(A) IN GENERAL.—An educational institution that receives a grant under this section shall establish an Academy that shall offer a workshop during the summer, or during another appropriate time, for outstanding students of American history, government, and civics to broaden and deepen such students' understanding of American history and civics.

(B) DURATION OF WORKSHOP.—A workshop offered pursuant to this section shall be approximately 4 weeks in duration.

(2) ACADEMY STAFF.—

(A) PRIMARY SCHOLAR.—Each Academy shall be headed by a primary scholar identified in the application submitted under subsection (b) who shall—

(i) be accomplished in the field of American history and civics; and

(ii) design the curriculum for and lead the workshop.

(B) CORE TEACHERS.—Each primary scholar shall appoint an appropriate number of core teachers. At the direction of the primary scholar, the core teachers shall teach the workshop attendees.

(3) SELECTION OF STUDENTS.—

(A) NUMBER OF STUDENTS.—Each year, each Academy shall select between 100 and 300 eligible students to attend the workshop offered by the Academy.

(B) ELIGIBLE STUDENTS.—A student shall be eligible to attend a workshop offered by an Academy if the student—

(i) is recommended by the student's secondary school principal (or other head of such student's academic program) to attend the workshop; and

(ii) will be a junior or senior in the academic year following attendance at the workshop.

(g) COSTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a student who attends a workshop offered pursuant to this section shall not incur costs associated with attending the workshop, including costs for meals, lodging, and materials while attending the workshop.

(2) TRAVEL COSTS.—A student who attends a workshop offered pursuant to this section shall use non-Federal funds to pay for such student's costs of transit to and from the Academy.

(h) EVALUATION.—

(1) IN GENERAL.—At the completion of all of the workshops assisted in the third year grants are awarded under this section, the National Endowment for the Humanities shall conduct an evaluation and submit a report on its findings to the relevant committees of Congress.

(2) CONTENT OF EVALUATION.—The evaluation conducted pursuant to paragraph (1) shall—

(A) determine the overall success of the grant program authorized under this section; and

(B) highlight the best grantees' practices in order to become models for future grantees.

(i) NON-FEDERAL FUNDS.—An educational institution receiving Federal assistance under this section may contribute non-Federal funds toward the costs of operating the Academy.

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $14,000,000 for each of fiscal years 2004 through 2007.

SEC. 5. NATIONAL ALLIANCE OF TEACHERS OF AMERICAN HISTORY AND CIVICS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—From amounts appropriated under subsection (e), the National Endowment for the Humanities shall award 1 or more grants to organizations for the creation of a national alliance of elementary school and secondary school teachers of American history and civics.

(2) PURPOSE.—The purpose of the national alliance is—

(A) to facilitate the sharing of ideas among teachers of American history and civics; and

(B) to encourage best practices in the teaching of American history and civics.

(b) APPLICATION.—An organization that desires to receive a grant under this section shall submit an application to the National Endowment for the Humanities at such time, in such manner, and containing such information as the National Endowment for the Humanities may require.

(c) GRANT TERM.—A grant awarded under this section shall be for a term of 2 years and may be reapplied after the initial term expires.

(d) USE OF FUNDS.—An organization that receives a grant under this section may use the grant funds for any of the following:

(1) Creation of a website on the Internet to facilitate discussion of new ideas on improving American history and civics education.

(2) Creation of in-State chapters of the national alliance, to which individual teachers of American history and civics may belong, that sponsors American history and civics activities for such teachers in the State.

(3) Seminars, lectures, or other events focused on American history and civics, which may be sponsored in cooperation with, or through grants awarded to, libraries, States' humanities councils, or other appropriate entities.

(4) Coordinate activities with other nonprofit educational alliances that promote the teaching or study of subjects related to American history and civics.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, and for any administrative costs associated with carrying out sections 3 and 4, $4,000,000 for each of fiscal years 2004 through 2007.

Mr. BAUCUS. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Resumed

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

The 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.

Pending:

Bingaman Amendment No. 933, to eliminate the application of an asset test for purposes of eligibility for premium and cost-sharing subsidies for low-income beneficiaries.

Dorgan Amendment No. 946, as amended, to provide greater access to affordable pharmaceuticals.

AMENDMENT NO. 946, AS AMENDED

The PRESIDING OFFICER. There are 4 minutes of debate equally divided on the Dorgan amendment.

Who yields time?

Mr. BAUCUS. Mr. President, who controls time?

The PRESIDING OFFICER. The Senator from North Dakota controls 2 minutes. The manager will control 2 minutes in opposition.

Mr. DORGAN. Mr. President, this amendment deals with reimportation of prescription drugs. It is designed to try to put downward pressure on prescription drug prices in this country. It is not my intention or desire that Americans go elsewhere to acquire prescription drugs. But the fact is that U.S. consumers pay the highest prices in the world for prescription drugs. In North Dakota, for example, there is a pharmacy in the town of Pembina, and if you buy a prescription drug in that one-room pharmacy—

Mr. BAUCUS. Mr. President, the Senate is not in order.

The PRESIDING OFFICER. The Senate will be in order.

Mr. DORGAN. Mr. President, 5 miles north of that North Dakota one-room drugstore, in Emerson, Canada, you will find, if you have breast cancer and have to buy Tamoxifen, that the drug that you pay $10 for in the U.S. can be purchased for $1 5 miles north.

The question is, why should that happen? It should not happen. Let the market system deal with this. These are FDA-approved drugs. It is the same pill put in the same bottle by the same company. We ought to have fair pricing for Americans, and if not fair pricing here, then allow them to access those prescription drugs from a chain of custody in Canada that is safe. We are only talking about licensed pharmacists and distributors being able to access that FDA-approved drug from a licensed pharmacist or distributor in Canada. We have accepted the Cochran language. We don't think that injures this because, in the circumstance, we have changed the reimportation amendment to deal only with Canada, which has nearly an identical chain of supply and would therefore represent a safe drug supply for our pharmacists and distributors to access and to be able to pass the savings along to the American consumer. That is the purpose of this amendment.

I reserve the remainder of my time.

Mr. JOHNSON. Mr. President, I rise today in strong support of addressing a major oversight in S. 1, the Prescription Drug and Medicare Improvement Act of 2003. The bill has absolutely no provisions to control the skyrocketing costs of prescription drugs, and, as currently written, is really just a blank check for big drug companies.

If one looks at the costs of prescription drugs, the numbers are just astounding. Seniors in the U.S. who lack drug coverage must pay twice as much for the five most popular drugs as purchasers in many foreign countries. All Americans who need prescription drugs could benefit from improved access to lower-priced drugs from Canada. Brand-name drugs cost an average of 38 percent less in Canada than in the United States. This could mean literally hundreds of dollars less a year for U.S. purchasers.

For several years now, many of my colleagues have been fighting to provide access to lower prescription drug

prices for seniors and all Americans by sponsoring a reimportation plan that is safe, effective and keeps savings in the pockets of seniors. I am happy to join several of my colleagues here today to cosponsor and support this amendment to the prescription drug bill. I want to especially thank Senator DORGAN for his leadership on this issue. He has worked hard to try to bring a solution to the skyrocketing prices seniors and all Americans must now pay for their prescription drugs.

As costs continue to rise for consumers, and pharmacies' profit margins continue to shrink, a quick look at net profits of drug firms paint the real story. While Fortune 500 companies have experienced close to only a 1-percent increase in net profits over the last 30 years, and pharmacies have experienced a net loss of about that amount, drug firms have experienced an over 1-percent increase in such profits. But still, we seem to ignore the manufacturers exorbitant U.S. prices over and over.

The Dorgan amendment would improve access to lower priced drugs by allowing wholesalers and pharmacists to import prescription drugs from Canada, which has a similar drug approval and distribution system as the United States. The amendment also would enable individuals to import prescription drugs from Canada as long as the drugs are for their personal use and they do not exceed a 90-day supply.

This amendment finally says to the drug companies, enough is enough. I think if we work together we get a handle on the unrestrained costs of drugs in this country. Efforts such as those in the Dorgan amendment and those just embraced by many of my colleagues who joined me in cosponsoring and supporting the generics amendment yesterday will make such an important difference in the true value of what a drug benefit can really do to help seniors. I sincerely hope that all of my colleagues, on both sides of the aisle, will commit to adopting the provisions in the reimportation amendment in order to enhance the value of this legislation.

Mr. HATCH. Mr. President, I rise to oppose the Dorgan amendment on drug importation.

Frankly, given the history of this amendment, I feel a little like we are in the movie, Groundhog Day. We have been there and done that. And like the Bill Murray movie, we appeared to have gone there and done that again last night. When I woke this morning, I had the feeling of deja vu all over again.

Each time the same thing happens. First we consider a flawed drug reimportation amendment. Then we adopt a second degree amendment that virtually guarantees the amendment can never be implemented. We did it in the 106th Congress, and Secretary Shalala—the Clinton administration's Secretary of Health and Human Services—could not certify the safety of reimported drugs. We did it in the 107th Congress again last year when the Senate adopted a reimportation amendment during the debate on the ill-fated vehicle, S. 812. And now last night we did it in the 108th Congress. The same dynamic played out yet again with the Dorgan amendment and the second degree amendment thereto.

Let me remind my colleagues. Here is what the Bush Administration's Secretary of Health and Human Services, Tommy Thompson, said about this idea last year: ''Opening our borders to reimported drugs potentially could increase the flow of counterfeit drugs, cheap foreign copies of FDA-approved drugs, expired and contaminated drugs, and drugs stored under inappropriate and unsafe conditions. In light of the anthrax attacks of last fall, that's a risk we simply cannot take.''

I agree with Secretary Thompson that reimportation was not ever a good idea. But, it could be even more deadly after September 11th. Although I am not a betting man, I can guess what Secretary Thompson will say if this unfortunate amendment survives the conference committee.

This year's version of the Dorgan amendment contains a new section relating to the effective date of the amendment. This modification attempts to make the proposal effective prior to the Secretary determining that the benefits of this law outweigh the risk.

Fortunately, the Cochran amendment we adopted last night by voice vote makes it clear that nothing in the Dorgan amendment can take effect unless the Secretary finds that the provision: first, poses no additional risk to the public health and safety; or, second, will result in a significant reduction in the drug costs.

My preference is for no Dorgan amendment at all. But if his language is adopted, it is essential that we have the Cochran correcting proviso so that the American public can be protected against unsafe drugs.

I agree with my friend, JOHN DINGELL, the Dean of the House of Representatives, and author of the 1988 Prescription Drug Marketing Act, PDMA, that helped put rigorous safety controls in the U.S. drug distribution system. Mr. DINGELL said, ''the very existence of a market for reimported goods provides the perfect cover for foreign counterfeits.''

Representative DINGELL's Energy and Commerce Committee produced a report that succinctly explained why the PDMA was needed: ''[R]eimported pharmaceuticals threaten the public health in two ways. First, foreign counterfeits, falsely described as reimported U.S. produced drugs, have entered the distribution system. Second, proper storage and handling of legitimate pharmaceuticals cannot be guaranteed by U.S. law once the drugs have left the boundaries of the United States.''

This view is consistent with the testimony that the experts at FDA have given before Congress numerous times.

As the FDA's senior associate commissioner for policy, planning, and legislation, Bill Hubbard, has warned: ''Even if the Canadian system is every bit as good as ours . . . the Canadian system is every bit as good as ours . . . the Canadian system is open to vulnerabilities by people who will try to enter the U.S. market . . . because that is where the money is.''

A bipartisan group of some 10 former FDA Commissioners have voiced their concern about the safety of reimported pharmaceuticals. So has the Drug Enforcement Administration.

We are told by the experts that the number of counterfeit cases is on the rise. FDA has opened more than 70 counterfeit drug cases since October 1998, including 26 arrests and 20 convictions through last June. In the last two months, FDA has issued alerts on counterfeit Lipitor. In March, the FDA found that doctored EPO—a product vital to patients fighting cancer and other deadly diseases—has been the target of counterfeiters in previous instances.

Let us remember the sage counsel we were all taught in elementary school—safety first. Unfortunately, the Dorgan amendment conflicts with this important lesson.

To summarize, my primary reason for opposing this amendment is a concern expressed by many public health and safety experts: Opening up the current closed U.S. drug distribution system to products of unknown pedigree will result in disaster down the road.

I know that Senator DORGAN and the other cosponsors of the amendment are motivated only by their desire to do right by their constituents and other Americans trying to obtain affordable pharmaceuticals. We all share in that goal. This is why we are working in a bipartisan fashion to craft a $400 billion Medicare drug benefit program. Let us focus on the Medicare drug benefit during this debate and not get sidetracked on ill-conceived measures like the Dorgan reimportation amendment.

Let me close by saying this to my friend from North Dakota, with whom I serve on the Finance Committee: We have worked together on several trade issues involving Canada. We have struggled with how to respond effectively to the problems associated by the influx of protected Canadian softwood lumber and the actions of the less-than transparent Canadian Wheat Board.

My friend from North Dakota does not like it when the actions of the Canadian government unfairly benefit Canadian producers of wood and wheat relative to American loggers and farmers. This is so even if the preferentially-treated Canadian products can undercut the prices offered by American producers to American consumers.

In this debate on drugs, we often hear heart-wrenching stories of seniors being forced to choose between paying for drugs or paying for food or paying the rent. When it comes to weighing

the interests of loggers and farmers versus the lowest cost goods, my friend from North Dakota carefully, and appropriately, factors in the long term interests of preserving vital U.S. industries. He does not automatically support policies that result in U.S. consumers, particularly our seniors, paying the lowest possible prices for such essential products as bread and wood.

Not so with price-controlled Canadian drugs. First, the Canadian government ratchets down the prices of drugs for its citizens. Comes now the Dorgan amendment that acts to pass on these controlled prices to U.S. consumers. If passing on Canadian government-controlled prices is such a good policy for drugs, then I ask why it is so bad when the Canadian government acts to artificially hold down the price of wheat and lumber and pass these savings along to the American consumer?

Let us face facts. Money is fungible. If the proper response to easing the choice among food, medicine and shelter is always to end up with the lowest prices then why should we not applaud equally the Canadian Wheat Board and the Canadian drug price control agency?

My answer is that government price controls, subsidy programs, and preferential treatment are never the preferred policy option—whether we are talking about food, medicine or the mortgage.

Let me close by saying that my fundamental objection to the Dorgan amendment is the safety risks it would engender. In addition, I have concerns over embarking on a policy that has the effect of imposing government price controls on a product highly dependent on investment capital, and let the Canadian government do the price controlling to boot.

I only hope that we can some day break the cycle of passing a piece of legislation with a circuit breaker provision that will always be tripped and ensure the underlying language, thankfully, will never take effect. Enough of Groundhog Day.

Mr. FRIST. Mr. President, I rise to oppose the Dorgan amendment on importation of foreign drugs. It is essential that my colleagues understand the gravity of what we are about to vote on today. My colleagues yesterday passed the Cochran second degree amendment by voice vote, ensuring that none of the provisions in the Dorgan amendment would become effective unless the Secretary of Health and Human Services certifies to Congress that the implementation of the Dorgan amendment would (1) pose no additional risk to public health and safety, and (2) result in a significant cost savings for Americans.

While this safety and cost savings certification threshold determines whether the Dorgan importation language would ever become effective in the first place, I believe that in this era of increasing bioterrorist threats, now more than ever, we should not pass new drug importation legislation at all. Allowing the importation of drugs from Canada by pharmacists and wholesalers would simply encourage further proliferation of schemes to use Canada as a transshipment point for sending unapproved, expired, counterfeit or otherwise dangerous drugs to American consumers. The Assistant Deputy Minister of Health Canada clearly stated in a May 9 letter this year that, ''The Government of Canada has never stated that it would be responsible for the safety and quality of prescription drugs exported from Canada into the United States, or any other country for that matter.''

Allowing pharmacists and wholesalers to import drugs directly from sources outside the U.S. will further encourage the proliferation of purportedly ''Canadian'' Internet Pharmacies that are not from Canada. A 2003 Global Options report stated that 33 percent of so-called ''Canadian'' internet pharmacies are not from Canada. One was ''Canadarxfree.com'' and the actual country of origin was Mexico. Another, ''Trustedcanadianpharmacy.com'' had Barbados as the actual country of origin.

Another troubling real-life example cited by Bill Hubbard, the Senior Associate Commissioner for Policy, Planning and Legislation at FDA during a June 12, 2003 hearing before the house Government Reform Subcommittee was, ''. . . we have an example of an 82-year-old gentleman who bought two drugs from a website.—[H]e was told on that website and when he made the phone call that he was getting a U.S. produced drug, sold in Canada and sold back to him. He got Indian drugs that are not approved, have no labeling, no information and he called the FDA and was outraged why are we letting this stuff in.'' The FDA determined the drugs were counterfeit.

The so-called documentation requirements in the Dorgan amendment could easily be circumvented, forged and lack verification standards. In July 2002, the Department of HHS sent a letter to Senator COCHRAN that described the problems with allowing pharmacists and wholesalers and even individuals to import drugs from Canada, ''Since counterfeits can easily be commingled with authentic product, either by the case, by the bottle or by the pill, there is no sampling or testing protocol sufficient to protect against the grave public harm they pose.''

All of my concerns about importation and risks to the health and safety of Americans that I have expressed do not even include the reasons I believe this Dorgan amendment is truly unnecessary. We are in the midst of debating and passing a landmark Medicare prescription drug bill. Through this historic legislation we will provide our seniors with affordable access to medicines, without exposing them to the very real risks of counterfeit, subpotent, unapproved, adulterated, or misbranded drugs from importation. We have also gone a step further in addressing the affordability of medicines by overwhelmingly supporting the Gregg-Schumer amendment yesterday, which will allow generics to enter the market faster. Together with the President's recently issued final rule, this amended bill will save Americans money by improving access to more affordable generic drugs. I commend the President for proposing in this 2004 budget request, an unprecedented increase of $13 million in spending for FDA's generic drug programs. By increasing the program's size by almost one-third of its current size, FDA will be able to hire more generic drug application reviewers and approve generics faster.

With all of the new information we now have about the dangers of importation and fraudulent websites, we owe it to our seniors to pass a meaningful, comprehensive Medicare drug benefit without exposing them to the very real risk of obtaining counterfeit imported medicines.

I again urge my colleagues to vote ''no'' on the Dorgan amendment, even as modified by my second degree amendment.

The PRESIDING OFFICER. Who yields time in opposition?

Mr. FRIST. I yield 2 minutes to the Senator from Mississippi.

Mr. COCHRAN. Mr. President, even though we adopted the Cochran amendment by voice vote, which requires certification that drugs imported through Canada are safe, and that they significantly reduce costs to American consumers, if the Dorgan amendment passes, it creates a new opportunity, a new source for importation of drugs into our country from other countries besides Canada. There are manufacturing facilities right now in India, in France, and in China, where drugs are being manufactured to look like American drugs that have been approved in this market but are counterfeit drugs. Some are truly unsafe because of the unsanitary conditions under which they are manufactured. Some do not contain anything like the ingredients the labels say they contain.

Mr. President, this is a new threat to the security and safety of American citizens. We don't have the Food and Drug Administration inspectors, U.S. Postal Service inspectors, or the U.S. Customs Service agents to monitor the new importation that will flood into this country from Canada—but not necessarily manufactured in Canada, not necessarily manufactured in the U.S. and sold in Canada and re-imported, which is the purpose of this amendment. But it opens a new door, a new opportunity, and it is a new threat to the security of the people of this country. I urge that we vote no on the Dorgan amendment.

I yield time to the Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I love this idea that we are going to let markets work and have free trade.

What the Senator doesn't tell you is the reason the price is $1 instead of $10 is that Canada sets the price. Canada says: If you want to sell drugs here, fine, here is what we will pay. If you don't agree, you cannot sell the drug. If we really want to sell your drug, we will steal your patent and we will make the drug up here and sell it for the price we want.

That is the law in Canada. So if you want free trade, great, we will have them set the price for all the agricultural products up there and be able to set that and send it back here and call that free trade.

Mr. DORGAN. Mr. President, we have price controls on prescription drugs in this country. It is just that the prescription drug manufacturers control the price. My friends want to have a debate we are not having. The only access to prescription drugs we are talking about is from licensed pharmacies or distributors—accessing prescription drugs from a licensed pharmacist or distributor in Canada and that would be FDA-approved. We are not talking about counterfeit drugs.

Mr. FRIST. Mr. President, on my leader time, I rise to speak in opposition to the Dorgan amendment on the importation of foreign drugs. Before the vote, I want to let my colleagues know that I do believe this amendment has the potential for opening doors that would be dangerous in this day and time. I say this in spite of us passing by voice vote the Cochran amendment yesterday, which does two things. It says none of the provisions of the underlying Dorgan amendment would become effective unless the Secretary of Health and Human Services says it poses no additional risk to public health and safety and, two, results in significant cost savings for Americans.

I supported that amendment. We all did; it was a voice vote. That is very important. It does change the threshold a bit, but I will vote against the Dorgan amendment because I believe in this era of increased bioterrorist threats, we, now more than ever, should not open the door and pass new drug importation legislation at all. The reason I say that, very quickly, is the Canadian Government has stated:

> The government of Canada has never stated that it would be responsible for the safety and quality of prescription drugs exported from Canada into the United States, or from any other country.

If we open this door, Canada has the potential for—first of all, they cannot certify safety but, secondly, become a transshipment port for other countries if we open this door to Canada. There are a number of statements that have been made. The other concern I have is on the documentation requirements. I am afraid, in the Dorgan amendment, they could be forged or circumvented, and there is a lack of verification standards, I believe.

Lastly, it is important we understand our underlying bill to which the Dorgan amendment is being applied has as its purpose to make drugs more affordable and lower that burden overall. I am hopeful we will accomplish that with the vote at the end of next week—drugs that are certified to be safe, that have gone through the FDA approval. I will be voting against the Dorgan amendment. I encourage my colleagues to do likewise.

Mr. DASCHLE. Mr. President, I yield 3 additional minutes of my leader time to Senator DORGAN.

Mr. DORGAN. Mr. President, to respond, we had 2 minutes equally divided and I think it is important, perhaps, to have the time truly equally divided. Let me respond by saying, if you think the U.S. consumer ought to pay the highest prices in the world for prescription drugs, then you ought to vote against my amendment. If you believe it is unfair that we pay the highest prices in the world for prescription drugs and we ought to have downward pressure on drug prices, vote for my amendment.

Don't believe this nonsense about counterfeit drugs and transshipments. It is not the case. Let me describe why. Let me do it in just the circumstance of one transaction.

A pharmacist from Grand Forks, ND, under this new law, would be able to go to Winnipeg, Canada, and buy FDA-approved prescription drugs only from a licensed pharmacist or a licensed distributor in Canada. The Congressional Research Service has researched both chains of supply and said they are almost identical in the United States and Canada.

We do not hear questions about drug safety in Canada. Why? Because they have exactly the same system we have from the pharmaceutical manufacturer to the distributor to the pharmacist. The control chain of supply of the same pill put in the same bottle by the same manufacturer assures safety in Canada and safety in the United States.

