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No. 96

Senate

The Senate met at 9:15 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, Rev. Richard A. Lapehn of Milton Presbyterian Church, Rittman, OH.

PRAYER

The guest Chaplain offered the following prayer:

Let us pray:

Triumphant and holy God, ruler of Heaven and Earth, You have given to us the privilege of living in these unprecedented times. We know that our hope is vain when it is placed in humankind. Scripture cries aloud, "As the heavens are higher than the earth, so are My ways higher than your ways, and My thoughts than your thoughts" declares the Lord (Isaiah 55:9). Blessed is the Nation whose God is the Lord.

May we listen for Your voice and learn, hear and obey You amid the competing pressures for our time. Our world will not thrive with pusillanimous leaders, bereft of the courage to speak and act for those things which are just and right in Your eyes. These uncommon days require leaders who will seek out Your vision, soak up Your wisdom, and rely upon Your strength for the rigorous task they face.

May debate be lively and leavened with hope, may conversations uplift and encourage, and may the words spoken in this Chamber bring persistent honor to Your Name. Bless each Senator with Your mercy, Your peace, and Your abiding Spirit. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

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

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, this morning the Senate will immediately resume consideration of S. 1, the prescription drug benefit/Medicare bill. Under the previous agreement, the Senate will begin two back-to-back rollcall votes shortly. We were in late last night, and we set those votes to occur the first thing this morning.

The voting schedule will be as follows: The first vote will be in relation to the Harkin amendment No. 991 dealing with demonstration programs. The second vote will be in relation to the Edwards amendment No. 1052 dealing with drug advertising. For the remainder of the day, we will continue to debate and vote on amendments to S. 1.

We have made very good progress over the last 2 weeks on this bill. The Democratic leader and I were just talking, and we still have 50 amendments pending. It is my hope a number of these amendments will be disposed of by voice vote. I know the managers are working along that line. Inevitably, though, we are going to have a very heavy voting schedule today and into this evening. Members should expect rollcall votes throughout the day and, if necessary, into the wee hours of the morning on Friday. We will know a little bit later today the pace of these amendments and how they can best be handled.

My intention was to finish this bill before the July 4 recess. I think everybody is working in good faith to do just that. With the cooperation of all Members, and if we are able to continue voting throughout the day and the debate-and-amendment process, we may be able to pass this legislation this evening.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The Democratic leader is recognized.

Mr. DASCHLE. Mr. President, I have indicated to the majority leader that I intend to work with him today to schedule as many of these votes and to work through the pending amendments.

As he noted, there are approximately 50 pending amendments. It is my hope that our managers might look carefully at many of them and perhaps accept them on voice votes, but those requiring rollcalls I hope can be scheduled earlier rather than later throughout the day.

We will work on our side to perhaps offer them en bloc, where we could have a sequence of rollcall votes throughout the day, but we certainly will work with the majority leader to see if we can accomplish as much as he has laid out for the schedule, with an expectation that perhaps by the end of this evening we will have completed our work on the bill.

I yield the floor.

RESERVATION OF LEADER TIME

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

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Resumed

The PRESIDENT pro tempore. Under the previous order, the hour of 9:15 a.m. having arrived, the Senate will proceed to the consideration of S. 1, which the clerk will report.

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:

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



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S8605

Kerry amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare Program.

Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.

Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.

Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.

Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare prescription drug plan, a Medicare Advantage organization offering a Medicare Advantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

Rockefeller amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage.

Akaka amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid Program and SCHIP to include citizens of the Freely Associated States.

Akaka amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Bingaman amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.

Baucus (for Lautenberg) amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Murray amendment No. 990, to make improvements in the Medicare Advantage benchmark determinations.

Harkin modified amendment No. 991, to establish a demonstration project under the Medicaid Program to encourage the provision of community-based services to individuals with disabilities.

Dayton amendment No. 960, to require a streamlining of the Medicare regulations.

Dayton amendment No. 977, to require that benefits be made available under Part D on January 1, 2004.

Baucus (for Dorgan) amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare Program.

Smith/Bingaman amendment No. 962, to provide reimbursement for federally qualified health centers participating in Medicare managed care.

Hutchison amendment No. 1004, to amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the Medicare Program at 6.5 percent.

Sessions amendment No. 1011, to express the sense of the Senate that the Committee

on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under Medicaid and SCHIP as part of the reauthorization of the Temporary Assistance for Needy Families Program.

Conrad amendment No. 1019, to provide for coverage of self-injected biologicals under Part B of the Medicare Program until Medicare prescription drug plans are available.

