us. We must act. I am confident we will act to provide a long overdue prescription drug benefit.

I yield the floor and I suggest the absence of a quorum.

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

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. CORNYN. Mr. President, I ask unanimous consent I be permitted to speak as in morning business for no longer than 15 minutes.

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

#### IMMIGRATION PROGRAM FOR THE 21ST CENTURY

Mr. CORNYN. Mr. President, I rise today to say a few words about our Nation's immigration policy.

The United States has been built on the labor, industry, and initiative of immigrants. The immigrant character that undergirds our country and enriches our society is expressed through our art, music, and culture—the fulfillment of one of America's greatest gifts to the world: the promise of thriving multi-ethnic democracy. In every war America has fought, from the Revolutionary War to Operation Iraqi Freedom, brave immigrants have fought alongside American-born citizens, with distinction and with courage.

And throughout history, those who have longed for the blessings of liberty

have looked to America as a beacon of hope, freedom, and the opportunity of a better life.

The American Dream itself is rooted in the immigrant spirit. What sets this country apart is our conviction that life, liberty, and the pursuit of happiness are not just American rights, but the gift of a benevolent Creator to all humanity. And so America has always welcomed immigrants from every shore, saying: "Give me your tired, your poor, your huddled masses yearning to breathe free."

Yet for too long, we have failed to address the flaws in our nation's current immigration policy. This issue is even more urgent in a post 9/11 world. Special interest groups dominate the discourse, employing the potent but morally repugnant rhetoric of fear.

We must acknowledge that we have done far too little to reform a system that cries out for change. The fruit of our current immigration policy is death, danger, and denial.

For immigrants willing to risk their lives for the opportunity to live here in America, exploitation at the hands of human smugglers can mean a slow and painful death.

According to some estimates, there are as many as ten million individuals who are in this country illegally; our homeland security demands an accounting of the identities of these individuals, their reason for being here, and whether they pose a danger to our citizens. And we can no longer afford to deny both the sheer number of undocumented immigrants in our country and the extent of our economy's dependence on the labor they provide.

Our relationship with Mexico, an important ally and trading partner, is a prime example of the ramifications of the tired old status quo. The stated desire of our Mexican friends for general amnesty for the millions of undocumented immigrants here in America is an untenable position in support of an unrealistic policy.

Instead, the guest worker program I propose acknowledges the vital role hard-working immigrants play in our economy and creates a comprehensive program, which will serve as an important step toward reestablishing respect for our laws and restoring dignity to immigrants who work here. It will enhance America's homeland security, facilitate enforcement of our immigration and labor laws, and protect millions who labor today outside the law. This program will benefit all participating nations and their citizens who wish to work in the United States and contribute to our Nation's prosperity.

Our immigration policy must adapt to modern realities. An effective guest worker program will acknowledge that millions of undocumented men and women go to work every day in America in violation of our immigration law, outside the protection of our labor law, and without any way of our Government knowing who, or where they are.