A licensed pharmacist in the United States can and should be able to acquire a lower priced supply of exactly the same drug in Canada and pass that savings along to the American consumer. Yes, in fact, it is the market at work.

If my colleagues do not believe in the market and they believe our country ought to pay the highest prices in the world for prescription drugs, then vote against this. Just vote against this. I understand. But if my colleagues believe we ought to put downward pressure on prescription drugs and we ought to have a free trade agreement with Canada and they believe in markets and free trade, then they should support this amendment.

I yield the floor.

Mr. GRASSLEY. Mr. President, the Dorgan amendment has been amended to further enhance the safety precautions included in the bill. The amendment now gives the Secretary of Health and Human Services the authority to certify that reimportation would be both safe and would save the hard-earned money of U.S. consumers. The HHS Secretary would also have the authority to terminate the program if for some reason it is not working.

The fact is, pharmaceutical manufacturers here in the United States are reimporting these very same drugs that seniors are forced across the border to obtain. But if it's safe enough for the manufacturers to do, then it should be safe enough for local pharmacies as well.

After all, these drugs are manufactured in factories that meet FDA standards. And it shouldn't matter whether these drugs come from New Jersey, Alberta, or Atlanta. In fact, a Congressional Research Service study found United States and Canadian drug development, manufacturing, and distribution systems have the same high level of integrity.

If this amendment is accepted and the bill is enacted, Americans will no longer have to drive through an international checkpoint to check out their prescription drugs. Instead, they will have the potential to save an estimated $38 billion out of the $100 billion Americans spend every year on their prescription drugs.

Consider the savings: A month's supply of Coumadin, a blood-thinning drug, costs $40 here in the United States and just $7 in Canada.

The emphysema drugs, upon which some seniors rely to breathe, can cost $1,700 for a 6-month supply in the United States and just $800 in Canada.

Again, let me say that, while the Dorgan amendment provides a step we can take right now to help seniors afford their medication, it is only a stopgap—not a solution. For the long-term, there is no substitute for passing a comprehensive Medicare prescription drug benefit. We need to accomplish this goal so that every senior in America has access to affordable prescription drugs.

With that, I want to again thank the Senator from North Dakota, Mr. DORGAN, for his leadership on this issue, and call on the Senate to accept this amendment and move forward to pass S. 1 to create a comprehensive Medicare prescription drug benefit without delay.

Mr. FIRST. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 946, as amended. The clerk will call the roll.

Mr. MCCONNELL. I announce that the Senator from Utah (Mr. BENNETT), the Senator from Colorado (Mr. CAMPBELL), the Senator from Nebraska (Mr. HAGER), the Senator from Indiana (Mr. LUGAR), and the Senator from Ohio (Mr. VOINOVICH) are necessarily absent.

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from North Carolina (Mr. EDWARDS), the Senator from Hawaii (Mr.

INOUYE), the Senator from Massachusetts (Mr. KERRY), and the Senator from Vermont (Mr. LEAHY) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) and the Senator from Vermont (Mr. LEAHY) would each vote ''yea.''

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

The result was announced—yeas 62, nays 28, as follows:

[Rollcall Vote No. 232 Leg.]

YEAS—62

Akaka	Dodd	McCain
Allard	Dole	Mikulski
Baucus	Dorgan	Miller
Bingaman	Durbin	Murray
Boxer	Ensign	Nelson (FL)
Brownback	Feingold	Nelson (NE)
Burns	Feinstein	Pryor
Byrd	Fitzgerald	Reed
Cantwell	Graham (FL)	Reid
Carper	Grassley	Rockefeller
Chafee	Gregg	Sarbanes
Chambliss	Harkin	Schumer
Clinton	Jeffords	Sessions
Coleman	Johnson	Smith
Collins	Kennedy	Snowe
Conrad	Kohl	Specter
Corzine	Landrieu	Stabenow
Craig	Lautenberg	Talent
Crapo	Levin	Warner
Daschle	Lieberman	Wyden
Dayton	Lincoln	

NAYS—28

Alexander	Enzi	Murkowski
Allen	Frist	Nickles
Bayh	Graham (SC)	Roberts
Bond	Hatch	Santorum
Breaux	Hollings	Shelby
Bunning	Hutchison	Stevens
Cochran	Inhofe	Sununu
Cornyn	Kyl	Thomas
DeWine	Lott	
Domenici	McConnell	

NOT VOTING—10

Bennett	Hagel	Lugar
Biden	Inouye	Voinovich
Campbell	Kerry	
Edwards	Leahy	

The amendment (No. 946), as amended, was agreed to.

The PRESIDING OFFICER. The Senator from New York.

Mrs. CLINTON. I rise today to address the matter we are debating in the Senate. I believe this legislation to provide a Medicare prescription drug benefit holds tremendous promise and also tremendous peril.

I applaud the leaders of this effort, Chairman Grassley and ranking member Baucus, for bringing this bill to the floor and working in a collegial, bipartisan manner to present it to the Senate and to the American people. It is absolutely essential we finally deliver on the promise many have made for years that we will pass a prescription drug benefit and make it available and absolutely secure to our seniors.

However, 3 weeks ago this Chamber learned a very important lesson. We learned about the importance of details and how a very small change in a very large piece of legislation in a conference report can mean 12 million children would be left out of a child tax credit. Therefore, I think it is imperative we spend the time to ask the hard questions about this legislation and that we exercise caution. So much is at stake for the people we represent.

For example, right now this bill excludes the lowest income seniors who are eligible for both Medicare and Medicaid. In my own State, 219,000 seniors and New Yorkers with disabilities fall into that category. We leave them at risk of a State's decision to curtail or limit or even eliminate certain Medicaid drug coverage and long-term care coverage.

Now we are all in a rush to try to do this to help our seniors, but we do not want to rush through this legislation at the expense of getting it tragically wrong. We have to go over this bill line by line and word by word. The details are changing every minute.

The Congressional Budget Office says one thing, committee staff say another thing. We do not know how much it is going to cost. We do not know exactly what all of the elements will end up being, particularly when we look at what the House has passed. Speaking for New York, that is totally unacceptable. Then we read today in the newspaper the President has a very different idea about two central features of this Senate proposal.

Let's address the real problems and not gloss over them and not rush to some judgment because we are going out on recess in a week. My constituents, from the 80-year-old widow in Utica to the 85-year-old man living in a nursing home in the Bronx, are counting on me to go over this process with care and to cast my vote in a way that will help them, not hurt them.

As I have been talking with my colleagues and certainly as I have been reading the commentary in the press, there is a lot of confusion about this bill. The question is, what exactly does this bill do? How does it work for our seniors? I bet we would get many different answers if I were to ask that on the floor of the Senate.

My constituents and people all over America are trusting us to examine this bill carefully and to gauge the consequences. If we do not take the time to do it, how will we know we are doing what is right?

I am deeply concerned in this case that old saying about haste making waste could certainly come true. For starters, why is this plan so complicated? Why would we purposefully create what I call a new Medicare maze instead of establishing a solid, straightforward foundation for generations to come? We have to look at how this would actually work for the people we say we are trying to help.

I have tried to map it out. Here is the question: How do you get prescription drugs under this plan? I have tried to put myself in the position of a senior, a person with a disability. It quickly became clear this will be a very confusing and in some instances a discouraging process for the vast majority of our seniors.

Here is where we should start in looking at how to answer this question. How do you get your prescription drug benefits under this plan? Let's start with the fact that if you are a senior or a person with disabilities, you are out of this process—no Medicare benefit for nursing home residents, for seniors. Who needs a Medicare benefit more than people in our nursing homes? They are the ones frailest, most at risk; they need more help in order to keep alive and have some quality of life, but they are gone. They are not in this program. If you are in a nursing home and you are getting support through Medicaid right now, you are not eligible. Instead, they would have to rely on what they do now, which is Medicaid. But they would be in an entirely different system, totally at the mercy of the individual States.

I don't know about other States, but in New York we have certainly made an effort to keep faith with these frailest people, seniors in nursing homes, people with chronic and life-threatening and debilitating disabilities, but we are not taking care of them in this plan. They drop out of the Medicaid maze before they even get started.

This plan is really for a senior who has to choose between traditional fee for service with a private drug plan or Medicare Advantage, the private PPOs.

We have created a new Government agency. I don't think a lot of people recognize that. This new Medicare Advantage will be administered by a new agency, the Center for what is called Medicare Choices, created under this bill. So we have ourselves a new bureaucracy. We are going to be spending money on bureaucrats and administrators, instead of on drugs, instead of taking care of our poorest seniors in nursing homes. Even before any benefit is available, this new bureaucracy gets built up and drains scarce resources out of what we can spend for our seniors.

To go back to our seniors here, our seniors have to choose between multiple plans. As you can see, they might have a PPO, with a $45-a-month premium, or an HMO, with a $32-a-month premium. They may have private plans that are available to them. They have to make these choices. Certainly I am all for choice, but we know, from what drug companies themselves have said, there will be many regions of our country where there will not be a lot of choice. So before seniors make that choice, they will need to register how the prescription drug benefits differ under each of these various proposals and whether the drug they need—this is a very personal consideration—whether the drug they need will be covered under the plan they are analyzing.

If a senior looked for the lowest premium—and I can guarantee most seniors will look for the lowest premium because most of our seniors are hard pressed, on fixed incomes, and they are going to be trying to save their dollars, so they will look for the lowest premium—the senior would choose the HMO at $32 a month.

But suppose this HMO doesn't cover the senior's doctor, someone the senior has relied on and trusted for years, but that doctor is not in the HMO? So the senior turns to the plan with the next lowest premium. On here, that would be private plan 2, where the premium is $37. But suppose the formulary used in this private plan doesn't cover the drug the senior needs. Let's assume the senior is on a drug for high cholesterol, and assuming the senior read the fine print, assuming the senior has informed help—which I think is a leap of faith in many parts of our country—the senior may sign up for this plan and not really know it does not cover the drug that has been prescribed for his or her condition.

So what does the senior do? She is in the plan. She finds out it doesn't provide the drug. She has a grievance procedure she can go to. Imagine, we have an 80- or 85-year-old widow. She is trying to understand this. She is in the plan. She gets to keep her doctor, but she doesn't get the drug the doctor wants her to take. The doctor says: In my professional judgment, this is the best drug for you, but I am sorry, the plan you are in doesn't include it on the formulary—the list of drugs that are permitted.

So what can the senior do? The senior can take a drug off the formulary, whether or not the doctor thinks that is the right thing, or the senior can file a grievance and can go through this grievance process, with a hearing, to try to get the drug that the senior's doctor tells her she should be taking for her high cholesterol.

If we do that, we know we have consumed valuable time. We have created yet another bureaucracy. Not only have we created this new Government agency to run this program, now we have created a whole grievance process, putting lawyers to work, putting advocates to work, to try to figure out how to get the drug the woman wants or get the doctor the senior wants. So we have used up a lot of paper, used up a lot of time, and unfortunately taken hard-to-have, scarce resources out of doing what we all want them to do; namely, get the drugs paid for that our seniors require.

Let's suppose we go from year 1—because this doesn't go into effect until 2006, so we are not quite sure how it is all going to work, but suppose we go from year 1 to year 3. I could not get everything on the chart, so we will skip 2007; we will go to 2008. These private plans are new. They have not refined all their business models. We know when the State of Nevada tried something similar, drug companies said: Wait a minute, there is no money in this for me. I don't want to provide drugs to the sickest, oldest people in America. I can't make anything on that. So they dropped out.

I think it is fair to assume that at the end of those first 2 years when a plan's contract expires, it may decide to drop out, just as Medicare HMOs have dropped out. As I am sure all of us have heard from our constituents, the number of Medicare+Choice plans has decreased by over half in the last 5 years, leaving thousands of seniors in the lurch when they pull out of the markets where the seniors live.

Those who did not pull out, they stayed but at a huge increase in price. They cut back benefits and raised premiums—15.5 percent last year alone. So all of a sudden, now, we have what used to be a $32 plan being a $47 plan. This is a monthly premium.

Let's say our senior waited it out, finally got the prescription drug she needed through a grievance hearing, but then after 2 years the plan she was in with the drug she needed did not find the market profitable and chose to pull out. The Government would have to be sure there was a Federal fallback in place, so our senior might then go into the Federal fallback. The Federal fallback would guarantee, for a limited period of time, that the senior would get the drug and the doctor of her choice. But this would only be for a limited time, only until this new Government agency could negotiate with private plans—and they can potentially subsidize up to 99.9 percent of their risks—in order to get two plans back into the marketplace.

Our senior would then have a plan at a higher price, with the Government basically subsidizing—some might argue, bribing—the private plan to come back into the marketplace. But by year 4, our senior might again have to change plans for the very same reasons, about coverage, including doctors, including drugs, and as you can tell, this is the most streamlined version I could put on one chart of what it is we are debating.

I think it is important to recognize that this new Government agency is giving a huge gift in a subsidy to these private plans, but it is giving another very large gift because it is basically saying you come into our plan and we will waive all State insurance regulation.

I don't know about you, but people who have dealt with insurance companies of all kinds sometimes have problems with them, and they go to their State insurance commissioner who is close to the problem, and they try to get it worked out and get some support. That will be gone. You will not have the right to go to your State insurance commissioner because this new Government agency up here will have said: All bets are off. We beg you to come into the market. We will pay you to come into the market. And guess what the sweetener is. We are not going to hold you to any of the regulations with which you would otherwise have to comply.

Last year, we passed in this body a prescription drug benefit known as Graham-Miller. It was simple, had the same premiums, deductibles, and copays, and there were no dropoffs. It was over 50 percent more generous than the bill before us today.

I know many of my colleagues prefer this Medicaid maze because they are such strong supporters of competition. So am I. Goodness gracious, competition, the free market, we all know that is one of the pillars of American success.

But I don't champion competition for the sake of championing it when it comes to health care and when it comes to the elderly and the frail and people who use the bulk of prescription drugs in our country. I champion it when it actually produces a good result.

Competition on a skewed playing field that excludes certain plans from staying in the market and creates inefficient administrative and transaction costs could actually leave customers less informed, less well off, and spend these scarce health care dollars on creating a new bureaucracy whose primary purpose is to somehow subsidize insurance companies.

I think drug plans should not compete for profits by attracting only the healthiest of people and dumping seniors they consider bad risks. They should not compete by cutting corners in quality. They should compete with each other on quality and price. Of course, the way to do that is to set some uniform benefit package to try to have a uniform premium so you can compare apples to apples and not apples to oranges to kumquats or bananas or whatever else is in the fruit basket. The Senate bill has taken some steps to try to rationalize its system. The House of Representatives' bill lacks even the basic protection for seniors. It lacks what we call a Federal fallback; that is, when your HMOs or PPOs or drug insurance programs pull out on you and don't give you the drug you need or won't let you see your doctors, then you can go into what is called the Federal fallback. The House doesn't even have that. They somehow magically assume—although we have seen no evidence of it and it defies common sense—that there are going to be all of these drug companies and all of these insurance plans competing to take care of that elderly woman or that elderly man with all of these drug costs.

As I mentioned, New York State has 219,000 low-income seniors who qualify for both Medicare and Medicaid. They are excluded. I fear they are being put at risk because they are going to have to rely on State programs in these times of big budget problems.

There are also some other people I worry about when I look at this Medicaid maze. For example, retirees who bargain for and obtain health care benefits for their retirement. The Congressional Budget Office says a third of Medicare retirees with drug benefits would lose coverage under this bill. In our State, that is 365,000 people.

Then we have another. New York has put into place its own prescription drug plan to help people who have incomes up to $50,000. If you go to New

York and you have friends or families in New York, you know we have a higher cost of living. In our State, middle-class people with big drug costs pay for those costs. There are 317,000 who are enrolled in the State's EPIC prescription drug program, and nearly 900,000 are excluded because they are in nursing homes or they have disabilities and under the calculations may have their retiree benefits put at risk, or who are going to have their State prescription guarantee also put at risk—one in three Medicare recipients in New York. Never in the history of the Medicare program has a Medicare beneficiary been denied access to a covered benefit. I am just so troubled that we are excluding our lowest income seniors. I don't know how we justify that.

I have a letter from our Republican Governor which I ask unanimous consent to have printed in the RECORD.

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

STATE OF NEW YORK,
June 12, 2003.

DEAR NEW YORK CONGRESSIONAL DELEGATION MEMBERS: Prescription drug costs continue to strain the budgets of the nation's senior citizens. I applaud your efforts this year to address this important issue. As you begin consideration of legislation to provide prescription drug coverage to all senior citizens, please consider two issues vitally important to New York State.

First, New York taxpayers continue to support a significant cost for prescription drug coverage for its dual eligible population. The dual eligibles are elderly and disabled individuals who qualify for both the Medicare and Medicaid programs. Medicaid is required to provide medical services not covered by Medicare—including prescription drugs.

More than 600,000 New Yorkers are considered dual eligibles and each year New York's Meidcaid program spends nearly $1.5 billion on prescription drugs for the dual eligible population alone. We have always believed that these costs should be borne by the federal government and strongly support efforts to federalize prescription drug costs for the dual eligible population.

In addition, New York administers the nation's largest prescription drug program for seniors, EPIC. Today, more than 300,000 seniors are enjoying the significant benefits EPIC offers and saving thousands of dollars each on vitally important medicines. Costs for this program exceed $600 million annually in State only dollars. Currently eighteen states have programs similar to New York's to provide prescription drug benefits to senior citizens.

Any federal program created this year to provide prescription drug coverage should recognize state efforts and allow seniors to choose their benefit plan (in New York, that choice would be between EPIC and the federal plan) while providing a direct Medicare subsidy to the state program for individuals that choose that option.

The Federal government has accepted responsibility of providing health care to senior citizens and I strongly urge an expansion to include prescription drug coverage. I applaud President Bush for his leadership on this issue and our congressional delegation for its commitment to our seniors.

Your efforts on this important legislation could dramatically improve the health of a segment of our population that has given so much to New York's and America's safety and prosperity. We urge you to work with us to ensure that our seniors get the prescription drug coverage they deserve, and that the federal government assumes its rightful role in supporting services for our dual-eligible population.

Very truly yours,

GEORGE E. PATAKI,
Governor.

Mrs. CLINTON. Mr. President, Governor Pataki has written to ask that in this plan Medicare cover the drug costs of these seniors and New Yorkers with disabilities. The Governor's record explains the importance of including these people who are called, in the jargon, ''low-income dual eligibles.''

Furthermore, I believe we should eliminate the penalty against retirees. By refusing to count retiree benefits as out-of-pocket expenses, this bill assures that 365,000 New Yorkers will never make it through the coverage gap. We should also try to support States such as New York that are putting their own money into programs to provide for continuing coverage.

The gap in coverage is very disconcerting. I don't even really get to that on this Medicaid maze.

I think it is important to recognize there is on average a $275 deductible and at least a $35 monthly premium that could certainly vary widely. As we have seen in these examples, depending upon where you live, and depending upon who is available, there is a 50-percent subsidy until your costs are $4,500. And then you go cold turkey. Some people call that a doughnut hole. That is not my image. There is a brick wall which you run into. Spend your money, and after that you get no help—none at all—until you get to what is called the catastrophic threshold of $5,813 in drug costs.

Many of us have heard from our constituents. In fact, we are deluged in my office with phone calls, e-mails, and other contacts from people asking, How is this going to affect me? What does this mean in my life? I think that is the real question. How do I get prescription drugs under this plan?

I want to talk about this one story, a woman named Arlene Francis. She lives in the Buffalo area. She was married to a Bethlehem Steel retiree who passed away. At one time, she had the retiree drug coverage that was part of her husband's contract with Bethlehem Steel. As we know, Bethlehem Steel went into bankruptcy and was bought by another company. All retirees and spouses of retirees lost their coverage.

Arlene takes Fosamax, a drug for osteoarthritis, which costs $68 a month. She has a hormone replacement patch. She takes antibiotics as needed. She is pretty healthy, when you think about it. That is not a lot for someone to be paying for prescription drugs and getting the coverage she needed. But it is a stretch for her because she has a very limited fixed income. Her drug costs total $998 a year. She relies on our New York program called EPIC, which covers seniors on a sliding scale up to $35,000 for singles, such as Arlene, who is a widow, and $50,000 for a couple. Under EPIC, her annual fee is $36 a year. Her copays are $3. Her share of her yearly $998 drug expense totals $336—roughly a third of what the cost would be.

But what happens under this proposal is very troubling to me. She would pay monthly premiums every month. Let us say we get it at the lowest level of $35 a month. That is $420 a year. She would pay a $276 deductible and a 50-percent copay. How much would she pay to get $998 in drugs? She would pay $1,157.

Arlene and many of my constituents aren't going to get anything from this bill. It is voluntary. You argue they don't have to go into it. But we are changing the incentive and the structure of delivering drug coverage for many people in a State such as ours which already tries to help people, which I believe will lead to the limitation or the elimination of the program we already have. Under this program, the Federal Government isn't lifting the States' costly burden of prescription drugs. It even adds some administrative costs on the State Medicaid offices that have to do all of these calculations.

Because a State will not receive reimbursement from the Medicare program for the benefits it provides up to the Medicare level, it very well could make a rational decision that it is just not going to continue doing that, and either cut back or end the program, which will be very bad news for the 360,000 seniors in our State, like Arlene, who rely on this very cost-effective way of getting their drugs covered.

When we have the Congressional Budget Office stating that seniors with prescription drug costs of $1,115 or less would end up paying more through premiums, deductibles, and cost sharing, they are not getting anything from this bill.

On the other end of the income and expenditure level, the bill falls short for patients with high drug costs as well. Even seniors who spend $5,000 will get only $1,700 in benefits. They have to manage 66 percent of the costs on their own.

I think we could do more to eliminate the gaps in coverage and to tear down the brick wall that stops people from getting help while they still pay for it until they reach the catastrophic level.

I will be introducing a series of amendments. But I think it is important to recognize the fundamental issues I am raising today about the Medicare maze are going to require all of us to work on it.

I am very pleased that one of the most important ways we can assure that competition is helpful instead of harmful is to ensure the plans actually do compete on quality.

So I appreciate that the bill includes a measure I have supported, along with Senator HATCH and others, to commission the Institute of Medicine to develop ways to think about paying for

quality outcomes. I have also filed an amendment to encourage the development of quality standards so that our seniors have some basis of comparison to choose among different plans.

I believe it is important to provide information about the efficacy of drugs and their cost-effectiveness so that seniors and others can see for themselves whether we are getting our money's worth for this $400 billion investment. I would like that information on the Internet. I would like it made available through the long-term ombudsmen, the Medicare and Medicaid representatives in every State.

I started by saying I think this legislation does hold tremendous promise. But I have tried to outline some—not all but some—of the questions I am having to answer from my constituents who come to me with very specific issues, who ask me how this will affect their lives, whether this will make them better off or worse off financially.