Conrad amendment No. 1020, to permanently and fully equalize the standardized payment rate beginning in fiscal year 2004.

Conrad amendment No. 1021, to address Medicare payment inequities.

Clinton amendment No. 999, to provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level.

Clinton amendment No. 953, to provide training to long-term care ombudsman.

Clinton amendment No. 954, to require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information.

Reid (for Boxer) amendment No. 1036, to eliminate the coverage gap for individuals with cancer.

Reid (for Corzine) amendment No. 1037, to permit Medicare beneficiaries to use federally qualified health centers to fill their prescriptions.

Reid (for Jeffords) amendment No. 1038, to improve the critical access hospital program.

Reid (for Inouye) amendment No. 1039, to amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a federally qualified health center or a Native Hawaiian health care system.

Thomas/Lincoln amendment No. 988, to provide for the coverage of marriage and family therapist services and mental health counselor services under Part B of the Medicare Program.

Edwards/Harkin amendment No. 1052, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.

Enzi/Lincoln amendment No. 1051, to ensure convenient access to pharmacies and prohibit the tying of contracts.

Enzi amendment No. 1030, to encourage the availability of Medicare Advantage benefits in medically underserved areas.

Hagel/Ensign amendment No. 1012, to provide Medicare beneficiaries with an additional choice of Medicare prescription drug plans under Part D that consists of a drug discount card and protection against high out-of-pocket drug costs.

Hagel amendment No. 1026, to provide Medicare beneficiaries with a discount card that ensures access to privately negotiated discounts on drugs and protection against high out-of-pocket drug costs.

Baucus (for Feinstein) amendment No. 1060, to provide for an income-related increase in the Part B premium for individuals with income in excess of \$75,000 and married couples with income in excess of \$150,000.

Baucus (for Akaka) amendment No. 1061, to provide for treatment of Hawaii as a low-DSH State for purposes of determining a Medicaid DSH allotment for the State for fiscal years 2004 and 2005.

Bingaman/Domenici amendment No. 1065, to update, beginning in 2009, the asset or resource test used for purposes of determining the eligibility of low-income beneficiaries for premium and cost-sharing subsidies.

Bingaman amendment No. 1066, to permit the establishment of two new Medicaid plans

for Medicare beneficiaries enrolled for prescription drug coverage under Part D.

Graham (SC) modified amendment No. 948, to provide for the establishment of a National Bipartisan Commission on Medicare Reform.

Stabenow/Levin amendment No. 1075, to permanently extend a moratorium on the treatment of a certain facility as an institution for mental diseases.

Stabenow/Levin amendment No. 1076, to provide for the treatment of payments to certain comprehensive cancer centers.

Stabenow/Levin amendment No. 1077, to provide for the redistribution of unused resident positions.

Ensign/Lincoln amendment No. 1024, to amend title XVIII of the Social Security Act to repeal the Medicare outpatient rehabilitation therapy caps.

Smith/Feingold amendment No. 1073, to allow the Secretary to include in the definition of "specialized Medicare+Choice plans for special needs beneficiaries" plans that disproportionately serve such special needs beneficiaries or frail, elderly Medicare beneficiaries.

Grassley (for Craig) amendment No. 1087, to permit the offering of consumer-driven health plans under Medicare Advantage.

Baucus (for Mikulski) amendment No. 1088, to provide equitable treatment for children's hospitals.

Baucus (for Mikulski) amendment No. 1089, to provide equitable treatment for certain children's hospitals.

Baucus (for Mikulski) amendment No. 1090, to permit direct payment under the Medicare Program for clinical social worker services provided to residents of skilled nursing facilities.

Baucus (for Mikulski) amendment No. 1091, to extend certain municipal health service demonstration projects.

Grassley/Baucus amendment No. 1092, to evaluate alternative payment and delivery systems.

Kyl amendment No. 1093 (to amendment No. 1092) in the nature of a substitute.

AMENDMENT NO. 991

The PRESIDENT pro tempore. There will be 2 minutes equally divided on the amendment.

Who seeks recognition?

The Senator from Iowa.

Mr. HARKIN. The amendment before us is the one where the money follows the purse. It is \$350 million a year for 5 years whereby States can use this money to get out of institutions, out of nursing homes, people with disabilities and get them into community, home-based living.