I believe it is important for us to be able to really scrub this, understand what it does and what it does not do, and also recognize that on the other end of this Capitol the House has a very different approach. I applaud the work Senators GRASSLEY and BAUCUS have done. But let's not forget, this body tried to protect lower income working families by giving them the child tax credit—people who pay a higher proportion of their income in taxes than I do, but who were told, at the other end of this building, that because they may not pay income tax, they should not get help for their children.

I have to ask, if that is the attitude on the other end of this building, if they have already passed a bill that is not going to help many seniors but provides even more of a giveaway to drug companies to try to get them to offer these plans, how can we trust, at the end of the day, that the more thoughtful debate and version we are working on here in the Senate will be what comes out of this process?

I was very disappointed when it was reported in the papers today that the President has weighed in on the side of giving subsidies, increasing benefits to insurance companies—not in the Senate version, but in the House version—and that the President does not want a Federal fallback. This is a huge difference in philosophy, in ideology, and, I believe, in life experience.

Medicare has worked. Since 1965, it has removed not only so much of the concern and worry and anxiety about growing older, of facing acute and chronic health care problems, it has removed a lot of burden from the American family.

My mother just recently turned 84, and I feel very fortunate that I am in a position to be able to help her. But I know, very well, that a lot of other families trying to save for tuition, for college for their kids, trying to make ends meet, when it comes to mortgages and car payments, they may not be in that position. Therefore, they look to Medicare to really help spread the burden of taking care of our elderly from one generation to the next. It is part of our social contract in America. We have a basic bargain: If you work hard, if you are responsible, we are going to help, through our Government, to make sure you do not fall into poverty, that you are not left without health care. We are going to do that because that is the kind of people we are. Those are the values we have. This could be a giant step back from that commitment.

Let's not also forget that this $400 billion, which we are trying to set aside, comes at a time when we are looking at deficits and increasing debt, which will impose even more burdens in the future on middle-class Americans and their families. So I hope we are able to answer the questions and, most fundamentally, explain clearly and unequivocally how someone gets their prescription drug benefits.

I do not know that I could take this chart to a senior center, to a nursing home, and explain this. I do not understand why it has to be so complicated, why we have to create a new Government agency, why we have to waive insurance regulations, why we have to cause this level of confusion and uncertainty among people who should have the peace of mind in their later years that they do not have to worry about filing grievances, fighting for their drugs and their doctors. Why are we doing this? Why are we creating these obstacles, this Rube Goldberg system that is going to be extremely hard to explain and very hard to understand?

Finally, I do not understand, either, why we are waiting until 2006. Medicare went into effect within a year—a totally new system, with no new agency to administer it. We were able to do it in a year. President Johnson went to Independence, MO, and signed that bill with former President Harry Truman, who had been one of the first of our leaders to say: We need to take care of our seniors.

That bill was signed, it has worked well, and it has a very low administrative cost. Two to three cents out of your tax dollars, your contributions that go into Medicare, go into administration, go into any kind of costs that can be compared to the high percentage that these private insurance companies spend. Some of them spend 30 to 40 cents out of your dollar, not on taking care of you but on taking care of themselves.

So at the end of the day, Medicare has worked. I am very proud of our country for making that commitment. Yet I worry that what we are about to do is not only difficult to understand, difficult to administer, and confusing but may very well be the beginning of undoing traditional Medicare.

The report of the President's letter today certainly gives me pause that we would not even have a Federal fallback. Our people who live in rural States, live in poor urban areas—who are not the most attractive clients for insurance companies because—guess what—they get sicker, they are poorer—where will they get their care if our Government does not have that fallback to provide the safety net?

And what do we do as States are making these budget cuts to take care of the hundreds of thousands of our poor residents in nursing homes, our people with disabilities, who depend upon this program?

We cannot forget about the larger issue at hand. Our fundamental responsibility and our goal must be, as a nation, to help our seniors by providing a prescription drug benefit that is reliable and comprehensive. And if we are to go down the route of introducing competition, then let's make sure it is competition on cost and quality, not competition to eliminate more and more of the sickest of our elderly or the people with disabilities whom we are trying so hard to take care of.

Our goal is not just choice or competition, it is compassion; it is coverage for those who need it. We have a rare bipartisan opportunity to do this. Let's get it right in the Senate, and then let's fight with all of our energy to make sure it is not changed in a conference committee with the House, so that we can, in good conscience, tell our seniors we have done the best we can to make sure they get the benefit we promised.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. THOMAS. Mr. President, certainly we are dealing with an issue and a proposal where there are huge differences. And there have been huge differences for some time. The Senator from New York represents quite a different point of view from several years past.

What we are trying to do is to provide better service, provide some options, provide some modernization of a program that is 40 years old, that has never been changed. So the question really is, How do we best serve all of the people who are in need of service? The question is not, How do we maintain and grow a Federal program, and keep it all Federal? That is not really what most of us have in mind.

We want to look at some alternatives. We want to look for choice, where people who wish to stay in the program as it now exists may do that. And that is what this bill provides. But it also provides an opportunity to move to something that could be different, have some choices, could even in fact be more efficient, more effective. I am afraid it is hard for me to accept the idea that Government programs are more efficient than the private sector. I don't think there is much evidence of that. Certainly what we are talking about here is having some opportunities for a change, some opportunities for some alternatives. I understand

there will be those who will be resisting those changes, but nevertheless we do have a bipartisan bill before us that incorporates that opportunity. We want to do it.

We are concerned, of course, about having services that reach out to everyone in rural areas. I think I am about as concerned about rural areas as anyone in this body. I come from one of the most rural States. I have to tell you how pleased I am that we have in this bill a substantial program for rural health care, one, by the way, that was turned down by many of the folks who are now worried about the rural areas in the tax bill. But it is here, and it will respond to the needs of rural constituents and rural beneficiaries. And that, of course, is of vital importance to all of us.

With respect to dual eligibles, the Senator, the speaker just recently, has raised a concern about how S. 1 treats seniors who are eligible for both Medicare and Medicaid programs. Those are known as dual eligibles. Under S. 1, these seniors will continue to receive their prescription drug benefit through the Medicaid program.

It is alleged that by having dual eligibles remain in the Medicaid program, Congress is treating them as second-class citizens and subjecting them to lower quality benefits. I don't believe this to be the case, nor is there evidence that it is the case. We worked diligently on the development of this package and reflected these concerns that were raised all the time during last year's debate. Learning from these lessons, we decided it was most beneficial to seniors to continue to build off existing Medicare and Medicaid low-income assistance programs as far as to offer a seamless benefit.

We do not want to divert scarce resources available for this benefit toward the development of a new government bureaucracy. I am confident S. 1 establishes this new benefit in a manner that will provide high quality, accessible care through a system that is familiar to seniors and easy to navigate.

It is also important to note that the Medicaid program is considered by most advocates and beneficiaries to be quite generous and far superior to the current Medicare program. Recognizing that this is a program for persons with low income, the Federal Government only allows States to charge nominal copayments to receive the drug benefit. Further dual eligibles have been and should continue to remain the joint responsibility of State and Federal Governments. However, in recognizing that the Federal Government should play a dominant role in delivering this vitally important benefit, we provide in this bill $14 billion in additional Federal dollars to help pay for increased costs associated with the new prescription drug standards included in the bill.

This is because the bill provides minimum standards to ensure that benefits provided through Medicaid are the same high quality as those provided through Part B of the Medicare program. For these reasons I am confident and I think our committee was confident that dual eligibles will continue to have access to prescription drugs that they deserve.

Some argue we should do more, perhaps even serve this population differently, but this bill was developed in a manner that we believe utilizes scarce dollars efficiently and helps to deliver care that is consistent with the current law and easy for seniors to navigate.

This is a discussion that has already been held to a great extent, how you deal with low income and to do it in a way that is consistent with what we have had in the past and was equal in benefits to what we have had in the past. That is the process that is designed here.

So as we move on, I hope we can continue to provide the things that are really the purpose of this whole bill. And there are two at least. One is to provide, of course, drugs, pharmaceuticals to seniors and do it in several different ways so that it meets the needs of those seniors somewhat dependent on income. The other is to provide some opportunities to improve the distribution system for Medicare, again, a program that has been in place for 40 years, has had relatively little, if any, change. And now we have an opportunity to give some choices to the beneficiaries and develop programs that are more efficient than what we have had in the past.

So it is kind of discouraging to have people stand and want not to change whatever we have had going on for 40 years. We are not talking about changing the benefits. We are not talking about the quality. We are talking about making a distribution system that meets the needs of the changes that have taken place in our society and be able to do that in a way that people would like to and will want to have choices.

So as we talk about these various amendments that will be raised, I hope we will continue to take a look at what it is we have as a goal here, to be able to do these things that have been described and focus on getting the kind of results we really have in mind when we put together this proposal and continue to have bipartisan support for the bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. ALEXANDER). Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I will take a moment to review the schedule under the previous order. Under the previous order, the following Senators are to be recognized to offer the following amendments:

Senator GRASSLEY on rural provisions; Senator HARKIN on mammography; Senator CONRAD on fallbacks; Senator KERRY on a grant program; Senator CLINTON on a study; and Senator GRAHAM has one with respect to premiums.

Republican Senators could offer amendments in an alternating fashion between Democratic amendments. A number of these Senators have chosen to offer amendments at a later time.

Thus, I ask unanimous consent that this order remain the order under which Senators would be recognized to offer amendments, except that the Senator from Florida, Mr. GRAHAM, now be recognized to offer his amendment, and immediately following Senator GRAHAM, the Democratic leader be recognized for whatever amount of time he wishes to speak, and that the pending amendments be temporarily laid aside so the Senator from Florida may offer his amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. THOMAS. Mr. President, I agree with what the Senator just said. I ask unanimous consent that the order of amendments provide that when a Republican amendment is offered, it be considered in an alternating fashion with the Democrat amendments; provided further, that it be in order for the amendment to be offered in any Republican slot.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

AMENDMENT NO. 956

Mr. GRAHAM of Florida. Mr. President, I am here this morning to offer an amendment to the Prescription Drug and Medicare Improvement Act of 2003. This amendment has as its goal to repeal the ''sick tax,'' which is part of the pending legislation.

I send the amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Florida [Mr. GRAHAM] proposes an amendment numbered 956.

Mr. GRAHAM of Florida. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill, and for other purposes)

On page 107, between lines 19 and 20, insert the following:

''(d) BENEFICIARY NOT RESPONSIBLE FOR PAYING APPLICABLE PERCENT OF THE MONTHLY NATIONAL AVERAGE PREMIUM WHILE THE BENEFICIARY IS IN THE COVERAGE GAP.—

''(1) IN GENERAL.—Notwithstanding subsection (c), if an individual, with respect to any period of a year, has reached the initial coverage limit under paragraph (3) of section 1860D–6(c) for the year but has not reached the annual out-of-pocket limit under paragraph (4) of such section for the year, the applicable percent under subsection (c) during such period shall be zero.

''(2) PROCESS.—The Administrator shall establish a process for carrying out paragraph (1). Under such process, the Administrator shall—

''(A) require eligible entities offering Medicare Prescription Drug plans, MedicareAdvantage organizations offering MedicareAdvantage plans that provide qualified prescription drug coverage, and entities with a contract under section 1860D–13(e) to furnish the Administrator with such information as the Administrator determines necessary to carry out paragraph (1); and

''(B) furnish the Commissioner of Social Security with such information as the Administrator determines necessary to collect the appropriate monthly beneficiary obligation pursuant to section 1860D–18.

At the end of subtitle C of title IV, insert the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

Mr. GRAHAM of Florida. Mr. President, I have many concerns with this legislation. Probably at its core is the fact that we are about to adopt a prescription drug benefit for 39 million older and disabled Americans, of which there is no current model. Virtually every question about this legislation has to be answered at a theoretical level because we cannot say the Federal health insurance plan that covers Federal employees, or a Blue Cross/Blue Shield plan, or any other plan has provisions to dispense prescription drugs through a prescription drug-only insurance policy.

In my judgment, that is a very fundamental concern that we should share. Understand that we are about to conduct a gigantic social experiment on 39 million Americans, many of whom are the sickest, most frail, most vulnerable of our citizens.

I am here today to talk about a specific troubling aspect of this legislation, and that is what has been referred to as the ''sick tax.'' What do we mean by that? This bill includes what has come to be known as either the donut hole or the benefit shutdown.

I think it is more like a black hole. Here is how that hole would develop. Seniors who sign up for this new benefit will face a gap in those benefits. Once a senior has reached $4,500 in drug spending, the Medicare prescription drug benefit evaporates, the senior falls into the black hole and gets no help with his or her prescriptions for the next $1,312.50.

I know of no insurance plan that has such a gap in coverage. The Federal Employees Health Benefits Plan, which has often been touted as the model we should use for Medicare, does not have such a gap in its benefit structure. If it is not bad enough that Medicare beneficiaries will get no help from Medicare during this gap, any contributions from the senior's former employer would not count to closing that gap. In many instances, individuals were members of unions and they negotiated a collective bargaining agreement under which they understood they were going to reduce their current income in order to get other benefits that would be paid at the point of their retirement.

Frequently, one of those benefits was some assistance in the payment of their prescription drugs. So they have already paid once for that benefit by not getting that raise that they had anticipated or not getting as much of a raise as they anticipated, and now they are going to be penalized a second time by not allowing those employer payments that contribute to covering the cost of prescription drugs to count toward narrowing the hole; that is, if a senior has a retiree prescription benefit, that benefit cannot be used to reach the catastrophic limit.

The final insult is that during this gap—when the senior is paying 100 percent of the cost—every penny of prescription drugs purchased during this period in the black hole will be paid by the senior beneficiary. But the senior will still have to keep paying the monthly premium.

This legislation suggests that is going to be $35 a month. Most people believe that number is likely to be exceeded in 2006. It certainly will be exceeded as medical and particularly prescription drug inflation takes hold in future years. The senior will have to continue to write that check every month, although they get absolutely no benefit.

Let me be perfectly clear. During months in which seniors are not getting any assistance whatsoever, they will continue to pay the monthly premium. Collecting monthly premiums, while a senior has fallen into this black hole, is the equivalent of levying a tax on the sick. They are asked to pay into the program without receiving any benefit.

The average Medicare beneficiary today spends a little over $2,000 a year on prescription drugs. We are talking about people who have already spent well over twice that to get to the $4,500 level. So we are talking about seniors who have significantly poorer health and, therefore, higher prescription drug costs, and that is a group of seniors we are going to discontinue from benefits until they have paid out of their pocket another $1,300-plus of prescription drug costs.

Why would there be this gap in prescription drug coverage? Why do we do what no other insurance policy in America does today? Surely, none of

my colleagues can believe this gap is a good insurance policy or good medicine for seniors. So let's call this gap what it is: a gimmick that is designed to lower the cost of this legislation at the expense of seniors who are most in need of the drugs.

What does the gap in coverage mean for a senior? I would like to take a few minutes to spell it out so that we will know exactly what we are voting for if we approve this legislation.

The gap with the black hole begins at $4,500 in total drug spending. Beneficiaries have to reach a point where their total spending—the spending of the beneficiary, the Federal Government, and any other source—reaches a level of $4,500, over twice the average Medicare beneficiary's annual prescription drug cost.

Once you reach that point, you receive no assistance for your prescription drugs until you have spent out of your own pocket—not counting any contribution made by your former employer—until you have spent $3,700.

How does the math work? To get to the $4,500 level, the out-of-pocket expenditures by the beneficiary will be, first, a $275 deductible. You have to pay that before you get any assistance. Incidentally, you are also paying the monthly premium during the time you are meeting that deductible requirement. Then between $275 and $4,500, you pay half, the Federal Government pays half. You would pay $2,112.50, and the Federal Government would pay $2,112.50. By the time the combined expenditures reached $4,500, you would have paid $2,387.50 out of your pocket. That is the deductible plus your coshare of prescriptions purchased. At this point, you would fall into the gap. You would receive no assistance.

In order to get out of this black hole, you have to have total expenditures out of your pocket of an additional $1,312.50 beyond the $2,387.50 you have already paid. So you will have to pay a total of $3,700 before you can escape. While you are in the black hole, you are continuing every month to pay the premium for a policy for which you are getting no benefit.

The sponsors of this legislation say the monthly premium is $35. However, look through the hundreds of pages of this legislation and you will not find a $35 number. It is going to be up to the private drug-only insurers to actually decide whether the premium will be $35. It could certainly be higher.

Again, we have no example of this type of prescription-drug-only insurance we can point to and say: Here is how we as Federal employees have been treated, or here is how a group of public or private employees under another standard plan have been treated. The reason is that there is no example of what we are about to impose on America's older citizens.

All of this talk of math and gaps may sound theoretical, but the gap will affect the lives of real human beings. Let me give one real example.

There are nearly 3 million Medicare beneficiaries in my State of Florida. One of those is an 89-year-old woman by the name of Virginia. Virginia, a widow of 11 years, is nearly blind. She lives in an assisted living facility. Her income is significantly below the median income. Her monthly income is $1,535, or $18,420 on an annual basis.

Virginia recently moved in with a roommate because she could no longer afford her own apartment. She could not afford last Christmas to buy her grandchildren presents. During her working years, Virginia was an editor and columnist for a smalltown newspaper. She was also a poet.

Virginia is one of the many Medicare beneficiaries in dire need of a Medicare prescription drug benefit. She suffers from high blood pressure, stomach irritation, pains in her joints, anxiety disorder, osteoporosis, hypothyroidism, trouble sleeping, and difficulty with her vision.

This chart lists her conditions. These are the medications that have been prescribed. This is the cost per month based on today's cost inflated by 3.6 percent per year to reach an estimated cost in the year 2006 when this plan will commence.

She is spending $489.22 a month, or $5,870.64 a year, to get the drugs she needs. Each day, she needs three medicines for her blood pressure and seven others to treat her other conditions. These medicines are necessary to reduce her pain and to prevent further health complications.

I would like to be able to tell Virginia the Senate is considering a bill that will give her a comprehensive, affordable Medicare prescription drug benefit. But I cannot do that. No Member of this Senate can tell its citizens, such as Virginia, that we are providing them with a comprehensive, affordable Medicare prescription drug benefit. Why? Because if this bill is approved, I will have to tell Virginia that after she has spent $275 before she gets any help to meet the deductible, then beginning on January 18, when her deductible has been met, until October 7, 2006, Virginia would expect to pay 50 percent of the cost of each prescription.

This chart shows the $35 estimated monthly premium and the out-of-pocket costs Virginia would have to pay. After spending $275, she will spend another $2,112.50 for her 10 medications. Those are the blue bars on this graph. Then what happens? If this bill is approved, I would have to tell Virginia that after October 7, while the $35 premium continues at the same level, she would receive no benefit. All of these black bars are what Virginia would have to pay, 100 percent out of her pocket. She still needs all the medications on October 8 and 9, throughout the rest of the year. Her needs have not diminished.

On October 7, she falls into the black hole. She would stay there until December 27. I am guessing she will not be sending any Christmas presents to her grandchildren in 2006, either.

To make matters worse, I would have to tell Virginia that in addition to paying 100 percent of the cost of her prescriptions, she would still have to pay the $35 every month and get nothing in return. How do I explain to this senior in my State that she would be getting no help from the drug benefit but would still be paying the premium? She would get no help for nearly 3 months but would pay the premium anyway.

Between the premiums, which are getting her nothing, and the full cost of her medicines, Virginia would have to spend 34 percent of her income to get the medications that she needs. Let me repeat that. Between the $35 a month premiums and the full cost of medicines that she would have to pay while she is in the black hole, Virginia would be spending 34 percent of her annual income on prescription drugs.

I do not think Virginia will believe this is a very adequate prescription drug benefit. It is neither comprehensive nor affordable.

At an absolute minimum, Virginia should not be asked to pay a monthly premium during the time that she is getting no benefit.

This gap is bad medicine. The gap is a gimmick that lowers the cost of the plan but at the expense of our seniors. One of the many pieces of information we need from the Congressional Budget Office in order to make an informed judgment on this bill is the number of Medicare beneficiaries who would fall into this gap. However, like so many other aspects of this legislation, we not only do not have any practical experience, we do not have the theoretical estimates of the Congressional Budget Office.

According to the administrator of the Medicare Program, CMS, 12 percent of the almost 40 million beneficiaries would fall into this black hole. I believe that number reflects the number of beneficiaries who would fall into the gap today, in June of 2003. By the time we get to 2006, however, when the bill would actually become effective, data from the Kaiser Family Foundation suggests that more than 20 percent of the beneficiaries would fall into this gap.

This debate would certainly be informed by more information from the Congressional Budget Office, but in the absence of CBO numbers I will use the CMS and Kaiser numbers. If CMS is correct, nearly 5 million Medicare beneficiaries would fall into the benefit gap if the benefits were available today. If the Kaiser projections for 2006 are correct, nearly 8 million Medicare beneficiaries would fall into the black hole in the first year of this program. Eight million seniors and people with disabilities would be forced to pay a premium when they are getting absolutely no benefit in return.

I do not believe we should tax those 8 million Medicare beneficiaries whose prescription drugs are high enough to place them in this black hole.

In my own State of Florida, it is estimated that there will be 600,000 Medicare beneficiaries who would fall into this black hole. I do not want to go home and tell 600,000 of my constituents that instead of getting a comprehensive, affordable Medicare prescription drug benefit, they are going to get a meager benefit run by private insurance, and to top it off they will have to pay the ''sick tax'' imposed upon them when they need the benefit the most.

One goal of a Medicare prescription drug benefit, which I believe is commonly shared, is that seniors will find it in their best interest to voluntarily enroll in this new program. Last week, we debated a provision that would have given greater choice to seniors. They could have elected either to stay in the plan that is now being imposed, albeit a plan that has no history of a drug-only insurance policy, or they could make an election to stay with standard Medicare fee for service. That proposal was rejected. In my judgment, that is going to suppress voluntary participation in this prescription drug program.

Surely, the success of any program depends on a high participation rate. The ''sick tax'' would be an even further discouragement and could doom the program to failure. We know seniors will reject a plan that does not provide them the benefits they need. We have already seen that with the passage and then the quick rejection of catastrophic Medicare benefits in the late 1980s.

People like Virginia will not enroll in a program that requires them to make a monthly payment while they get nothing in return.

This amendment to suspend the payment of premiums once a beneficiary's drug utilization is within the gap in coverage would eliminate the unfair provision under which beneficiaries with high drug costs would continue to pay premiums while receiving no benefit.

In summary, the amendment that is before us would say if a beneficiary is in the black hole, if they are not receiving any benefits, they would not have to pay the monthly premium.

I bring to the attention of my colleagues that there has been some defense given of this legislation which says we cannot vote for any amendment which would change the basic structure of the bill; that would change, in my judgment, the unwise reliance on an unproven, drug-only insurance benefit. I want to emphasize, this does not change the structure. Rather, this removes a clear inequity but maintains the fundamentally flawed structure of this legislation. Yes, it has a cost. Again, we do not know what the cost is from CBO, but I am going to suggest an offset which will be more than adequate to pay the cost.

There are some who say we cannot afford any amendments which would increase the benefits of this program. That reminds me of the old story about the child who shot his mother and his father and then threw himself at the mercy of the court because he was an orphan. The fact is, we shot a legitimate prescription drug benefit for Medicare by passing a reckless tax cut that has absorbed the resources that would have enabled us to provide a legitimate benefit.

The offset that I am offering is an amendment which would secure the savings attributable to a clarification of the Medicare secondary payment provisions. For most of the history of Medicare, the assumption has been that if a person had double coverage, the primary payer would be that payer other than Medicare, and Medicare would wrap around that primary payer. A recent court opinion has reversed that assumption.

There is a provision, which is included in Chairman TAUZIN's House Energy and Commerce Committee mark, supported by the Justice Department, that would clarify the circumstances in which Medicare is the secondary payer.

I ask unanimous consent to have printed in the RECORD a letter dated January 17 from the Assistant Attorney General, William E. Moschella, outlining the Department of Justice support for this offset.

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

U.S. DEPARTMENT OF JUSTICE, OFFICE OF LEGISLATIVE AFFAIRS, OFFICE OF THE ASSISTANT ATTORNEY GENERAL,

Washington, DC, June 17, 2003.

Hon. W.J. (BILLY) TAUZIN,

Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This is to advise you of the Department's support for a provision in the Medicare Prescription Drug and Modernization Act, set forth in Title III, Section 301, which would protect the integrity of the Medicare Trust Fund by clarifying that Medicare must be reimbursed whenever another insurer's responsibility to pay has been established. The Section is consistent with the litigation positions taken by this Department and the Department of Health and Human Services (''HHS'') in numerous court cases.

Congress enacted the Medicare Secondary Payer (''MSP'') statute in 1980 to protect the fiscal integrity of the Medicare program by making Medicare a secondary, rather than a primary, payer of health benefits. To ensure that Medicare would be secondary, Congress precluded it from making payment when a primary plan has already made payment or can reasonably be expected to pay promptly. Congress recognized, however, that in contested cases, payments under such plans would be delayed. To protect, providers, suppliers, and beneficiaries, Congress authorized Medicare to make a ''conditional'' payment when prompt resolution of a claim cannot reasonably be expected. The Medicare Trust Fund must be reimbursed, however, once the primary insurer's obligation to pay is demonstrated.

Some recent court decisions have held, however, that Medicare has no right to reimbursement unless the primary insurer could reasonably have been expected to make prompt payment at the outset. *See e.g., Thompson v. Goetzmann* 315 F.3d 457 (5th Cir. 2002). These rulings make the statute's reimbursement mechanism inoperative in some jurisdictions. Section 301 of this legislation would end this costly litigation and provide clear legislative guidance regarding Medicare's status as a secondary payer of health benefits. The technical changes in Section 301 make clear that Medicare may make a conditional payment when the primary plan has not made or is not reasonably expected to make prompt payment.

The technical amendments of Section 301 clarify other provisions of the MSP statute, as well. They make clear that a primary plan may not extinguish its obligations under the MSP statute by paying the wrong party (*i.e.*, by paying the Medicare beneficiary or the provider instead of reimbursing the Medicare Trust fund. The Section clarifies that a primary plan's responsibility to make payment with respect to the same item or service paid for by Medicare may be demonstrated, among other ways, by a judgment, or a payment conditioned upon the recipient's compromise, waiver or release of items or services included in the claim against the primary plan or its insurer; no finding or admission of liability is required. In addition, section 301 makes clear that an entity will be deemed to have a ''self-insured plan'' if it carries its own risk, in whole or in part. Finally, the Section makes clear that the Medicare program may seek reimbursement from a primary plan, from any or all of the entities responsible for or required to make payment under a primary plan, and additionally from any entity that has received payment from the proceeds of a primary plan's payment. These provisions of Section 301 will resolve contentious litigation and are designed to protect the fiscal integrity of the Medicare program.

We hope that this information is helpful. The Office of Management and Budget has advised that there is no objection to this report from the standpoint of the Administration's program. Please let us know if we may be of additional assistance.

Sincerely,

WILLIAM E. MOSCHELLA,
Assistant Attorney General.

Mr. GRAHAM of Florida. This amendment is endorsed by the National Committee to Preserve Social Security and Medicare. I ask unanimous consent that their letter of endorsement be printed in the RECORD.

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

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE,

Washington, DC, June 16, 2003.

U.S. Senate,
Washington, DC

DEAR SENATOR: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare (NCPSSM), I am writing in support of Senator Graham's ''No Premium in the Gap'' amendment to ''The Prescription Drug and Medicare Improvement Act of 2003.''

We understand that the amendment would suspend the payment of premiums once a beneficiary's drug utilization is within the gap in coverage. Charging seniors a monthly premium without offering any benefit in return is the equivalent of levying a tax on the sick.

The amendment would improve the ''The Prescription Drug and Medicare Improvement Act of 2003'' by eliminating the unfair provision under which beneficiaries with high drug costs would continue to pay premiums while receiving no benefit.

We applaud your efforts and dedication on behalf of America's seniors, and appreciate

your continued leadership on these issues. Please support Senator Graham's ''No Premium in the Gap'' amendment and we look forward to continuing to work with you.

Cordially,

BARBARA B. KENNELLY,
President and CEO.

Mr. GRAHAM of Florida. I urge my colleagues to join me in amending this legislation and repeal the ''sick tax.''

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. 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 will comment on the amendment, the no premium on the donut amendment.

First, let me say that I wish we did not have a gap in coverage. Unfortunately, eliminating the gap in coverage could add as much as $200 billion to the cost of this proposal. As we all know, we are working within a budget of $400 billion and this bill targets those funds to those who need it most.

Most seniors, however, will not be affected by the gap in coverage at all. This is because their drug spending will not reach limit, or because they qualify for the additional assistance in the low-income benefit, or because they have additional coverage from a retiree health plan, or coverage they have purchased themselves.

Most seniors will not have drug spending in a year that exceeds the benefit limit. According to the Congressional Budget Office, 80 percent of seniors will not even have prescription drug spending that exceeds the $4,500 benefit limit.

That means that right off the bat only one senior in five would even have drug spending high enough to be affected by the gap in coverage at all.

Now, the drug benefit package for lower income seniors does not have a gap in coverage. In drafting this bill we have targeted resources to those who need it most. We made it a priority not to have any gap in coverage for lower income seniors.

This means that beneficiaries with incomes below about $15,000 and couples with incomes below about $20,000 in 2006 will have no gap in coverage. That is 41 percent of Medicare beneficiaries who are completely unaffected by the benefit limit.

In addition, beneficiaries who have coverage from a retiree health plan will not be affected by the benefit limit when the plan provides that additional coverage. Today, about 32 percent of beneficiaries have retiree coverage and this bill provides generous Federal assistance to retiree-sponsored plans so that they can continue to offer coverage to their former workers.

Other seniors will be able to purchase additional prescription drug coverage from their prescription drug plan or through their MedicareAdvantage plan. This additional drug coverage will be seamlessly integrated into their drug benefit package and will ensure that seniors who want additional coverage will be able to get it.

As a result of the elimination of the gap for 44 percent of seniors who have lower incomes and the fact that many seniors have additional coverage, we estimate that only about 2 to 12 percent of seniors will ever be affected by the gap in coverage.

Now every single beneficiary who enrolls in the drug benefit will have comprehensive coverage including coverage against catastrophic drug costs. That coverage is present even for those 2 to 12 percent who are in the gap in coverage. These seniors are always protected against higher drug costs.

Any enrollee will have 90 percent of their prescription drug costs covered if they have $3,700 in out of pocket spending on prescription drugs in a year.

Now Senator GRAHAM calls the benefit limit a sick tax because he believes that seniors should not pay a premium for the coverage for catastrophic costs if they hit the benefit limit. This is like saying that you should not pay for fire insurance if your house isn't on fire.

But of course that is not how insurance works. People purchase insurance to protect them against unfortunate events like a house fire, an accident, or some other tragedy.

To get the coverage in your insurance policy, you pay an insurance premium. If you do not pay the premium, then your insurance policy is not going to give you the coverage.

That is the same idea here with coverage for prescription drugs. Any senior who wishes to enroll in the voluntary benefit will pay a monthly premium for that coverage. The coverage is voluntary and the premium is an affordable $35 per month. And 44 percent of beneficiaries with lower incomes will have very low or no premium at all for the coverage offered in this bill.

Finally, if we were to close the gap in coverage for seniors at higher income levels it could cost over $200 billion, which would require us to take benefits away from the seniors with the lowest incomes. Personally, I cannot justify that action.

Of course, today's seniors receive no assistance from Medicare for outpatient prescription drugs, and this bill changes that by adding a new comprehensive prescription drug benefit to the program. The average senior will save at least 53 percent, about $1,700, off their prescription drug costs after paying an affordable monthly premium of $35. And lower income seniors will have 80 to 90 percent of their drug costs covered.

We have worked hard to minimize the gap in coverage within the resources available for the proposal. We have done that. Most seniors will not have spending that hits the benefit limit, and for those who do, many of those will have coverage above the limit through the low-income benefit package, from retiree plans or from additional coverage provided by their plan.

I urge my colleagues to vote against the Graham amendment.

I urge we not consider the Graham amendment, that, in fact, this has been covered and is covered in the bill as it now exists and is designed to help those beneficiaries with the lower incomes.

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. DASCHLE. 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. DASCHLE. Mr. President, I wish to alert my colleagues this morning to an important new study that has just been published by the Institute of Medicine entitled ''Hidden Costs, Value Lost: Uninsurance in America.''

According to the Institute's findings, the United States economy loses between $65 billion and $130 billion each year because of the cost of the undiagnosed or untreated illnesses of those Americans who lack insurance. In short, the report found that the cost of not providing insurance is higher than the cost of providing insurance.

If these findings are borne out, this would represent an astonishing fact that should force the Congress to rethink our approach to the health care and insurance, policies in the country today. The report also examined the effect being uninusured has on individuals and their families.

It states:

> Unisured individuals and families bear the burden of increased financial risk and uncertainty as a consequence of being uninsured. Although the estimated *monetary* value of the potential financial losses that those without coverage bear is relatively *small,* the psychological and behavioral implications of living with financial and health risks and uncertainty may be significant.

Recently, I was home in South Dakota meeting with citizens. I saw firsthand the effect that the lack of insurance and the fear of losing insurance has on the people of my State.

Day after day, too many South Dakotans know that they are one layoff, one bad crop, one accident, or one illness away from being totally unprotected. I met with veterans who are picking up a greater share of their health care costs, because cuts to their health benefits are causing longer waits and worse care in the VA system.

I met with self-employed people, small business owners and farmers, who buy their own insurance and as a result face premium costs as high as $20,000 a year. I met with the families of National Guard members who just a few weeks ago were afraid that their loved ones might get hurt in the line of

duty in Iraq. Today, they were worried that their husbands or wives will lose their health coverage when they return home. And I met with citizens from all walks of life who can't afford the high cost of insurance and live in constant fear that an illness or an injury could throw them and their family into bankruptcy.

I recently heard from a couple in Springfield, SD, who own a small business, but who do not have insurance. The husband is a veteran and he has been on the waiting list to receive benefits for himself through Veterans Health Administration for a year-and-a-half. In the meantime, he has looked for health insurance for both for he and his wife. But, the only policy they could find had monthly premiums of $800 and deductible of $2,500. In addition, the insurance would not cover the couple's pre-existing conditions. This policy was too expensive, so they are forced to live without coverage of any kind until the Veterans Administration is able to provide it. They may wait for as long as 2 years.

To bring resources for Veterans health more in line with the overwhelming need, many of us introduced a bill, S. 19, that would change the funding process for the Veterans Health Administration. The bill would mandate increased funding to correspond to any increase in the number of patients. This section, which is identical to S. 50, the Veteran Health Funding Guarantee Act introduced by Senator JOHNSON, would help ensure that the VA can provide medical services to every eligible veteran.

Our failure to provide coverage to veterans is one of the most glaring examples of the unfairness in our health care system. But the problem extends throughout our entire country. Forty-one million Americans lack health insurance today, and high costs are driving that number even higher. With the release of the Institute of Medicine's report, we learn that doing what's right is in fact less costly for our country than doing nothing. We can do better. This is a national problem and it demands national leadership to fix it.

We have an obligation to focus on the troubles of our economy and the Americans who are struggling to work and raise families. We certainly want to do everything we can to keep the Senate's attention focused on the crisis in health care. Our citizens are asking for our leadership, and we have an obligation to answer their call.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, as we did with the Graham amendment, I would now like to allow consideration of the Kerry amendment, and thus I ask unanimous consent that all the terms of the previous order remain in place except that the pending amendments be temporarily set aside, and that the Senator from Massachusetts be recognized to offer his amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Massachusetts.

AMENDMENT NO. 958

Mr. KERRY. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Massachusetts [Mr. KERRY] proposes an amendment numbered 958.

Mr. KERRY. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To increase the availability of discounted prescription drugs)

On page 204, after line 22, insert the following:

SEC. ___. ACCESS TO DISCOUNTED PRESCRIPTION DRUGS.

(a) IN GENERAL.—From amounts made available under subsection (c), the Secretary of Health and Human Services shall award grants to covered entities described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) to enable such entities to pay the start-up costs associated with the establishment of pharmacies to provide covered drugs under such section 340B.

(b) APPLICATION.—To be eligible to receive a grant under subsection (a), a covered entity shall prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(c) FUNDING.—The following sums are appropriated, out of any money in the Treasury not otherwise appropriated to the Prescription Drug Account established under section 1860DD-25 of the Social Security Act, $300,000,000 to carry out this section. Amounts made available under this subsection shall become available October 1, 2004, and shall remain available until expended.

Mr. KERRY. Mr. President, I thank the distinguished ranking member and congratulate both him and Senator GRASSLEY on what is obviously an extraordinarily important, complicated, and difficult road—to try to move toward prescription drug coverage for seniors in America. I wish to share a few words, if I may, at the outset, before moving specifically to the amendment, and to talk generally about the bill itself.

Obviously, all across our country we have accomplished an extraordinary service for seniors through what we have achieved through Medicare. It is one of the great social programs of the United States of America. I can remember years ago a shared responsibility by Republicans and Democrats alike. I think it was President Nixon who signed the enormous proportion of it into law in the beginning of the 1970s. We lifted a great many seniors in this country out of poverty as a consequence. It has benefited millions of Americans who would otherwise go without quality health care and otherwise either be forced into poverty or remain in poverty. The face of poverty in the United States of America changed because of this program.

I might add that it is a Government program. Often, the Government comes under great criticism. But the truth is that this is a program that has worked, a program that has made a difference in the lives of our fellow Americans, and a program that a large proportion of America appreciates, respects, and doesn't want to see destroyed. I think we have a duty to try to strengthen and improve the program by adding a comprehensive, affordable, and guaranteed prescription drug benefit to Medicare.

Notwithstanding the very best efforts of the chairman and ranking member and others on the committee on which I serve, there are still questions as to whether this in fact does that at this point in time.

That doesn't mean it isn't perhaps for some people worth voting for. I haven't made a final decision with respect to final passage. That may depend somewhat on what we achieve over the course of these days. But we need to put to the test the question of what we are doing versus what we could do. This is a fair standard for us to try to measure.

My concern today is that the underlying bill as currently drafted is a good start, it is a good foundation, but it doesn't fulfill the full measure of the promise of comprehensive, affordable, and guaranteed in ways in which I think we could do it. Our Nation's seniors, I fear, will experience a very severe case of sticker shock when they learn how far the bill falls below their expectations for relief.

Also, I wish we did not have to wait until 2006. I have serious questions about why, given it took us only 11 months to set up Medicare itself, it takes us 2½ years to set up the Medicare drug benefit. Frankly, it is beyond my acceptance of what is a legitimate reason. I know the reasons. I have heard the reasons. But think about that: We set up the entire Medicare Program in about 11 months, and now we are told to add a benefit within it, we ought to wait about 2½ years. I think it has far more to do about budgets and far more to do about elections than it does with the realities of what we need to do.

Seniors, obviously, need this relief. Nearly 40 percent of Medicare beneficiaries report having no—zero—prescription drug coverage. And the average amount they pay out of their own pocket for prescription drugs has increased from $644 in the year 2000 to $996 in 2003. These expenses are projected to grow to $1,147 in 2004 and $1,454 by 2006, which is the year when the benefit actually gets implemented. So we are talking about a much larger bill than we have today.

People who are measuring this bill by what we have today are actually measuring it short of what the need is because the need is going to be the year

of implementation, 2006, and then we will have more than doubled the amount that individuals are paying for prescription drugs. That means the average annual out-of-pocket spending by seniors for prescription drugs will have doubled over that period. And I think seniors are to going to question: Well, if they all knew that, why am I still having such a hard time paying for prescription drugs?

Now, again, I want to underscore, I know how hard it is for the chairman and Senator BAUCUS to try to do this. And the reason it is so hard is because we have been given an arbitrary number. And I will say something more about that in a minute.

Let me say, for a moment, what I think is good that we have accomplished. No. 1, we have rejected President Bush's efforts to force seniors into private plans. We have rejected the President's plan to disadvantage seniors who want to stay in traditional Medicare and to keep the same doctors they have now. We have rejected the President's plan to give a windfall of incentives to PPOs to encourage their participation in the program. And we have adopted certain longstanding Democratic principles that include significant cost-sharing protections for low-income beneficiaries, a guaranteed fallback plan, and some key efforts that are targeted at improving the traditional fee-for-service benefits under Medicare.

But there are concerns I expressed in my ''no'' vote in the Finance Committee, and I want to express those concerns now on the Senate floor.

First of all, there are crucial areas I would hope we would try to find a way to improve. The most important of those is this gap in the coverage, in the donut hole as it is called, where seniors are charged a premium, but they do not get anything for the premium.

It seems to me there ought to be adequate protection to ensure, also, that employer coverage is not substituted or dropped. We do not want to create a situation where employers are covering people today, but because you have a fallback situation, they may decide, OK, we are going to drop that coverage, and, in fact, people are downgraded in what is available to them because there are not enough private people coming in to make up for that; therefore, the fallback is what they get. In addition, we must improve the stability of the fallback plans to minimize confusion and inconvenience to seniors.

Finally, I think we have to protect lowest income seniors by making sure they, too, can get the Medicare benefit. We ought to guarantee—or do our best to guarantee—a uniform national premium, somehow, for that benefit, and try to eliminate the new increases in beneficiary cost sharing under traditional Medicare and be more aggressive about providing additional benefits under the program.

But the stark reality is, all of these constraints are not the fault of Senator BAUCUS or Senator GRASSLEY. There is a reason we are operating under this straitjacket where we have had to tell a bunch of seniors they are going to pay a premium, they can buy insurance, they get to buy insurance up to $3,000—whatever it is—$4,500, and then they stop, but they continue to pay premiums. They continue to pay, but they are not going to get any benefit. They have to go back and start paying their full premium. But then when they get up to the $5,800 of catastrophic level, it begins to cut back in.

The reason we are there is fundamentally that $400 billion is all the Congress was given to deal with this—the arbitrary: Let's pick a number. Here is what we will put into prescription drugs.

I think every American has a right to ask—and they will ask over the course of the next years—why they were limited to $400 billion when the U.S. Congress chose to take $3 trillion off the table in tax cuts that went to upper income Americans over the course of the last 2 years.

Now, that is a fair question. That is the choice in America today. We make choices. People sent us here to make choices. And the choice made on behalf of the American people is that it is more important to reward people earning $315,000 a year than to make certain a lot of seniors don't have a donut hole in their coverage in prescription drugs.

When I heard Senator CRAIG THOMAS a moment ago say not that many seniors are going to be left out, I said, well, that is interesting because in the next breath he said we can't afford it because it is going to cost $200 billion. Well, if it costs $200 billion, it sounds to me as if somebody is being left out to a pretty large amount of money.

You cannot have it both ways. If it is expensive, it means it is meaningful to a lot of people. And if it is meaningful to a lot of people, we ought to be thinking about why we are not doing it.

Warren Buffett—the second richest man in the United States of America—wrote a letter a couple weeks ago where he said: Well, I own my own company. And now that I own my own company, and I've been given this very nice dividend benefit by the Republicans, I can pay myself $1 billion. And when I pay myself $1 billion, I'm not going to have tax, in this first year, on $365 million of it. It's tax free. That's it. He said he thought it would have been better to give 365,000 families in America $1,000 each. He did not think he ought to get that benefit.

Now, I think it is going to be fair for a lot of seniors in this country to ask the question, as we go forward, why Warren Buffett thinks that, and a whole bunch of people here think it is OK to do something else.

So if we are going to offer a prescription drug benefit that stands the test of time, the test of coverage, the test of fairness, and ultimately the test of the compact that Medicare created with our seniors, I think we ought to try to eliminate the coverage gap in this bill.

I think it is hard to turn to a senior at some point in time and say: Look, we want to help you buy drugs, but we are only going to help you up to the point where it gets really expensive. Then, when it gets really expensive, you are going to have to start carrying the bigger weight until it gets really, really expensive, and then we will come back and help you. It seems to me a lot of seniors are going to be asking questions about that choice.

I think we also could do better in protecting seniors with retiree coverage. The current bill contains a flawed definition for the true out-of-pocket costs by prohibiting any drug spending payments made on behalf of Medicare beneficiaries by an employer-sponsored plan from counting toward the stop-loss threshold.

In other words, they have an employer. That employer has given them a plan as a retiree, and they retire. They are qualified for Medicare. They paid into their retiree plan. It is their deal. But that is not now going to count toward their out-of-pocket expense. So they could, in fact, be left without the coverage that they deserve as a consequence of this definition. And that means that retirees covered under employer-sponsored plans will likely never reach the stop-loss threshold, and they will effectively be denied benefits under the catastrophic portion of the Medicare plan, even though they qualify for Medicare and worked just like everybody else for retirement and put money into the system.

Seniors who have retiree prescription drug coverage from their former employer worked a lifetime. They made wage concessions over the years, with the expectation they were going to receive those benefits. This bill comes along and, in effect, denies them benefits and treats them unequally in the context of the Medicare plan. It is unfair to change those rules after the fact. We ought to try to change it and reward employers who do the right thing and provide retiree coverage for their employees.

We also ought to try to strengthen the guarantee of a fallback plan and provide seniors with more stability and less confusion. Under the current bill, when a fallback program is available, it may not be available for very long. Medicare beneficiaries who are in the fallback program and like it will have to leave that program if two private insurers decide later to serve their region. In other words, the bill says there is only a fallback if you don't have two providers. But the minute you have two providers in a region, people who may have gone into the fallback program will have to turn around and leave the fallback program because there are now two providers, even if the two providers are providing more expensive premiums than they had in

the fallback. So they will be forced out of their fallback into a more expensive plan which a lot of seniors are going to find both oppressive as well as very confusing to them as to why they have to do that.

Some people are going to argue there is another area of concern. That is how we treat low-income seniors in this bill. These are our most vulnerable and poorest seniors. They are eligible for both Medicare and Medicaid. But under the bill, they are going to get their benefit from the Medicaid Program. They won't be allowed to go into the Medicare Program because they are poor.

Some people are going to come to the floor and say: Wait a minute, a lot of States offer a better benefit in Medicaid. It is true. Some do. But we are not offering them an option. We are telling them they have to get it from Medicaid. And the problem is a whole bunch of States have a very limited Medicaid drug benefit. For instance, in the State of Texas, the benefit covers only three prescriptions. That is not a lot of protection. So we are forcing people into Medicaid in a State where, because they are poor, they have to take Medicaid, and they may only have three prescriptions available to them in the whole program. We are asking for trouble if that stays the way it is.

Moreover, we all know a lot of States are facing the worst deficits in a generation. That means States are beginning to cut back their benefits. There isn't one of us who hasn't seen a State where a Governor is forced to start to clip back on Medicaid. That means we are going to see higher copayments. We will have tighter formularies, more bureaucracy, and we will not necessarily be achieving the goal we are seeking.

Requiring low-income seniors to stay in a Medicaid prescription program is a bad deal for seniors because of the States that provide an inferior prescription drug benefit in Medicaid. We are now essentially creating the very thing we have always tried not to do. We are creating a second-class tier of citizens based on their income within the Medicare Program. We will for the first time say to seniors who paid into Medicare through a lifetime that just because now in their old age, because of their low income, they are going to have to accept a lesser benefit. That is wrong. For the first time in the history of the Medicare Program, seniors will be denied a benefit simply because of their income. It is a terrible precedent. It strains the social compact that was the foundation of Medicare in the first place.

Another concern in the underlying bill is the lack of the guaranteed premium or uniformity of it. Under this legislation, insurance companies providing the new drug benefit have the freedom to design their prescription drug plan. That is great. I am for the marketplace. I am all for companies offering a private prescription plan to the degree they want to or choose to or can. They can decide what premiums and copayments they want to charge. But the point is, under Medicare, we have always decided there was a fundamental compact with seniors for which they could pay and which ought to have some uniformity of treatment in essence. What we are doing now is throwing that whole sense of the system into the competitive structure of sometimes very limited choices which may ratchet up prices in a way that is going to become very complicated for a lot of Senators and Congressmen to explain to seniors who are used to the Medicare plan being something different in the context of the compact.

The bill promises an ''average premium'' of about $35 per month. But premiums are obviously going to vary from region to region in the country which means some seniors may pay $39 a month in Alabama, maybe $40 a month in Tennessee, but be charged $160 in New York. I believe we have to be very sensitive and thoughtful about what happens to people on fixed incomes. This is not your average marketplace. This is not a place where people even have the same set of choices.

When a senior on a fixed income winds up with high blood pressure, diabetes, perhaps prostate cancer or a mastectomy, any number of different problems that seniors cope with, they are forced into an economic status, not choosing to get into one. The question is whether we are going to do our best to try to protect them from that kind of volatility.

It is estimated in the first year of the program, approximately 35 percent of the Part D beneficiaries are going to pay more in premiums and out-of-pocket cost sharing than they will save from the new drug benefit; 35 percent will pay more than they are going to save from the new benefit. And to add insult to injury in that context, the bill doesn't just fail to provide an affordable, comprehensive drug benefit, but it also increases cost sharing for other Medicare benefits.

In that context, there are two troublesome cost-sharing requirements. It increases the Medicare Part B deductible from $100 to $125. And then it indexes it by inflation and permits a new coinsurance for clinical laboratory services. That means Medicare beneficiaries will be asked to carry the burden of an additional $24 billion in new cost-sharing requirements over the next 10 years. Wait until your grandmother finds out about that one.

For all of my concerns, we have certainly come closer than we have been at any time in recent years to trying to achieve the great goal of putting prescription drugs into some kind of Medicare benefit. I believe with additional persistence, with additional negotiations between us and the administration, we could make those concerns I just expressed go away or we could mitigate them. We could diminish them. I intend to support a number of amendments on the floor seeking to do that.

I have an amendment I have just called up that seeks to do one part of that. Let me explain it very quickly. I want to talk about an amendment I have and I will get to the one I just called up in a moment.

We have talked for a long time in the Senate about mental health parity. It is a goal we really want to achieve in this country. Senator DOMENICI has been a champion for it. There have been bipartisan efforts to try to get there. I would like to see us end the discriminatory practice of charging seniors in Medicare a 50 percent copay for mental health services, when we only charge a 20 percent copay for the other physician services. Too many seniors have mental illnesses that go untreated, and we should try not to make that worse by making it harder for people to be able to get the care.

I have an amendment to bring parity for mental health services for seniors. I am also working with Senator SUNUNU to try to improve the Medicare benefit by adding vision rehabilitation services to the list of covered services.

I am also pleased to join with Senator HUTCHISON and Senator KENNEDY as a lead cosponsor of an amendment to increase the Medicare indirect medical education—so-called IME—payments for teaching hospitals. I appreciate very much the efforts of Senator BAUCUS and Senator GRASSLEY to try to accommodate us to find a way to deal with this issue. It is a critical issue. Teaching hospitals incur a different set of costs, and you cannot measure the Medicare reimbursement against the expenses of the hospital in the same way.

Fifty percent of the doctors in Montana were taught at hospitals in, I think, 11 or 12 States, including Massachusetts, New York, California, and a few others in the country. So 11 or 12 States are spending money in their teaching hospitals to provide the benefit to the rest of the country of that quality medical education. When 50 percent of the doctors in Montana were educated in 11 or 12 States, Montana has a benefit, but it is not measured in the Medicare reimbursement. We need to make up that difference so we can continue to have the quality medical instruction and education in our country from which every American benefits.

In the spirit of improving this legislation, the amendment I offer today, which has bipartisan support, would dramatically improve the bill for some of the things I said I think are problems. It does it for very little money.

My amendment will help seniors who are in the coverage gap. What it does, it doesn't fill the whole ''donut,'' but it will offer significant help to seniors who fall into the donut by expanding access to the existing prescription drug safety net.

The Federal Government currently sponsors a discount prescription drug program for those qualifying entities, such as a community health center or

a public hospital or the Ryan White grantees, and others. Under this program, which is known as the 340(b) covered entities program, they have access to discounted prescription drug pricing for their patients in the program. In other words, if you have a community health center and your community health center has an in-house pharmacy, they could fill the prescriptions for seniors at discounted rates. They are allowed to do it. We have already had that under law. The problem is, we know a whole bunch of community centers and public health hospitals don't have the in-house pharmacies.

The benefit of this is to provide drugs that are significantly lower than the retail and wholesale prices. Based on a recent analysis of 200 very popular drugs, under 340(b) prices, on average, those drugs were 54 percent lower than the average wholesale price. Another recent survey showed that 340(b) prices were 24 percent lower than those available to groups purchasing as group organizations. So it is a sound program, but it is underutilized. Not all health centers and hospitals have an in-house pharmacy.

One of the biggest barriers to participating in 340(b) for many of the qualifying entities is the very expensive upfront capital cost of putting in place a pharmacy in their facility. So what I would do is establish a $300 million grant fund from the prescription drug trust fund created under the bill for HHS to award grants to health centers, hospitals, and other qualifying 340(b) institutions to help them with the startup costs associated with establishing a pharmacy in their entity. CBO scoring of this bill showed there is about a $10 billion surplus available in the current scoring, and so we have come in under the $400 billion. We have some cushion here. If we took that $300 million and made it available to these in-house entities to create those discount drug centers, then we could have those people who fall into the donut hole go to those centers, get the discount drugs, and significantly reduce the impact of the donut, which I think is a worthwhile effort.

We estimate there are up to 2,000 organizations in communities all across the country who would be assisted to set up in-house pharmacies as a result of this amendment. That will mean seniors all across the country who find themselves in the coverage gap will be able to purchase their prescription drugs for as much as 50 percent below the wholesale price. That savings is very significant in the context of what we are facing here.

My amendment is endorsed by the National Association of Community Health Centers, the National Association of Public Hospitals, and the Public Hospital Pharmacy Coalition. I hope it can earn the support of my colleagues so we can address one of the unintended consequences of dealing with only a $400 billion benefit, such as we are today.

I thank my colleagues for the opportunity to share these thoughts with them. I hope we can pass this amendment or have it accepted at the appropriate time.

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

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, as we hear more and more about this bill, of course, it causes us to reflect on it and that is the purpose of having conversation, that is the purpose of having debate. There will be much more of that, of course, but it is interesting to listen to what is being discussed, much of it based on the fact we need more money for this and more money for that, when we are adding to Medicare $400 billion, continuing to support the basic Medicare Program as it is financially, and adding to it this additional amount.

Medicare will be improved in every way as this happens. So I know it is a logical time to talk about how we might do more, how we might provide a Government program, as the Senator from New York talked about this morning, for everyone; take all the payments out, and that is a point of view.

I think, however, the concept of this business of Medicare is one in which we all pay into it, we pay something for it. Obviously, one of the principles of health care is for the recipient to pay something. We have found when they do not, it is out of control entirely.

We have a lot of worrisome times about Medicaid where there is no initial payment and we have overutilization. These are all part of the elements that go into it. I know it is great to talk about giving everything to everyone, but the fact is, that is not what is going to happen.

We have to get a balanced program that does what we really want to do. We talk about the gaps and helping people. The fact is, there is no gap for people who are below 160 percent of poverty. If we are going to assist someone, we assist those who are less able to assist themselves. That is what it is all about. That is what we seek to do.

Is it perfect? Of course not. If there were 100 of us sitting here working on the plan, we would probably have 100 different ideas as to how to do it, but we have to come to some consensus as to what our goals are and how we can best achieve those goals. Over time, it is something that is useful.

We have to keep that in mind as we go forward. Obviously, there are all different kinds of ideas, such as the fact we had a tax reduction and, therefore, we should be able to spend more. We had a tax reduction because we have an economic problem. We are trying to fix the economy—that is why we had a tax reduction—along with terrorism and other needs. To say we should pay more because we already had a tax reduction is not relative. That is not where we are.

Out-of-pocket expenses, of course, are always important, and should be. That is one of the keys. Here we have a program on which we have a certain amount of money we can legitimately spend. How do we best do that? How can we deal with everyone the same? Do we do more for those with low income and those who are less able to afford it? Of course. The true out-of-pocket limit targets the drug benefit to those who need it the most. That is what it is about.

The purpose of out of pocket is to protect seniors from high out-of-pocket costs. It is that simple. Spending that counts toward the out-of-pocket limit spending by the beneficiary. If the beneficiary drug is covered by some other source, such as a retiree's health plan, that money does not count out of pocket.

Seniors with additional coverage are not penalized for having additional coverage. They are protected if they have $3,700 out-of-pocket spending. In addition, they continue to benefit from additional drug coverage beyond that point, of course.

In addition to out-of-pocket spending by the beneficiary, spending by family members or friends also counts toward the out-of-pocket limit, as does spending by State pharmacy assistance programs, by State pharmacy plus programs. These programs target resources to lower income seniors who need additional assistance. They are in place now.

Allowing this spending to count toward the out-of-pocket limits allows these lower income seniors to receive additional assistance and still be protected against prescription drug costs that are not covered by Medicare drug benefits.

We should care about what the individual beneficiary has to pay, not what others pay on their behalf. This is the purpose of out-of-pocket limits in the proposal. Those who reach the amount of spending available will have 90 percent of their drug costs covered.

The House and Senate bills encourage employers to continue providing benefits by allowing them to avail themselves of 100 percent of the subsidies for offering standard benefit. If employers want to provide more, they are free to do so.

These are tough issues as to how we deal with some limitation on the spending and how we distribute it. We will hear more about it, and, indeed, we should.

There will be finally some principles involved as to the best way to spend the amount of money that is legitimately available. I hope we continue to focus primarily on those who are in that category of 160 percent of poverty level, and that is where it will continue to be.

Mr. President, we will continue to hear more. We certainly should hear

more. We will continue to have more amendments, and that is fine. The Senator from Massachusetts was a member of the committee. We worked on it in the first place, and he has had an opportunity for input. Many of these proposals have already been voted on in the committee. Of course, if they are being proposed again, they were not successful in committee. Nevertheless, they should be brought up to this body, and they will.

Again, my hope is we can take a look at where we want to be in the year 2006, but what we want the result to be and make the adjustments that are necessary to get us to that point and not be taking up issues that are not even a part of debate. We are going to have to be very careful that we keep it limited to the issues that do impact Medicare and are in this area. I know we will continue to do that.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. 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. BAUCUS. Mr. President, we are now awaiting the arrival of Senator LINCOLN from Arkansas who has two amendments she wishes to offer. She will be arriving shortly. Until she arrives, I have a few words about a particular provision in the bill. It is called MARCIA, Medicare Appeals Regulatory and Contracting Improvements Act. Last year I joined my colleagues, Senator GRASSLEY, Senator KERRY, and now-Governor Murkowski, in introducing what we called the Medicare Appeals Regulatory and Contracting Improvements Act, otherwise know as MARCIA.

Today this bill is an essential part of our Medicare improvement proposal, the underlying bill. The purpose of the provision is to make Medicare a better business partner to providers, a smarter purchaser of services for our taxpayers, and a more customer-friendly organization for our beneficiaries. MARCIA will strengthen and improve Medicare and will help bring the program's administration into the 21st century.

The provisions provide for regulatory improvements. I have heard from hundreds of doctors, as I know all in this body have, and many providers who complain that the sheer number and complexity of Medicare regulations can drive them crazy and, at times, drive them out of business.

While we cannot make Medicare into a simple program, this bill would make and does take some helpful steps in the right direction.

For one thing, it will require the Secretary on a regular basis to review the thousands of pages of statutes and regulations to see if there are any inconsistencies in Medicare's many requirements.

Just a couple of days ago, the majority leader from Tennessee held up a book which showed the Medicare requirements back, I think it was 1965. It was a fairly thick volume, actually. Then alongside that he also held up a book with the current Medicare regulations, which was a gigantic volume. It is similar to the problems we face in the Tax Code, as we all know.

I am not standing here to say the provisions of this bill are going to make Medicare simple and easy, that we are going to cut the number of pages down to half. But I am saying we are trying to do our very best, and the provisions in this bill should help reduce some of the inconsistencies and the complexities that do now occur in the Medicare regulations. At least we are focusing on that problem and requiring the Secretary to address that, specifically giving that direction.

Second, our legislation would cut down on the CMS practice of using so-called interim final rule authority to impose major new regulations without even giving the public an opportunity to comment. It just stands to reason that the public should have an opportunity to comment on rules because it is more likely if they do, the rules are going to be better rules or, on the other side of the coin, if there is not an opportunity for the public to comment, there is going to be a tendency over time for CMS or any agency to be a little less sensitive to what that is really all about, which is about serving people because, after all, we are all public servants, including CMS personnel. Our real job is to serve the people in the country, and I think this will help move CMS in that direction.

The third provision would make sure that new regulations cannot be applied retroactively. Intuitively, I think it makes sense that it does not apply retroactively. I think these new requirements are just a simple matter of fairness.

The underlying bill, as we are talking about the regulatory provisions, would also make improvements to the Medicare appeals system. In the year 2001, on average it took 441 days to complete an appeal before an administrative law judge. The next level of appeal took almost 2 years. It is true certain provisions in the 2000 law that we passed tried to speed up the appeals process, but unfortunately that law did not provide the resources or the realistic timeframes necessary to make these changes work.

MARCIA, the regulatory provisions, would make some important improvements to get this appeals system back on track so our Medicare beneficiaries and providers can get justice more quickly. Clearly, 441 days for the first level of appeal and 2 years for the second is not right, for a whole host of obvious reasons.

The bill also requires CMS to submit a plan to develop and train a group of dedicated Medicare ALJs, administrative law judges. This plan would ensure that administrative law judges remain truly independent, which I think is a crucial feature of any fair appeals system.

Medicare contractors will also have to bid and compete for contracts under this bill. That is a very significant change from current practice. Essentially, under the current practice, Medicare contractors, especially talking about the intermediaries, are essentially nominated by the intermediaries. They themselves nominate who it is going to be, and there is no limit to how long a contracting period can be. I think it tends to be a little bit too close and there is not enough fresh air to help assure, at least the best we can, that the contractor selection process is one that provides more efficiency and better service to our people.

The Medicare contractors will have to bid now. They are going to have to compete for contracts under this bill—that is new—thereby assuring that the Medicare Program and the taxpayers are getting the best service for the lowest price the market will allow.

In assessing the bids, CMS will have to consider customer service and accuracy. That is required when CMS is now selecting contractors and getting bids from contractors. Again, we are talking generally about the so-called intermediaries who are the ones who deal directly with providers. They deal between the providers and the beneficiaries and the Government.

In assessing the bids, CMS will have to consider customer service and accuracy, as I said, and contractors will also have to provide much more information to providers and to beneficiaries. If the providers raise questions about Medicare claims or policies, contractors will have to answer them in writing. That, too, is new.

The bill also would require the Secretary to standardize the way in which Medicare conducts audits, the way it conducts prepayment and postpayment reviews of provider claims. We often hear of great, almost gross, inconsistencies among different parts of the country, different regions. It makes sense to standardize this a little bit better. I am encouraged that CMS has already taken steps in this direction to make the audit process more fair but to ensure that providers are treated fairly and consistently, I believe the law has to require it.

Finally, I am pleased this bill also contains money for continued strong enforcement against waste, fraud, and abuse in the Medicare Program. I have long believed the Medicare integrity programs must be firm, but they must also be fair. This bill takes important steps to ensure honest dealing with taxpayer money and fair treatment for the professionals who serve our seniors every day.

Essentially, these are provisions that hopefully address a good part of the regulatory complaints, the legitimate

complaints that all of us in this body have been hearing about from doctors and hospitals as they try to do their very best job in providing care, in this case, to seniors. I think these are good, solid provisions.

Turning to another matter, as we did for Senator GRAHAM and Senator KERRY, I would now like to make it possible for the Senator from Arkansas to offer her amendments. I ask unanimous consent that the pending amendments be temporarily set aside and that the Senator from Arkansas be recognized to offer up to three amendments in succession.

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

The Senator from Arkansas.

Mrs. LINCOLN. Mr. President, I begin by complimenting my colleagues from the Finance Committee: Senator GRASSLEY, our chairman; the ranking member, Senator BAUCUS; and all of the other members on the committee who have really focused on what is most important to the American people, and that is to get a good, commonsense product out of the Senate that encourages our seniors and lets them know that we do understand that this is a critical issue. It is critical not only in terms of the quality of life for our seniors but also in regard to economics. We want them to understand we can provide cost savings not only to our Nation but to our aging families by providing a prescription drug package which will allow them to be healthier individuals; to not cause or create greater costs for this country and for the other parts of the health care system in this great Nation through acute care or difficulties in long-term care, in nursing homes and emergency rooms, but being able to have a quality of life and providing a good economic way to deal with the aging process.

As we went through this bill in committee, we talked an awful lot about ways that we could improve Medicare; looking at coordination of care, at how we could provide a better, commonsense way of administering health care to our elderly in this country not only through a prescription drug package but recognizing that disease management is an enormous part of what we are doing for our elderly, and that with the multiple diseases they are dealing with, if we can manage that disease management of multiple diseases and have a coordination of care, we are going to get a better bang for our buck in Medicare.

I am excited about the possibilities and want to compliment my colleagues on a lot of hard work that has been done, particularly recognizing that rural areas of our Nation also have great needs. I certainly applaud the chairman and the ranking member on that.

Today I bring up several of the amendments I have to offer. Many of these amendments we discussed in the committee. In my approach in the committee I was willing to visit with the chairman and the ranking member and say I hoped we could work through whatever we needed to in order to get these passed and get them in part of the bill. Those discussions are ongoing and I compliment my colleagues for working with me on these critical issues.

Hopefully we can resolve them without going to a vote, but I want these amendments placed and filed and in the queue so my colleagues have an opportunity to comment on them and work with me in order to get them done.

AMENDMENT NO. 934, AS MODIFIED

First is amendment 934 which has already been filed. Medicare Part B does not currently cover insulin or syringes used to inject insulin for the majority of enrollees in the Medicare Program. This is a horrific oversight in a program that should be designed to deal with our elderly but, more importantly, dealing with, again, some of these diseases that are predominantly in our aging population, especially when we see that of the 7 million or so Americans over 65 with diabetes, 40 percent inject insulin every day to control their diabetes.

Providing syringes for insulin will go a long way to helping seniors keep their diabetes in control. It is a fabulous preventive measure. It is obviously a critical area of need for our seniors. The management of blood glucose levels for diabetes helps prevent long-term complications like kidney failure, blindness, amputation, and a multitude of other chronic illnesses and problems that arise when diabetes is not kept in check.

Syringes are required to inject insulin because there is no oral or inhaled form of insulin. The lack of coverage for syringes means syringe purchases will not count toward their yearly maximum out-of-pocket expenses and their copayments. This will lead to the reuse of syringes that are not FDA approved for more than one use. We recognize it is a very minimal cost to the overall package and makes a huge difference.

I encourage my colleagues to take a look at this amendment. I compliment the ranking member and the chairman for being willing to work with me as we go through this process. I hope it is something we can get accepted. If it is not, I hope my colleagues will recognize for this very small amount of money we can make an enormous difference in a huge population of our elderly who are suffering from diabetes. I look forward to working with my colleagues on that.

I call up amendment 934 as modified.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN], Ms. COLLINS, and Mr. MILLER, proposes an amendment numbered 934, as modified.

(Purpose: To ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin)

On page 8, line 12, insert ''(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Administrator)'' before the semicolon.

On page 174, line 14, insert ''(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Secretary)'' before the comma.

Mrs. LINCOLN. I ask unanimous consent to lay that amendment aside to proceed to the next amendment.

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

AMENDMENT NO. 935

Mr. President, the next amendment I bring up has to do with the graduate medical education 2-year program in geriatrics. One of the provisions of my geriatric care act bill pertains to the Medicare graduate medical education financing of this second year of a geriatrics fellowship training. It clarifies that geriatric training programs are eligible for 2 years of fellowship support. This can be done administratively. We have worked with Tom Skully at CMS, and he is interested in making something such as this happen.

The fact is, out of 125 medical schools in this great country, only three have a department of geriatrics. At a time when we are getting ready to see 41 million Americans over the age of 65 blossom into well over 70 million Americans over the age of 65, it is not just a critical measure to provide a prescription drug package.

We have to be prepared with the types of physicians and medical technicians who can care for our aging population, who understand what coordination of care actually means in bringing together this disease management. In understanding that it is not just one medical visit, but that has to be coordinated with a nutritionist, perhaps dealing with depression, a psychologist, they have to deal with orthopedics, they have to deal with a multitude of other disease management areas.

If we can include that 2 years of funding for geriatric training, then we will be able to not only train the geriatricians we need, but we will also be able to maintain the level of academic geriatricians who will be the ones teaching geriatric medicine and geriatricians for the future. It is a critical part of what we have to do.

We worked out a compromise in the committee after having come through the committee, and in talking to CMS they suggested some changes. These are only technical changes. I don't think anyone will have a problem with them. I hope not. I want to make sure I get them out there and make sure we can work through those differences. I look forward to working with the chairman on that.

I call up that amendment, which is amendment 935.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN] proposes an amendment numbered 935.

(Purpose: To clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs)

Strike section 410 and insert the following:

SEC. 410. EXCEPTION TO INITIAL RESIDENCY PERIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS.

(a) CLARIFICATION OF CONGRESSIONAL INTENT.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.

(b) INTERIM FINAL REGULATORY AUTHORITY AND EFFECTIVE DATE.—The Secretary shall promulgate interim final regulations consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003.

Mrs. LINCOLN. I ask unanimous consent that amendment be laid aside for my next amendment.

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

AMENDMENT NO. 959

Mrs. LINCOLN. The next amendment is amendment numbered 959. I am offering this amendment that authorizes a 3-year, five-State demonstration project of direct access to outpatient physical therapy services within the Medicare Program without the sometimes burdensome requirement of seeking a physician referral.

This is not a new concept. Several health professionals currently enjoy practice without referral under Medicare for their respective scopes of practice—dentists, podiatrists, chiropractics, optometrists, nurse practitioners. They all practice independent physician referral.

Non-Medicare citizens in my State of Arkansas and 36 other states, including Iowa, Utah, Maine, Arizona, Wyoming, Pennsylvania, the home State of our Presiding Officer, Tennessee, Oregon, Kentucky, Montana, West Virginia, South Dakota, North Dakota, Florida, New Mexico, and Massachusetts, all of which have Senators represented on this committee, allow direct access to licensed physical therapists as authorized by their State law.

However, Medicare requires its beneficiaries in my home State and yours to obtain a referral in order to access the services of a physical therapist. I certainly believe it is time to study the example of the States in a demonstration project to see if the referral requirement is indeed necessary. We are talking about seniors who are striving so diligently to claim the final years of quality of life. Physical therapy, occupational therapy, vocational therapy, all of these therapies are the tools that allow these individuals to go back into their home and to live their life, with the quality of life, with the dignity they want in their end-of-life years. It is so critical they can get the necessary access to these services in order to be able to do that.

I encourage my colleagues and certainly the ranking member, Senator BAUCUS, and our chairman, Senator GRASSLEY, to work with me on this program. I believe it is budget neutral. It simply is moving forward on the concept that many of our States have already embarked on. It is very practical on behalf of the aging community that we are working on right now.

With that, I call up amendment 959.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN] proposes an amendment numbered 959.

(Purpose: To establish a demonstration project for direct access to physical therapy services under the medicare program)

At the end of subtitle B of title IV, add the following:

SEC. ___. MEDICARE DEMONSTRATION PROJECT FOR DIRECT ACCESS TO PHYSICAL THERAPY SERVICES.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project under this section (in this section referred to as the ''project'') to demonstrate the impact of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services on—

(1) costs under the medicare program under title XVIII of the Social Security Act; and

(2) the satisfaction of beneficiaries receiving such services.

(b) DEADLINE FOR ESTABLISHMENT; DURATION; SITES.—

(1) DEADLINE.—The Secretary shall establish the project not later than 1 year after the date of enactment of this Act.

(2) DURATION; SITES.— The project shall—

(A) be conducted for a period of 3 years;

(B) include sites in at least 5 States; and

(C) to the extent feasible, be conducted on a statewide basis in each State included under subparagraph (B).

(3) EARLY TERMINATION.—Notwithstanding paragraph (2)(A), the Secretary may terminate the operation of the project at a site before the end of the 3-year period specified in such paragraph if the Secretary determines, based on actual data, that the total amount expended for all services under this title for individuals at such site for a 12-month period are greater than the total amount that would have been expended for such services for such individuals for such period but for the operation of the project at such site.

(c) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program under title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary to conduct the demonstration project.

(d) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—

(A) IN GENERAL.—The Secretary shall conduct interim and final evaluations of the project.

(B) FOCUS.—The evaluations conducted under paragraph (1) shall—

(i) focus on the impact of the project on program costs under title XVIII of the Social Security Act and patient satisfaction with health care items and services for which payment is made under such title; and

(ii) include comparisons, with respect to episodes of care involving direct access to physical therapy services and episodes of care involving a physician referral for such services, of—

(I) the average number of claims paid per episode for outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services;

(II) the average number of physician office visits per episode; and

(III) the average expenditures under such title per episode.

(2) INTERIM AND FINAL REPORTS.—The Secretary shall submit to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives reports on the evaluations conducted under paragraph (1) by—

(A) in the case of the report on the interim evaluation, not later than the end of the second year the project has been in operation; and

(B) in the case of the report on the final evaluation, not later than 180 days after the closing date of the project.

(3) FUNDING FOR EVALUATION.—There are authorized to be appropriated such sums as may be necessary to provide for the evaluations and reports required by this subsection.

(e) DEFINITIONS.—In this section:

(1) COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—Subject to paragraph (2), the term ''comprehensive outpatient rehabilitation services'' has the meaning given to such term in section 1861(cc) of the Social Security Act (42 U.S.C. 1395x(cc)).

(2) DIRECT ACCESS.—The term ''direct access'' means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

(A) without regard to any requirement that—

(i) an individual be under the care of (or referred by) a physician; or

(ii) services be provided under the supervision of a physician; and

(B) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

(i) certification and recertification; and

(ii) establishment and periodic review of a plan of care.

(3) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term ''fee-for-service medicare beneficiary'' means an individual who—

(A) is enrolled under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.); and

(B) is not enrolled in—

(i) a Medicare+Choice plan under part C of such title (42 U.S.C. 1395w–21 et seq.);

(ii) a plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm);

(iii) a program of all-inclusive care for the elderly (PACE) under section 1894 of such Act (42 U.S.C. 1395eee); or

(iv) a social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).

(4) OUTPATIENT PHYSICAL THERAPY SERVICES.—Subject to paragraph (2), the term ''outpatient physical therapy services'' has the meaning given to such term in section 1861(p) of the Social Security Act (42 U.S.C. 1395x(p)), except that such term shall not include the speech-language pathology services described in the fourth sentence of such section.

(5) PHYSICIAN.—The term ''physician'' has the meaning given to such term in section 1861(r)(1) of such Act (42 U.S.C. 1395x(r)(1)).

(6) QUALIFIED PHYSICAL THERAPIST.—The term ''qualified physical therapist'' has the meaning given to such term for purposes of section 1861(p) of such Act (42 U.S.C. 1395x(p)), as in effect on the date of enactment of this Act.

Mrs. LINCOLN. I ask unanimous consent that amendment be laid aside so I can bring up my final amendment.

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

Mrs. LINCOLN. Before I get to my final amendment, I want to touch on one other issue and that is the issue of our rural ambulance providers. I see my colleague, Senator THOMAS. He and many others who are in the rural health caucus have done a tremendous job in working through this bill and providing great access issues for our rural areas. I am encouraging my colleagues, as well as the ranking member and the chairman, to work with us on the issue of the rural ambulance providers.

We do not have an amendment as of yet and I am hoping we can work through some of those details as we move forward in this piece of legislation. I encourage them to work with us and hopefully we can finish that on Monday and move expeditiously on a piece of legislation that will benefit all of the seniors across the Nation.

AMENDMENT NO. 963

My last amendment is an amendment we have brought on the fallback issue, which is a critical piece of this bill. I think it is absolutely essential, as we look toward making sure private industry can play a role in providing a Medicare prescription drug package. We have seen, over the course of many past years, where private industry has certainly the option, even today, to participate in Medicare and the application of it. In some of our areas across this great Nation they are reluctant to do so because the profitability is not there for them.

We want to make sure there is every opportunity for private industry to come in and provide a product for everyone across this Nation. But if, in fact, in the time it takes to implement this program certain areas of our Nation find themselves in the same predicament they are today, which is private industry does not find it quite profitable enough to come in there, we want to make sure there is a fallback. We don't want anyone left behind. We think all seniors in this great Nation are equally important. We are going to make sure, across this great Nation, if for some reason there is an area that does not meet the test for private industry, there is a fallback.

In that fallback we want to make sure they have the same contract benefit the private industry does. We have talked a little about this issue in the past. We want to make sure, as we move forward on all these issues, again, that the fallback measure that is going to be there in some of our less populated areas is going to have that 2-year contract ability.

In the Finance Committee, when we brought the bill up, we found in many instances it primarily affects our rural States, and primarily rural areas. We want to make sure we offer them the same opportunity we do in private industry.

It improves stability, provides a more stable benefit by reducing year-to-year variability in premiums and cost sharing, and provides better assurances that needed medications and local pharmacists will be covered. It improves choice. After all, that is what we are here to do, to provide our seniors with as much choice as we possibly can.

It provides that once seniors are in a fallback plan, they have the option to remain in that plan for 2 years. One of the concerns we have had in our State is that when we have seen private plans come in, they come in and then they leave and then they come back. Seniors do not know what they can depend on. They have to make different decisions. Each year, because there is no standard design here, their choices are going to be different. They are going to have different premiums, different formularies, different pharmacies they can go to. So we want to make this the least confusing possible. Providing them the ability to have the same stability in the fallback as they do in the private plans I think is very important. And I think it is fair. Therefore, we do improve on fairness, providing the seniors in the fallback plan the same rights given to seniors who are in a drug-only plan, the opportunity to stay in for that same 2 years.

Continuing the first bidding rights for drug-only plans—maintaining first bidding rights for the drug-only plans, allowing fallback plans to enter a region only after it has been determined the two private drug-only plans will not be available—I encourage my colleagues to look at this. If there are two private plans, there is no fallback. You do not have to worry about a 2-year contract. You do not have to worry about a 1-year contract. That is because the fallback doesn't even exist. These are just emergency measures, to make sure individuals in rural areas are going to get the same benefit and they are going to be covered. We are not asking anything more of a Government fallback plan than we are of private industry. If private industry is there, you do not have to worry about it because the fallback is not going to exist.

I encourage my colleagues to take a look at this. It comes at a very minimal cost. It adds substantial stability to the system and, certainly, by not costing much more in dollars.

We again plead with our colleagues to make sure those seniors in rural States will have the same benefit there as have other seniors across this great country. We look forward to working with them if there are any concerns they have.

Mr. President, I appreciate your patience in allowing me to bring before the Senate my amendments to this very important bill and to encourage my colleagues. These are probably some of the most important policy decisions we will be making. As we embark on this journey to provide a critical component of health care to an enormous population in our Nation, as far as I am concerned, one of the most important as well as the most vulnerable, I think it is critical for all of us to look at ways we can improve this bill. Once this bill is passed, once it is signed into law, are changes going to be easy to make? No, they are not. So it is critical for each of us to take the time and recognize where we can make these slight changes and improvements in a bill. It is going to make a remarkable difference in the lives of the elderly of this Nation.

I encourage my colleagues to take a look at these very simple amendments that I think will be improving amendments to a bill that is moving down the pathway, something we encourage everyone to support in the coming days as we come to completion on a remarkable piece of legislation and a remarkable help to the seniors of this Nation.

I thank the Chair and my colleagues for their indulgence today and for being able to offer these amendments.

The PRESIDING OFFICER. Did the Senator offer her last amendment?

Mrs. LINCOLN. I do so now.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Arkansas (Mrs. LINCOLN), for herself, Mr. CONRAD, Mr. MILLER and Mr. CARPER, proposes an amendment numbered 963.

The amendment is as follows:

(Purpose: To allow medicare beneficiaries who are enrolled in fallback plans to remain in such plans for two years by requiring the same contracting cycle for fallback plans as Medicare Prescription Drug plans)

On page 83, strike lines 1 through 7, and insert the following:

''(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

''(A) The contract shall be for a 2-year period.

''(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

''(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

Mrs. LINCOLN. I yield the floor.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

AMENDMENT NO. 963 WITHDRAWN

Mrs. LINCOLN. Mr. President, there seems to be some confusion as to the last amendment which I submitted. At this point, I ask unanimous consent to withdraw that amendment, and I will reintroduce it on Monday.

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

Mrs. LINCOLN. Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside.

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

AMENDMENT NO. 964

Mr. BAUCUS. Mr. President, on behalf of the Senator from Vermont, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS] for Mr. JEFFORDS, proposes an amendment numbered 964.

The amendment is as follows:

(Purpose: To include coverage for tobacco cessation products)

Beginning on page 8, strike line 1 and all that follows through page 9, line 2, and insert the following:

''(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the term 'covered drug' means—

''(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2);

''(ii) a smoking cessation agent that is approved under section 505 of the Federal Food, Drug, and Cosmetic Act as a non-prescription drug and is dispensed upon a prescription;

''(iii) a biological product described in clauses (i) through (iii) of subparagraph (B) of section 1927(k)(2); or

''(iv) insulin described in subparagraph (C) of such section;

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—The term 'covered drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraphs (E) and (G) thereof insofar as they relate to smoking cessation agents, or under section 1927(d)(3).

Mr. BAUCUS. Mr. President, I ask unanimous consent, again, that all pending amendments be set aside.

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

AMENDMENT NO. 965

Mr. BAUCUS. Mr. President, I send a second amendment to the desk on behalf of the Senator from Vermont and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS] for Mr. JEFFORDS, proposes an amendment numbered 965.

Mr. BAUCUS. Mr. President, I ask unanimous consent reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To establish a Council for Technology and Innovation)

At the end of subtitle B of title IV, add the following:

SEC. ___. COUNCIL FOR TECHNOLOGY AND INNOVATION.

Section 1868 (42 U.S.C. 1395ee), as amended by section 534, is amended—

(1) by adding at the end of the heading the following: ''; COUNCIL FOR TECHNOLOGY AND INNOVATION''; and

(2) by adding at the end the following new subsection:

''(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

''(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (as appointed or designated under paragraph (4)).

''(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes with respect to new technologies and procedures, including new drug therapies, under this title in order to expedite patient access to new technologies and therapies.

''(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology

and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title, and shall prepare reports to Congress required under section 1869(f)(7).''.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. NELSON of Florida. 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. NELSON of Florida. Mr. President, I wanted to come to the floor and offer some comments about the Medicare prescription drug bill. I wanted to give my accolades to the chairman and ranking member of the Finance Committee for how they have so expertly crafted a bill in a bipartisan fashion which is how this body ought to be operated, and so often we are operating exactly the opposite way. There are just too many partisan votes around here. They have shown, Senators GRASSLEY and BAUCUS, that the spirit of bipartisanship in fact does live and that good work products can be accomplished.

ANTISPAM LEGISLATION

Before I make my remarks on the legislation, I want to recall to mind another bipartisan work product that was produced out of the Commerce Committee yesterday and will be coming to the floor. It is the antispam legislation. I have reserved for the floor to offer a major amendment to it. It is very possible that we will work out and the prime sponsors of the bill will accept my amendment, but it has to do with the question of spam, which is all of that unwanted e-mail everybody gets on their computer.

I was just absolutely dumbfounded; One day I went in my Tampa office and I said: How about printing out for me the e-mail we received today, just one day. And they produced a full letter-sized sheet, single spaced, of e-mail that we did not want, that had come anyway. Of those e-mail messages, two of them were pornographic which, if that is happening in the office of a Senator, you can imagine what is happening all across the country. That is exactly what is happening.

People are fed up. They want the Federal Government to do something about it. Fortunately, we have finally gotten the political will now that we are going to do something about it.

I bring this up not only as an example of bipartisanship reflecting what Senator BAUCUS has done with this masterful crafting of a legislative package, but I wanted to alert the Senate to the fact that the antispam bill is going to come. I am going to have an amendment that will improve it.

In the bill the only penalty is a misdemeanor. What I want to do is to strengthen that penalty and to give the prosecutors the tools so that the violation of sending unwanted and undisclosed in its address e-mail becomes an element that will trigger the Racketeer Influenced Corrupt Organization act, RICO.

What that does is give prosecutors the tools to go after the criminal enterprise and then take their assets. Let me tell you what is in this morning's paper. Here is a good example of an e-mail scam that used a retailing giant's name in an attempt to capture credit card numbers and other personal data on a nationwide basis. They sent out millions of these e-mails. What they did is, they took a retailer, Best Buy, and they sent a message that said they wanted to offer something on Best Buy. Of course, it was all fraudulent. It was claiming to be Best Buy's fraud department. They said they were informing people their credit card number had supposedly been used in a suspicious purchase through Best Buy dot com. And then it instructed the card holders to go to a special Web link to help resolve the problem.

Then when those Best Buy customers went to that Web link, they offered their credit card number and then ''Katie bar the door.''

Here is obviously a deceptive scheme, taking the advantage of a legitimate business, using a deceptive message in order to obtain credit card numbers which they then will use fraudulently to bilk people of millions of dollars. And because they send out hundreds of millions of these e-mail messages, it is time for us to get serious and not just come in with an antispam bill that is going to spank people on the hand with a misdemeanor but is going to go after the assets of the criminal enterprise under the RICO Act.

I bring this to the attention of the Senate. That debate will be coming up hopefully fairly quickly. I must say, ever since I happened to talk about this down in Tampa that day I just checked my e-mail in the Tampa office, I have gotten so many calls and letters to say: Right on, Bill, right on.

We can't even use our computer and our e-mail anymore, because we are so cluttered up with e-mail. It is time for the Federal Government to do something about it.

We have a crime against mail fraud. The Presiding Officer, as a former U.S. Attorney, knows all about prosecuting mail fraud. If you did that kind of scheme I just showed you in today's Orlando Sentinel, and instead you used the mails and you sent out 100 letters like this same thing, posing as a department store, saying we have reason to think your credit card has been stolen, give us your card number so we can correct this—of course, it is a deceptive scheme; it gets your credit card number so they can charge—you would prosecute under the mail fraud statute. But that is sending out a hundred letters—my goodness gracious—through e-mail—snap, just like that, 175 million e-mail messages. Think how many people are going to bite and how many credit card numbers are going to be stolen—just in this particular case.

That is why we have to give them strong penalties in the bill that is going to be considered by the Senate. That is why we have to be able to hook it as one of the elements that triggers the RICO Act—the Racketeer Influenced and Corrupt Organization Act—so that the prosecutors can go after the assets of the organized criminal thug ring.

PRESCRIPTION DRUGS

Mr. NELSON of Florida. Mr. President, I came to talk today about this prescription drug bill. I certainly support this bill, and I am going to vote for it. I commend the chairman and the ranking member for how they have crafted this legislation. I commend the Finance Committee for how it has put it together. If I had my druthers, we would have passed those amendments that we would have had in the last few days that we didn't pass because, clearly, giving an option for seniors to go directly through Medicare for a prescription drug benefit is, in my opinion, keeping faith with the seniors. So many of us have already suggested that we wanted to modernize Medicare from a 1965 health insurance system funded by the Federal Government for senior citizens—modernize that to the year 2003.

If you were writing Medicare today instead of in 1965, 38 years ago, would you include a prescription drug benefit? Of course you would because the miracles of modern medicine, the miracles of prescription drugs so often today will take care of the ailments and the chronic problems; so that when the Medicare system was set up in 1965—38 years ago—the state of the art of medical care was centered around a hospital and doctors. But hospitals and doctors have new tools today. Some of those tools, by the way, that I will share with you sometimes come directly out of America's space program. They are the spinoffs of technology. Some of them have come out of the State of the Presiding Officer at the Marshall Space Flight Center. I am telling you, there is some miracle equipment that has come out of the space program.

Part of the miracle of modern health care is prescription drugs. For that, I give great commendation to NIH, to our universities, and all the research institutions, and to the research departments of the pharmaceutical companies that are producing these new wonder drugs of today. But we ought to be modernizing Medicare with a prescription drug benefit that is a part of Medicare. The problem is, we cannot get the votes to do that.

So what the Finance Committee has done is fashion a plan whereby you can offer in the private sector, through a preferred provider organization—a PPO is a managed care kind of concept—and they will provide it or the senior citizen can go and get two separate drug

plans and directly there. But if they fail, there is a backup of the Federal Government doing its own prescription drug plan, according to the elements in the outline of what they have done in the legislation.

I would prefer it if a senior citizen could, in fact, go to the private sector or have the choice of getting their prescription drugs directly from Medicare. That would be the senior citizen's choice. But we could not get the votes for that amendment.

So we are proceeding on with the bill, and I am certainly going to support the bill because it is a major first step along the way to providing prescription drugs for senior citizens. We need to keep faith with those seniors. This is what a lot of us have talked about and said we wanted to do, and this is a first major step to do it. Since the Senator from Montana has come back in, I have been commending him on this package saying that I wish we had adopted a couple of the amendments that were offered over the last couple of days, but that I support the package. I commend him. This is a major first step on the road to keeping faith with our seniors. I appreciate what he has done.

I would like to take a few moments to critique some parts of the bill.

Mr. BAUCUS. Mr. President, before the Senator critiques the bill, if the Senator from Florida will yield, I very much appreciate his kind remarks. As virtually every Senator knows, this is not the perfect bill. Each Senator would like to change it a little bit. This Senator, in particular, would like to have had more money, frankly. We have $400 billion over 10 years. If we had a little more, maybe we could accommodate many of the provisions to which the Senator is referring. They are good ideas. But I think this legislation is a good first step, a chapter in a very long Medicare book. Chapter 1 was in 1965, when it was first enacted. There will be many more chapters as we work to improve Medicare, so that our senior citizens get the benefits they rightly deserve.

I thank the Senator very much for his working with us. He has given us some great ideas. I think over time, in the next couple to 3 years, we will have another chance. I thank the Senator.

Mr. NELSON of Florida. Mr. President, I think the Senator from Montana is ''Merlin the Magician'' to finally be able to craft a package that will get through in a bipartisan fashion with a huge number of votes in this Chamber. And I think if it is appropriate with the ranking member—and I believe parliamentary-wise, it is appropriate—I will lay down a couple of amendments now that can be taken up at a separate time, and then I will discuss them.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside so the Senator from Florida may proceed to offer up to two amendments.

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

AMENDMENT NO. 938

Mr. NELSON of Florida. Mr. President, I send to the desk amendment No. 938.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Florida (Mr. NELSON) proposes an amendment numbered 938.

Mr. NELSON of Florida. I ask unanimous consent that further reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To provide for a study and report on the propagation of concierge care)

At the end of subtitle B of title IV, add the following:

SEC. ___. GAO STUDY AND REPORT ON THE PROPAGATION OF CONCIERGE CARE.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care—

(A) is used by medicare beneficiaries (as defined in section 1802(b)(5)(A) of the Social Security Act (42 U.S.C. 1395a(b)(5)(A))); and

(B) has impacted upon the access of medicare beneficiaries (as so defined) to items and services for which reimbursement is provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) CONCIERGE CARE.—In this section, the term ''concierge care'' means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C))), or other individual—

(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or

(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

(b) REPORT.—Not later than the date that is 12 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)(1) together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.

AMENDMENT NO. 936

Mr. NELSON of Florida. Mr. President, I send another amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Florida (Mr. NELSON) proposes an amendment numbered 936.

Mr. NELSON of Florida. I ask unanimous consent that further reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To provide for an extension of the demonstration for ESRD managed care)

At the end of subtitle C of title II, add the following:

SEC. ___. EXTENSION OF DEMONSTRATION FOR ESRD MANAGED CARE.

The Secretary shall extend without interruption, through December 31, 2007, the approval of the demonstration project, Contract No. H1021, under the authority of section 2355(b)(1)(B)(iv) of the Deficit Reduction Act of 1984, as amended by section 13567 of the Omnibus Reconciliation Act of 1993. Such approval shall be subject to the terms and conditions in effect for the 2002 project year with respect to eligible participants and covered benefits. The Secretary shall set the monthly capitation rate for enrollees on the basis of the reasonable medical and direct administrative costs of providing those benefits to such participants.

Mr. NELSON of Florida. Mr. President, I will tell you just very briefly about these amendments, and I want to make comments basically on the underlying bill. I think these amendments are such that it is my understanding that they may be accepted—perhaps even in a managers package. But one of them involves extending the Federal role in the end stage renal disease demonstration project, which is a project that we have in Florida. I will speak about it later. It will stand on its merit.

The other is amendment No. 938 to require a GAO study to examine the extent of how concierge care has been expanded in the country and what we need to do about it. I am working with Senator BREAUX on this particular amendment.

What is happening is we have a Federal health insurance system for senior citizens that is available to all senior citizens if they qualify on the age. Lo and behold, a practice is arising around the country where some physicians are saying: I will no longer serve you unless you pay me a dollar amount per patient per year—in the case of some physicians in Florida, $1,500 per year. At the same time they are cutting the number of patients they see, they are saying: For this $1,500 entrance fee that you pay, we are going to give you specialized treatment, same day appointments, hot towels; you can call us at any time of the night—all of that personalized concierge care for $1,500 a year per patient. But if you do not pay us that, you cannot be my patient, and, oh, by the way, I still want to receive reimbursement from the Federal Government for the reimbursable services I am giving to you, the senior citizen.

That was not how Medicare was set up. Medicare was set up for all senior citizens, not just those who can pay $1,500 a year to see the doctor.

This concierge care popped up here and in several other States. This amendment is to require a GAO study to examine the extent to which this might ultimately be a destructive force against the Medicare reimbursement system and the entire Medicare system because the logical conclusion of this kind of concierge care is we would have completely two tiers of service within Medicare. We would have those who could pay the $1,500 per year, and, by the way, that is just in one case. There is another case in California where they are having to pay $24,000 per year per patient just to be under the care of that particular doctor. So we would

have two tiers under Medicare. We would have the Medicare recipients, the senior citizens, who qualify, and they would pay that money and would go to certain doctors, and the doctors who were not going to charge that, who would be left over, would get all the rest of the Medicare patients who could not afford to pay the fee.

That is not the way Medicare was set up, and that is not how Medicare is intended to deliver health care services to senior citizens that are paid for by the Federal Government.

Instead of just coming in here and breaking down the door, I took the suggestion of the senior Senator from Louisiana. In this bill, he has a special provision having to do with speciality hospitals, but he first did a GAO study to show the extent to which those speciality hospitals were being utilized. That became the basis for changing the law. That is what I will be doing by offering this amendment No. 938 which we will discuss at a future time.

I inquire of the Senator from Montana—I am just getting ready to get into my comments about the bill—does the Senator from Montana know of somebody else who wishes to speak and, if so, can he give me an indication of how long he would like me to speak? I yield to the Senator.

Mr. BAUCUS. Mr. President, I ask the Senator from Florida how long he wishes to entertain us and to educate us.

Mr. NELSON of Florida. With the enormity of this subject, Mr. President, I could go all the way from 5 minutes to 55 minutes. So what is the pleasure of the Senator from Montana?

Mr. BAUCUS. I was expecting a longer speech, frankly. I suggest the Senator speak for, say, 10, 15 minutes or whatever time the Senator wishes to take.

Mr. NELSON of Florida. I yield to the distinguished majority leader.

Mr. FRIST. Mr. President, for scheduling this afternoon, in 15 or 20 minutes I am going to speak for 20, 25 minutes, and then Senator BYRD is going to come over later as well. We have plenty of time, but if sometime in the next 30 minutes or so I may have the floor for 20 or 30 minutes, that will be helpful.

Mr. NELSON of Florida. I thank my colleagues. I was actually willing to step down and let the distinguished majority leader go ahead. He is very kind.

I would like to point out some critiques. I want it nailed down that I support this package. I think we can improve it, but at the end of the day, if we have not been able to improve it by the amendment process, it is my intention to vote for it because I think it is a major step in the right direction. Over the course of time, we are going to be able to add to the law and improve it so that at the end of the day, perhaps in a year or two down the road, we are going to have a prescription drug benefit under Medicare for senior citizens.

This legislation does many things, not the least of which is the most comprehensive attempt at expanding one of our Government's most successful experiments, this Medicare Program.

Today, almost 80 percent of our seniors take at least one prescription drug a day and over half of them take an average of four prescription drug medications each day. Prescription drugs are responsible for keeping people out of the hospital and helping them maintain their health. Spending money on medicines not only reduces the suffering of millions but it also reduces their health-care-related costs.

Let me give an example. There is a lady named Ms. Rita Salls from Sebring, FL. She takes at least 12 medications each day and sometimes even more than that. Those medicines are what allow her to continue to live on her own, an independent life.

Like many of our colleagues, when we first ran for the Senate, we talked to our constituents—and we still do—and we said we were going to try to enact this prescription drug benefit under Medicare.

What do many of our seniors without the prescription drug coverage do? They have to skip doses to make their prescriptions last longer or they have to spend less on food. Can you imagine in the year 2003 in the United States of America that there are senior citizens who are having to make a choice between food or their medicine because they do not have enough money? In some cases, they are completely unable to fill a prescription solely based on its cost. The need for this benefit has never been clearer.

While this legislation is certainly an exceptional effort to fulfill our promise for a prescription drug benefit, it does fall short in some categories.

My first concern is as it relates to the provider of the drug benefit. Given Medicare's mixed experience with Medicare HMOs—what we call Medicare+Choice; it is an HMO created under Medicare— we have not had too good of an experience with that because those Medicare HMOs have folded up and are cancelling out beneficiaries all across the country, particularly in rural areas such as Montana, and many of the rural counties in my State. How do I know that? Before I came to the Senate, I was the elected State insurance commissioner of Florida and I saw in county after county, as the regulator, where I had to go beg, cajole, and wheedle when a Medicare HMO stopped serving a rural county to get another Medicare HMO to come in and fill that role.

Should these companies come in, I still believe there should be the Government's fallback provision in the bill. It is certainly a very important provision. I wish it were in place permanently as the first option a senior could go to, but that amendment from a couple of days ago did not pass. In other words, I believe all seniors should have the option of receiving their drug benefit through Medicare rather than just through the private insurer. I think that ought to be the senior citizen's choice and yet that is not the case with the bill.

Another worry I have is how this plan is going to treat low-income seniors. In my State of Florida, over one-third of the seniors have incomes low enough to qualify for the low-income benefit of this legislation. This is especially true in Florida because the State pharmacy assistance plan in the State of Florida provides only a very limited benefit and is only available to a very small fraction of low-income seniors in Florida.

This Grassley-Baucus compromise provides premium and deductible assistance to seniors well above what Medicaid is required to do and what my own State is doing, but under the bill, some low-income seniors will not be eligible for the Medicare benefit because the plan insists that they continue to receive their benefit through Medicaid. Furthermore, beneficiaries will be subjected to an asset test in order to qualify for the benefit, which could deter some eligible beneficiaries from seeking the assistance in the first place.

Another grave concern I have is the coverage gap faced by the seniors under this legislation. Beneficiaries with drug costs in excess of $4,500 a year will find themselves continuing to pay a premium while not getting any benefit until the catastrophic provision kicks in, which is around $5,700. It is as if we are penalizing the sicker beneficiaries who depend on more prescription drugs.

Assistance to seniors should focus on individuals like Mr. and Mrs. Lomax of Longwood, FL. Mr. Lomax is 67 years old. He cannot afford to quit working because he and his wife would not be able to afford their prescription drug costs. So he continues to provide them coverage through his employer, because the cost of his medications add up to over $600 per month. Under this bill, Mr. Lomax would be required to pay over $4,200, over 40 percent of his annual drug costs.

Another critique I would make of the bill is it fails to address an issue not only affecting our Nation's seniors but anyone who has to purchase prescription drugs. I have talked to my former chairman of the Finance Committee and now the ranking member, Senator BAUCUS, about this. We realize these are the hard realities because nothing in the bill today guarantees that when Medicare or private plans on behalf of Medicare purchase their drugs from manufacturers that they get the very lowest possible price. If taxpayers are going to have to face the long-term burden of ensuring a viable prescription drug benefit for years to come, we should make certain the Government uses its purchasing power to the best of its ability.

That is a question that no doubt will be answered over the years as this new bill becoming law begins to be added to and perfected over the course of time.

In addition to expanding coverage of drugs in Medicare, this legislation does include some very worthy provisions aimed at easing the States' increasing burden of providing care to our Nation's immigrants. Immigrants and Florida, the two so often go hand in hand because of the desirability of coming to this wonderful country of ours. Where do so many of them come? To the shores of the State of Florida.

In this bill, by allowing the States the option to cover legal immigrant children and pregnant women through Medicaid and the State Children's Health Insurance Program, SCHIP, States will finally be able to obtain Federal dollars to offset the States' costs for immigrants. Similarly, increases in Federal reimbursement for providers of emergency treatment to undocumented aliens is welcome.

Florida ranks fifth among States with the highest population of illegal immigrants. Providing uncompensated care to illegal and legal immigrants is a major and growing problem for many of our hospitals in Florida. This provision in the bill will go a long way in helping to ease that situation.

Another major component of this proposal would increase funding to rural health care providers by more than $30 billion over the next 10 years, but I must say I am troubled by the way this bill pays for necessary increases in provider reimbursements by passing along their costs to Medicare's beneficiaries. They are already struggling to pay for their share of the health care costs. Their share of these costs can often exceed 45 percent of the total. So I think it is unconscionable to think that as we ask them to pay an additional $35 per month for drug coverage and an increased deductible we would ask them to pay for things they have not had to pay for in the past such as new deductibles and copayments on such things as outpatient lab services.

Furthermore, we are again threatening the ability of some of our sickest beneficiaries to receive the care they so desperately need. While we all agree that the method for payment of anticancer agents should be reformed, reducing the reimbursement from 95 to 85 percent of the average wholesale price without appropriate increases in payments for essential patient services could further jeopardize access to quality cancer care in a physician's office setting.

I, along with my colleagues, will do all we can over the course of the next several days to improve this legislation with amendments ensuring that the Government maximizes its purchasing power and ensuring a beneficiary's coverage is stable. They will, hopefully, be accepted. It will strengthen this legislation.

This is a starting point. We must also ensure that is a solid foundation for a comprehensive benefit that fulfills our promises to America's seniors.

Mr. BAUCUS. I know the people in Florida very much appreciate the hard work the Senator does. Part of that is on behalf of senior citizens.

I ask unanimous consent that the pending amendments be set aside.

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

AMENDMENT NO. 967

Mr. BAUCUS. Mr. President, on behalf of the Senator from Iowa, Mr. HARKIN, I send an amendment to the desk with respect to approving access to mammography services.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. HARKIN, proposes an amendment numbered 967.

(Purpose: To provide improved payment for certain mamography services)

At the end of subtitle B of title IV, add the following:

SEC. ___. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 13951(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: ''and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2004.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside.

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

AMENDMENT NO. 968

Mr. BAUCUS. On behalf of Senator HARKIN, I send a second amendment to the desk restoring certain reimbursements for nursing home services.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. HARKIN, proposes an amendment numbered 968.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents)

At the end of subtitle B of title IV, add the following:

SEC. ___. REIMBURSEMENT FOR TOTAL BODY ORTHOTIC MANAGEMENT FOR CERTAIN NURSING HOME PATIENTS.

(a) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall issue product codes that qualified practioners and suppliers may use to receive reimbursement under section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) for qualified total body orthotic management devices used for the treatment of nonambulatory individuals with severe musculoskeletal conditions who are in the full-time care of skilled nursing facilities (as defined in section 1861(j) of such Act (42 U.S.C. 1395x(j))). In issuing such codes, the Secretary shall take all steps necessary to prevent fraud and abuse.

(b) QUALIFIED TOTAL BODY ORTHOTIC MANAGEMENT DEVICE.—For purposes of this section, the term ''qualified total body orthotic management device'' means a medically-prescribed device which—

(1) consists of custom fitted individual braces with adjustable points at the hips, knee, ankle, elbow, and wrist, but only if—

(A) the individually adjustable braces are attached to a frame which is an integral component of the device and cannot function or be used apart from the frame; and

(B) the frame is designed such that it serves no purpose without the braces; and

(2) is designed to—

(A) improve function;

(B) retard progression of musculoskeletal deformity; or

(C) restrict, eliminate, or assist in the functioning of lower and upper extremities and pelvic, spinal, and cervical regions of the body affected by injury, weakness, or deformity,

of an individual for whom stabilization of affected areas of the body, or relief of pressure points, is required for medical reasons.

Mr. BAUCUS. I ask that all pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is ordered.

AMENDMENT NO. 969

Mr. BAUCUS. On behalf of the Senator from Connecticut, Mr. DODD, I send an amendment to the desk permitting open enrollment on a drug benefit for 2 years.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana (Mr. BAUCUS), for Mr. DODD, proposes an amendment numbered 969.

(Purpose: To permit continuous open enrollment and disenrollment in Medicare Prescription Drug plans and MedicareAdvantage plans until 2008)

At the end of subtitle C of title II, add the following:

SEC. ___. PERMITTING CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT UNDER MEDICARE PARTS C AND D UNTIL 2008.

(a) UNDER MEDICARE PRESCRIPTION DRUG PLANS.—Subclause (II) of section 1860D–3(a)(1)(A)(i), as added by section 101, is amended to read as follows:

''(II)(aa) during 2006 and 2007, may change an election under this clause at any time; and

''(bb) during 2008 or a subsequent year, may make an annual election to change the election under this clause.''.

(b) UNDER MEDICAREADVANTAGE PLANS.—Section 1851(e) (42 U.S.C. 1395w–21(e)), as amended by section 201, is amended—

(1) in paragraph (2)(A), by striking ''THROUGH 2005'' and ''December 31, 2005'' and inserting ''THROUGH 2007'' and ''December 31, 2007'', respectively;

(2) in the heading of paragraph (2)(B), by striking ''DURING 2006'' and inserting ''DURING 2008'';

(3) in paragraph (2)(B)(i), by striking ''2006'' and inserting ''2008'' each place it appears;

(4) in paragraph (2)(C)(i), by striking ''2007'' and inserting ''2009'' each place it appears;

(5) in paragraph (2)(D), by striking ''2006'' and inserting ''2008''; and

(6) in paragraph (4), by striking ''2006'' and inserting ''2008'' each place it appears.

Mr. BAUCUS. Mr. President, I ask that all pending amendments be laid aside temporarily.

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

AMENDMENT NO. 970

Mr. BAUCUS. I send an amendment on behalf of Senator DODD expanding low-income protections to 250 percent of poverty.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. DODD, proposes an amendment numbered 970.

(Purpose: To provide 50 percent cost-sharing for a beneficiary whose income is at least 160 percent but not more than 250 percent of the poverty line after the beneficiary has reached the initial coverage gap and before the beneficiary has reached the annual out-of-pocket limit)

Section 1860D–19(a) of the Social Security Act, as added by section 101, is amended by adding at the end the following new paragraph:

''(5) REDUCTION OF COST-SHARING FOR ADDITIONAL LOW-INCOME BENEFICIARIES.—

''(A) IN GENERAL.—In the case of an additional low-income beneficiary (as defined in subparagraph (B)), such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 50.0 percent.

''(B) ADDITIONAL LOW-INCOME BENEFICIARY.—Subject to subparagraph (H), the term 'additional low-income beneficiary' means an individual—

''(i) who is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

''(ii) whose income is at least 160 percent, but not more than 250 percent, of the poverty line; and

''(iii) who is not—

''(I) a qualified medicare beneficiary;

''(II) a specified low-income medicare beneficiary;

''(III) a qualifying individual;

''(IV) a subsidy-eligible individual; or

''(V) a dual eligible individual.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be laid aside.

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

AMENDMENT NO. 942

Mr. BAUCUS. Mr. President, I call up amendment No. 942 on behalf of the Senator from Washington, Ms. CANTWELL.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Ms. CANTWELL, proposes an amendment numbered 942.

(Purpose: To prohibit an eligible entity offering a Medicare Prescription Drug plan, a MedicareAdvantage Organization offering a MedicareAdvantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements)

On page 204 after line 22, insert the following:

SEC. 133. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

(a) MEDICARE.—Subpart 3 of part D of title XVIII of the Social Security Act (as added by section 101) is amended by adding at the end the following new section:

''PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS

''SEC. 1860D–27. Notwithstanding any other provision of law, an eligible entity offering a Medicare Prescription Drug plan under this part or a MedicareAdvantage organization offering a MedicareAdvantage plan under part C shall not enter into a contract with any pharmacy benefit manager (in this section referred to as a 'PBM') to manage the prescription drug coverage provided under such plan, or to control the costs of such coverage, unless the PBM satisfies the following requirements:

''(1) The PBM is not owned by a pharmaceutical manufacturing company.

''(2) The PBM agrees to pass along any cost savings negotiated with a pharmacy to the Medicare Prescription Drug plan or the MedicareAdvantage plan.

''(3) The PBM agrees to make public on an annual basis the percent of manufacturer's rebates received by the PBM that is passed back to the Medicare Prescription Drug plan or the MedicareAdvantage plan on a drug-by-drug basis.

''(4) The PBM agrees to provide, at least annually, the Medicare Prescription Drug plan or the MedicareAdvantage plan with all financial and utilization information requested by the plan relating to the provision of benefits to eligible beneficiaries through the PBM and all financial and utilization information relating to services provided to the plan. A PBM providing information under this paragraph may designate that information as confidential. Information designated as confidential by a PBM and provided to a plan under this paragraph may not be disclosed to any person without the consent of the PBM.

''(5) The PBM agrees to provide, at least annually, the Medicare Prescription Drug plan or the MedicareAdvantage plan with all financial terms and arrangements for remuneration of any kind that apply between the PBM and any prescription drug manufacturer or labeler, including formulary management and drug-switch programs, educational support, claims processing and pharmacy network fees that are charged from retail pharmacies and data sales fees.

''(6) The PBM agrees to disclose the retail cost of a prescription drug upon request by a consumer.''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

''SEC. 714. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

''The provisions of section 1860D–27 of the Social Security Act shall apply to a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan under part D of title XVIII of the Social Security Act or to a MedicareAdvantage organization offering a MedicareAdvantage plan under part C of title XVIII of that Act.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following:

''Sec. 714. Pharmacy benefit managers transparency requirements.''.

(3) EFFECTIVE DATES.—The amendments made by this subsection shall apply with respect to plan years beginning on or after the date of enactment of this Act.

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) is amended by adding at the end the following:

''SEC. 2707. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

''The provisions of section 1860D–27 of the Social Security Act shall apply to a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan, in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan under part D of title XVIII of the Social Security Act or to a MedicareAdvantage organization offering a MedicareAdvantage plan under part C of title XVIII of that Act.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to group health plans and health insurance issuers in connection with group health plans for plan years beginning on or after the date of enactment of this Act.

(d) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.—

(1) IN GENERAL.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-51 et seq.) is amended—

(A) by redesignating such subpart as subpart 2; and

(B) by adding at the end the following:

''SEC. 2753. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

''The provisions of section 1860D–27 of the Social Security Act shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to an eligible entity offering a Medicare Prescription Drug plan under part D of title XVIII of the Social Security Act or to a MedicareAdvantage organization offering a MedicareAdvantage plan under part C of title XVIII of that Act.''.

(2) EFFECTIVE DATE.—The amendment made by subsection (c)(1)(B) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date of enactment of this Act.

(e) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by inserting after section 9812 the following:

''SEC. 9813. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

''The provisions of section 1860D–27 of the Social Security Act shall apply to a group health plan in the same manner as they apply to an eligible entity offering a Medicare Prescription Drug plan under part D of title XVIII of the Social Security Act or to a MedicareAdvantage organization offering a MedicareAdvantage plan under part C of title XVIII of that Act.''.

(2) CLERICAL AMENDMENT.—The table of contents for chapter 100 of such Code is amended by inserting after the item relating to section 9812 the following:

''Sec. 9813. Required coverage of young adults.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after the date of enactment of this Act.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. 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. FRIST. Mr. President, on this Friday we have had a number of speakers come forward over the course of the morning and the afternoon on the topic of how best to improve Medicare, strengthen Medicare, preserve it, and build upon what we have learned in the past to bring it up to date and to give seniors the opportunity to receive the type of health care available today of which most people in the private sector are able to take advantage but to which, because of the structure of Medicare today, seniors simply do not have access in a way they really deserve: Things such as prescription drugs, which, as we heard debated 20 or 30 minutes ago by the distinguished Senator from Florida, are so absolutely critical to the health care toolbox, to the armamentarium out there today to take care of seniors and individuals with disabilities to prevent more serious illness for people on those pills that keep their blood pressure down at a reasonable level, that prevent debilitating strokes, prevent massive heart attacks; if they do not take that pill, those acute diseases that become chronic diseases occur, or episodic acute diseases occur.

There is such a high barrier for prescription drugs that they are less likely to reach out and get the drugs. The whole purpose is to reverse the burden in a way that is sustainable over time. As politicians, we want to help people, we want to help them now. But if we do it in a shortsighted way, we can create bigger problems for people 3 years out, 5 years, 10, 15, 20 years out, or at this time we must think 30 years out.

In the next few minutes, I will again step back and look at where we are in health care, what we are doing. Then we will be able to come back in next week and look at a lot of the individual amendments. They can be very technical. They involve a lot of terms that are unfamiliar to even a lot of Senators but also to the public at large.

In the next few minutes, I want to take this big-picture look and introduce the demographic challenge that should be the backdrop for all of our discussions when we look at health care for seniors, for promises we are making today that we are writing into legislation to make sure we are doing it in a way that can be sustained over time. This is talking to seniors but, even probably more directly, to the near seniors and to the younger generation because it is their health care we are talking about. It is their money we are using, in large part, to pay for the health care security for seniors today. Thus, I think we have to look at it in this intergenerational way.

In the big picture, the U.S. health expenditures for the dollars spent in 2001 and 2002 are similar, although this chart shows the most recent data for today of all health care dollars spent in the United States of America. The red on the chart is public expenditures, public programs—what is government—and the blue is the private sector. It is an interesting chart because it shows about half of the health care dollars run through government programs—Federal, State, and local—and half of the health care dollars are spent in the private sector.

What we have the opportunity to do now is marry these two with public-private partnerships, to take care of one segment of these health care dollars, and that is this 17 percent, this bright red 17 percent—almost a quadrant—but 17 percent of the overall health care dollar which is spent on and for and by senior citizens and individuals with disabilities, about 40 million people. That is 17 percent.

What we were concentrating on the last week, really the last several months, is this part of the pie. Medicaid, which is lower income, other Federal programs, other State and local programs are the other public programs—46 percent of the overall pie.

What we are going to be doing is capturing the very best out of the private sector, in terms of health care delivery, technology, prescription drugs—which, remember, are not up in this red sector—capture the best of the private sector with the best of the public sector, marry the two, and thereby give the seniors who fall into this sector here, this piece of the pie, better health care, better value that can be sustained over time. We are capturing the best of this section with the best of this section, marrying public and private.

It is a new concept. Traditionally, Medicare has been command and control, Washington, DC-based: we dictate; we say what is in it, what is not in it. We dictate, micromanage the decisions. The problem with health care today, with the advances in health care delivery, with the new innovations, with the human genome project, with the new technology, it is not being adopted into this sector. To me, that is sort of the big picture I want to begin with.

The challenge, if we are looking long term, if one of the goals of what we do now is we must be responsible for the future, we need to recognize what the demographic backdrop is. What does the future look like? The future looks different now, from a demographic standpoint—demographic being numbers of people, ages of people, genders of people. That is what I am talking about when I am talking about demographics. That backdrop is changing more radically than ever, than at any time in the history of this country. I will tell you why shortly. It is changing in several ways.

This chart is the number of Medicare beneficiaries. That 17 percent I just showed you was of the overall health care dollar, how many people fall in that section of that pie chart. Just look at two bars on this: This is the year 2000; this is in the year 2030. The important thing is there are 40 million beneficiaries—beneficiaries just means seniors, people who are in the program in the year 2000. You see it goes up, but just jump over and you can see it is 77 million in the year 2030. It seems like a long time from now, but it is not. That is not very long from now. But from this green bar to this green bar is a doubling in the number of seniors.

Historically, we did not have that. I will show why we had this doubling that we have to face up to if we are responsible legislators.

No. 1 is the baby boom. I love this chart because it is the way I view the baby boom. You see, it really is a baby boom. This, along this Y axis, is births per woman. You can see how it has changed over time. This is 1940, 1950, 1960, 1970, 1980, 1990, 2000—so we are about where this dotted line is now.

You can see that we had this baby boom, this fertility curve, this increase in population right after 1945, up to about 1970, with the peak around 1959, 1960. You just add 60 or 65 years to this part of the chart and you quickly get out to 2010, 2015, 2020. That is what we need to look for. In other words, this fertility curve, this baby boom, this increase in the population has just moved right across this chart, and this baby boom is going to begin to hit us in about 2008—5, 6, 7 years from now. It just begins to hit, and then over the next 5, 10, 15 years it peaks and then goes back down. But it goes back down over a period of about 30 years. So we are talking 2010 out to 2040, 2050.

The big thing is this anomaly is unprecedented in entitlement programs. This is what we have to prepare for.

If this is the Medicare system here, and we are taking care of seniors, we are going to have a doubling in the number of seniors. One of the reasons is because of the baby boom. The other reason—and I am proud of this reason. I think we all are. I am, as a physician, because physicians focus their lives on health care and improving length of lives as well as quality of life. This is probably, to me, the easiest way of looking at the fact that people are living longer now than they did 10 or 15 years ago, and as we improve health care, as we do better with preventive care and better technology and get people to eat better and exercise more, we are going to continue to have these seniors—which are already doubling in number—live longer. Let's just take an example.

This is what it was like in 1940, 1950, 1960. What this means is—let's say I am 65 years old. If I am 65 years old, in the year 2000 I would be predicted to live another 20 years. This is years of life remaining at age 65. That is pretty good.

Let's say if it were for me, 60 years old, I would be 65 plus 15 is 80.2 years of age. If I were a woman, I would be able to say I am 65 years of age, and I am

going to live 20 more years. That is pretty interesting.

But the good news is that when Medicare started, when you were 65, say, back in 1965, if I was 65 years of age, they would say I am only going to live 13 more years. But because health care has gotten better now, I am going to live 15 more years, and if I am out in 2030, I am going to live 17 more years.

You have not only more seniors but each one of those seniors is living longer. Thus they are going to be in the Medicare system for a longer period of time than what we would have thought or predicted back, either in 1965, the year 2000, or 2030.

If we are good, which I think we are in terms of science, technology, health care, this is going to increase more and more. I don't know where it is going to stop. Nobody really knows, in terms of how long people will live. But it is interesting, doubling the number of seniors because of the fertility curve, and each one of those seniors will live longer, of which we are all proud.

As an aside, this differential between women and men is pretty remarkable. If I am talking to a woman 65 years of age, I say you are going to live 20 more years. If I am talking to a man, you are only going to live 15 years. Why is that? There are a lot of hypotheses, and we don't fully know why the difference, why it is. But the point is they both are going to live longer.

This is sort of a summary chart. In 1970, we had 20 million people. Now we have 40 million people. You are going to see this line break. In 2030, we are going to have 77 million people. Again, the summary chart: A lot more people coming out of the system. That is one component.

Let's say this is the Medicare system. We say trust fund but it is not really a trust fund like in a bank or the way you envision money accumulating and then paying it out. That is just not the way it happens. It is a pay-go system, which means for every senior over here taking out for health care, you have workers—that is most of the people who are probably listening to me right now, people who have been working—who have to support it. The moneys they pay on April 15, or whenever they pay their taxes, go out to support these seniors. The money we are spending is not money seniors paid in in the past; it is a pay-go system. That is why this trust fund is not really a trust fund.

What is interesting there, not only do we have a doubling of the number of seniors, but we have fewer workers paying into the system, which the very next day are paying out to support an increasing number of seniors. This is fascinating because it, too, is a part of that fertility curve, in the 1940s and 1950s.

You will see in 1970 there were 7 of these individuals, 7.3 to be exact—paying taxes to support every senior in the system. What is interesting is that in the year 2000 that has come way down. Instead of having 7 people over here working to support each senior, you have 3.9—say 4. You have these 4 working. So, therefore, they are having to work twice as hard or pay twice as much for taxes, or work twice as many hours a day than they were working in the past because you have fewer of them supporting each worker—for health care.

Again, with the fertility boom, as it comes through, this is going to fall, by 2030, to only 2 or 2.4 workers, and they are going to have to work that much harder to support whatever we promise and whatever health care we give to seniors.

All of sudden, we saw a huge challenge. We can promise so many things right now. We can promise to improve their benefit. We can promise to give them whatever they ask for and what they want. But in doing so, if we fulfill our obligation to both this generation and also the next generation, we need to do so in a way that can be sustained. We have a doubling of the number of seniors with fewer people paying in, which compounds the challenge of technology and adding benefits and the challenge of looking at chronic care.

The product of that is, if we didn't change the law at all—if we just kept the Medicare law as it is, which is not realistic because it will change no matter what—we are spending about $226 billion a year now. In 2030—not with this bill—we are going to be spending $448 billion and fewer people are going to be paying into that system to expend the $448 billion that we have today. That is why you will hear again and again from Members such as the Senator from Oklahoma, Mr. NICKLES, and also the Senator from New Hampshire, Mr. GREGG. They will again and again remind me and our colleagues in our caucus that whatever we do, we need to do it in a way that can be sustained over time. We can't be making promises that cannot be in any way upheld or fulfilled in the future by putting an unnecessary and unfair burden on that next generation.

This is a chart which I almost hesitate showing. This summarizes and puts things in perspective why we have to address Medicare now.

No. 1, because seniors deserve better health care security. It is just too obvious to me that without prescription drugs, and without preventive care and disease management within Medicare today, they are not getting what they deserve.

The second issue is as important as Social Security. At some point we need to come back and address Social Security as well as the cost of the demographic shift because of our responsibility to seniors and that next generation.

But if we look—this is the financial challenge—at the unfunded promises over the next 75 years—I am not going any further out than 75 years, but it is important having gone out 30 years to mention the next 75 years—if you add up all of the unfunded promises, promises that are made, mandates that are in the law but we haven't determined how to best pay for them; as comparison, the debt held by the public of $3.6 trillion, just for comparison purposes—if we look over the next 75 years for Social Security, what is the shortfall there? That is why we have to come back and address it at some point, and I am not sure when it will be. But it is $3.6 trillion, and somebody is going to pay for it. We are going to have to address that.

But Medicare and health care for our seniors—this is not the bill on the floor; this is today, the current law as it exists—there is a $13.3 trillion Medicare shortfall over the next 75 years.

That is one of the reasons I think it is important for us to address Medicare now, relatively early in this Congress, why we should not delay, why we do need to finish the bill next week, and have the House do the same, have the President sign it as soon as possible, but also stress the point that we have to get this thing right. We have to do it responsibly because what we are doing as a product of modernizing Medicare is making sure we get the very best value, that it is an efficient system, that it is adding a brandnew benefit of prescription drugs which even isn't calculated in this. This $13.3 trillion is Medicare as we have it today.

One of the things we are going to do is add the $400 billion benefit over a 10-year period—not 75 but a 10-year period on top of this already $13.3 trillion Medicare shortfall. We are going to add a benefit on top of that. That is why we can't just add a benefit on top without addressing Medicare overall. That is why you heard the President from day 1 say yes, we have to have prescription drugs; yes, we have to improve the nature of the benefits; but at the same time we have to address reform because not to do so would be irresponsible as the leader of the United States of America. And the same thing goes on in this body today.

That is why the bill we have brought to the floor is not just a Medicare package and not just a bill that says let us promise pills to seniors, but says, yes, those medicines are critical and vital, but at the same time we have to address the overall integrated delivery of health care which, I would argue, allows us to have a more efficient system, a system that has more value, and a system that allows us to address, as we look out to the future, this huge unfunded promise we have made in the past.

When we are in the middle of talking about each of these individual amendments and the technical nature of materials, it is hard to back up and look at some of these principles that underlie doing this thing right—doing it in a bipartisan way, allowing ample time, as we have had all week, to fully debate the amendment process.

This is the issue Senator DORGAN talks about a lot, and he talks about

the Finance Committee a lot. And we are beginning to talk about it a lot on the floor. I don't want to get into the debate, but it will be a backdrop for much of the discussion next week.

If you look at Medicare beneficiaries and a pie chart of 40 million people, all of those 40 million people are not very expensive in what they actually expend in terms of health care expenditures.

Over here, these are all the beneficiaries. This is 100 percent of the 40 million people. Over here is health care expenditures.

The point of this is, if you just focus on the orange, 6 percent of all Medicare beneficiaries, about one in two—if this whole body were filled right now, there would be only about five or six of them in the whole body, just six desks, who would be responsible for 50 percent of all the money we put in Medicare. Of that $220 billion which we put in, only six desks—you probably see these six desks around me—would be responsible for half of that money. Why? Because they are sicker; they have more chronic diseases.

Right now, I think as we say in approaching a program that is sustainable that gives very good care, wouldn't it be great to be able to identify this 6 percent which accounts for 50 percent of these expenditures—or it could be the top 15 percent or 14 percent—this 6 percent, and the 8 percent which accounts for 76 percent—wouldn't it be great if we made absolutely sure that in that population we gave them the very best care possible in terms of prevention, in terms of management, in terms of coordination, in terms of an integrated way of taking care of their health care problems and making sure they are treated and cared for?

I am absolutely convinced—and I say this having taken care of thousands of Medicare patients, which I was blessed to be able to do before coming here—if we had the data system to be able to identify who they are and had them in the appropriate system to manage their care, they would be better cared for with a better value for the dollar.

But this is a fascinating chart on which very few people have focused. We will get back to it I think in the debates next week.

I mentioned Senator DORGAN. He and I have been discussing the same charts many times. This chart is very similar to the prescription drug expenditures as well. We can focus on certain populations.

This is an extension of Senator DORGAN's conversation, and my conversation with him. These ''CCs'' are ''chronic conditions.'' A chronic condition is something such as congestive heart failure. Congestive heart failure is when the heart gets big, it just does not pump quite as well. It is like water behind a dam; it begins to fill up in the body. It fills up in your lungs. You get short of breath and swelling in your feet. If you see people who are a little short of breath, typically it is an element of congestive heart failure, if they have heart disease at all.

But what is interesting is, if you look at Medicare expenditures, for people who only have one chronic condition such as heart failure, they account for about 4 percent of expenditures. If they have two chronic conditions—say, heart failure and diabetes—they would account for an additional 7 percent of expenditures. If they have three or four or five chronic conditions, they account for about 65 percent of expenditures.

What I am suggesting is, if you could identify people with five chronic conditions or four chronic conditions—and right now, it is amazing, because in Medicare, in our data base, you really cannot do that, but in a newer system, an up-to-date system, if you could identify these people and then manage them better, to make sure you had integrated care, coordinated care—maybe it would be a phone call from a nurse once a week, to say: Have you weighed yourself today to see if you picked up any weight? If you have picked up weight, you better come in and see us because your lungs are filling up with water. But in a newer system we could catch it before they are hospitalized, and all of a sudden you have saved the hospitalization or maybe someone's life.

That sort of integrated care is just not a part of Medicare today, and it should be. Thus, if we better manage these people—and ''management'' is not a great word. If we better treat them, if we better care for them, we would cut overall costs and improve the quality of care. We simply cannot do that in the Medicare program today.

Thus—and this comes to what this bill is all about—how do you address some of those issues? The bill on the floor allows us to address each of the issues I have mentioned.

In 2006, seniors, after having had access to a prescription drug card—and every senior could have a drug card in about 9 months from now. If we can pass this bill next week, get it through conference, have the President sign it, probably 6 to 8 months after that every senior could have a prescription drug card that would give them some benefit in terms of lowering the cost of their prescription drugs. That is a pretty good, immediate response, if we can get this bill through on time.

In the year 2006, though, the prescription drug card begins to be replaced by three options an individual senior would have. They could keep what they have today—traditional Medicare—and with that they could have access to an insurance drug package; No. 2, they could take advantage of Medicare+Choice, which is a coordinated care, integrated care type program; or, No. 3, they could take advantage of a PPO, which is an integrated health care, coordinated health care delivery system that includes prescription drugs, preventative care, and that chronic disease management.

Thus, as we look ahead in designing this program—and this, as shown on the chart, is sort of the general outlay of the bill itself—you will hear about a lot of amendments over the next week, and those amendments will talk about, for example: Well, what about the size of the drug package in each? A decision in the bill was made to have this same drug benefit under traditional Medicare and Medicare+Choice, which, by the way, has 5 million people in it. And this other program has 35 million people in it today. This prescription drug benefit is the same.

Some people might say: Well, we ought to change the benefit. Some people will say: Let's make sure this is a truly competitive model that takes advantage of what we know in the private sector works, which has more market-based principles—yes, that is highly regulated by the Government—to make sure those benefits are delivered; and those benefits have to be a part of each PPO that comes forth and bids, but let's make this more competitive. And Monday and Tuesday and Wednesday we are going to hear a lot about how to make this a really up-to-date system and as competitive as possible, which would improve quality and improve the value of each dollar put into the system.

So you will hear about market-based competition. It will be maximized in this area, as shown on this part of the chart. Again, people will be able to keep exactly what they have today. So I say to seniors who are listening, you do not have to worry about things being taken away from you or the question: What is Government going to do? Are they going to come in and take away benefits you already have? No. You are going to get access to additional benefits, even if you stay in traditional Medicare. You will be able to take advantage, like 5 million people do, of an HMO.

People start running when they hear that word HMO, but let me tell you, 5 million people who are in these HMOs are pretty pleased because they have access to prescription drugs today or people can choose this PPO model, which is the model that works best in the private sector today. It is the model most people who have employer-sponsored insurance today have. It definitely is the model of the future because of this continuity of care delivered in a seamless way as we look to the future.

Mr. President, I am going to cover just one more little bit different concept as a preface to what we will be talking about next week in the Medicare debate, and that is on what is called the donut. Now I am coming back down from 35,000 feet to about 5,000 feet to look at what will be one of the hot topics and an issue that will be debated in terms of what is called a gap or a donut. I guess those are the two words that are used mainly.

The concept is that people will get a lot of assistance, especially if you are

under the poverty level or under 160 percent of the poverty level. There is no donut for 44 percent of all seniors. There is no gap. There is no donut. I will come back and talk a little about what the donut is. If you are under 160 percent of poverty—that is about $16,000, $17,000, if you are married, of income every year as a senior—there is no donut, there is no gap.

This chart I show you deals with those individuals who are below 100 percent of the Federal poverty level. What this chart shows, in the blue, is the percent of your total expenses in a year that is paid for by the plan. The green is the amount that is paid for by the beneficiary.

So if you have $1,000 of drug expenses a year, and you are below the poverty level, you will have almost 98 percent of all of your drug expenses paid for by the plan, and you will pay $25—very little. It is a very generous benefit.

I will have one more chart that goes above the poverty level to 160 percent of the poverty level.

If you have $2,000 of expenditures in drugs a year, again, if you are below the poverty level, the plan pays for 98 percent of all your drug expenses. If you have $3,000 of expenditures a year, again, the plan pays for about 95 or 98 percent of all your drug expenses. You can see that goes up. If you have $7,000 of drug expenditures a year, again, the plan pays about 98 percent of that.

And this is one of the beauties. Remember, none of these people get prescription drug coverage through Medicare today. I do not know what it is below the poverty level, how some of them get it through other plans. In fact, if you look at all seniors, about two-thirds do get some element of prescription drug coverage somewhere. And we have to be very careful because we do not want to have everybody coming to a Government program.

But the point I want to make is, if you are under the poverty level or indeed at 160 percent of the poverty level, the plan itself is very generous. We are going to hear on the floor next week the question: Is that too generous? Or maybe it is not generous enough. It is hard to argue it is not generous enough, given the fact that 44 percent of all seniors are going to have no donut and get a very generous benefit, and everybody is going to get a benefit.

Referring to the same chart again, for example, this shows, for an individual who has $1,000 of drug expenses or $2,000 of drug expenses, how much they are going to pay for those prescription drugs. So whoever is listening to me right now, they would be able to know how much they could spend on drugs every day and know where they are going to fall.

For example, if you were a heart transplant patient of BILL FRIST 10 years ago, you would have probably had about $7,000 in drug expenses every year. Every time I transplanted a heart or a lung, the patient would have anywhere from $5,000 to $7,000 of drug expenses every year. Drugs are expensive and can take your life savings. For every patient I had who had a heart or a lung transplant, they did not go through that procedure without expending $6,000 to $7,000 on prescription drugs every year.

Most of them are seniors. That is one of the reasons why this plan means so much to me. I have a personal interest in that these are people whose faces I have looked into and eyes I have looked into over the years.

Let me go above 160 percent and you see it looks different. What I want to focus on, of the 40 million people out there, of the seniors, the 50 percent richest, 50 percent highest income people. They still get a lot of help. Just graphically look at it. Remember in blue and gray here is the percent paid by the plan. This is 100 percent at the top. So you can see it is anywhere from 30 to 50 percent coming all the way through. This chart, you can look at it all sorts of different ways, but the point I want to make, in the bill, when we talk about gap, it doesn't mean you will be left out. If you fall into what is called a donut or gap, you benefit all the way up until that level, and then through that gap you pay for your prescription drugs. But then at the other side of the gap you are picked up again.

Thus, at the end of a year, what happens? The gap is right about $4,500 to about $5,800. I am looking to my staff member because the figures have changed a little bit as we tried to narrow the gap over the last several weeks. But that means the gap is somewhere right around $4,500 to this bar here, this is $6,000. But, remember, if you are an individual and you are listening to me and you have $4,500 in expenditures, still about 45 percent of all your expenditures are paid for by the plan. And if you are in the gap, the so-called donut, it is little bit less, it is a couple percentage points less, but still right at 42 percent, at $5,000. And then if you are into $6,000, you are back up around 40 percent, $6,000, $7,000, $8000, coming up. The reason why I show this chart is because I have seniors calling me now and saying: What about if I am in the hole of that donut? What about if I am in that gap? Does that mean the Government excludes me, doesn't help me? The answer is absolutely no. You just pick where you are on here and graphically you can see that these are for the wealthiest seniors, and the bar graph I showed you for the poor. I am showing you the two ends, the two extremes. But above 160 percent of poverty, this is the gap right here. So still you are getting huge assistance at the end of the year.

Again, probably the best example, because the gap is between $4,500 and $5,800, would be the $6,000 that at the end of the year you are in the gap between $5 and $6,000, and you are still getting about 40 percent of your drugs paid for. Some people say it should be higher; some people say lower. The point is, on the gap itself, it doesn't mean you are left out in the cold. Over time we tried to minimize it and keep it as small as possible.

We will come back to that later. It is a concept that takes a little bit of time to explain. Depending on who is arguing which side in terms of the gap, there will be some, as you try to make the point, who make that gap sound real bad. Others might minimize it. The reality is, you will be helped wherever you are, even if you are in the gap. You will get huge help as you go forward.

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that there now be a period of morning business with Senators speaking for up to 10 minutes each.

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

Mr. FRIST. Mr. President, I see the Senator from West Virginia. I have about 10 more minutes. I know he has been around all afternoon. These Friday afternoons give an opportunity for people like you and me to make some points where you are not rushed and it is real pleasant to be able to stand back and look at issues that are terribly important. When you have so much going on during the day, it is a little bit harder to do. Let me take a couple more minutes and then we will be happy to yield the floor to the Senator from West Virginia.

CHILDHOOD OBESITY

Mr. FRIST. Mr. President, an issue outside of Medicare but one that has been in the news, one that deserves more attention, is an issue that is changing a little bit, like the demographics I just went to, in an unprecedented way. That is childhood obesity. This is flipping from Medicare, where we are talking about seniors, all the way to the other end of the spectrum as we look at an epidemic occurring in children that we have never seen before. It is a medical issue. It is an issue I first became aware of as a physician, but it has gotten worse. Many of us saw the release by the Centers for Disease Control and Prevention from this past weekend which led me to want to restate the importance of addressing this issue.

Historically childhood obesity was thought of in moral terms, there was an unfair stigma to obesity.

But what we have become aware of in medical science only recently, and that is childhood obesity is a serious condition that has implications not just to the child as a child or as an adolescent but has grave lifelong complications. The kids, are not just at risk for developing bad habits but now we know they are at risk of adult diseases, of developing evolving adult diseases because of that childhood obesity, because of that inactivity.

It was last weekend, Friday or Saturday, that the CDC released statistics