Thirteen years ago, this Congress and the President signed a bill called the Americans With Disabilities Act. One of the premises of that was we no longer wanted to segregate people with disabilities in our society. We wanted to integrate people with disabilities in education, work, travel, jobs, everything. However, under the Medicaid system, it is still segregation.

Seventy percent of our Medicaid money goes to institutional care, only 30 percent to community-based care. What this amendment says is that for the first year, the Federal Government will pick up the full share of the State so the State can take people out of institutions and put them into community-based living.

This was proposed by President Bush in his budget proposal for next year. It is exactly what the President proposed.

The PRESIDENT pro tempore. The Senator's time has expired.

Mr. HARKIN. I ask unanimous consent for an additional 30 seconds.

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

Mr. HARKIN. The offset we use is also an offset supported by the administration. I have a letter Senators can look at—I put it in the RECORD last night—from the Department of Justice, supporting the offset we use to pay for this to ensure that we can get people in community-based settings and out of institutions.

I yield the floor.

Mr. SMITH. Mr. President. I would like to urge my colleagues to support the Harkin/Smith Money Follows the Person Amendment pending before the Senate.

This amendment would authorize the 2004 Money Follows the Person initiative in Medicaid, a part of the President's New Freedom Initiative to integrate people with disabilities into the communities where they live.

This amendment would create a 5-year program to help States move people with disabilities out of institutional settings and into their communities. For example, under this legislation, Oregon's effort to help an individual move out of an institutional care facility and into a community home would be 100-percent federally funded for 1 year.

After that first year, the Federal Government would pay its usual rate. Under the provisions of this amendment, states like Oregon can take advantage of \$350 million dollars of Federal assistance for 5 years for a total of \$1.75 billion.

This amendment is important to the disabled community for many reasons. First, by supporting States' efforts to help Americans who have been needlessly placed in institutional settings move into community settings, this amendment will help States increase access to home and community-based support for people with disabilities.

Second, by assisting the movement of people who are not best served by an institution into a community care facility, this amendment gives them the freedom to make choices. Too often, Americans with disabilities are unable to take advantage of opportunities others take for granted—to choose where they want to live, when to visit family and friends, and to be active members of their communities.

Third, this amendment helps honor those veterans whose disabilities resulted from noble and selfless service to this Nation. This morning, I heard from the head of the Oregon Chapter of the Paralyzed Veterans of America. He confirmed that this amendment would benefit countless disabled veterans in Oregon alone. I would ask unanimous consent that the letter that I received from the Paralyzed Veterans of Amer-

ica in support of this amendment be printed in the RECORD.

I likewise ask unanimous consent that a letter I received from United Cerebral Palsy and The Arc of the United States in support of this amendment be printed in the RECORD.

Finally, this amendment would help States comply with the Americans with Disabilities Act. As my colleagues in the Senate are well aware, we are nearing the 13th anniversary of the Americans with Disabilities Act and of the Olmstead Supreme Court decision.

That decision ruled that needless institutionalization of Americans with disabilities constitutes discrimination under the Americans with Disabilities Act. I urge my colleagues on both sides of the aisle to support this important amendment and to support the freedom of choice for Americans with disabilities.

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

THE ARC AND UCP
PUBLIC POLICY COLLABORATION,
Washington, DC, June 25, 2003.

Hon. GORDON SMITH,
U.S. Senate, Russell Senate Office Building,
Washington, DC.

DEAR SENATOR SMITH: On behalf of United Cerebral Palsy and The Arc of the United States, we applaud your co-sponsorship of S. AMDT. 991 to the Prescription Drug and Medicare Improvement Act that would authorize the Money Follows the Person initiative in Medicaid proposed by President Bush in his FY 2004 budget as part of his New Freedom Initiative.

Senate Amendment 991 and the President's proposal would create a five-year program to provide 100 percent federal funding for one year on behalf of individuals who move from an institutional setting to the community with home and community services and supports. Money Follows the Person would assist states in meeting their obligations under the Olmstead Supreme Court decision to serve people with long term support needs in the least restrictive setting. The Arc and UCP believe that the Money Follows the Person initiative will help states increase access to home and community-based supports for people with disabilities and help states take greater steps to permanently re-balance their long-term supports delivery system. Changes in the institutional bias in the Medicaid program are long overdue. The Money Follows the Person initiative will assist states in making a transition for people who want to leave institutional settings.

UCP is a national organization that works with and for people with cerebral palsy and related disabilities and their families. It is committed to promoting and improving supports and services for people with disabilities so that they can live, work, go to school and otherwise be fully included in their communities. UCP also supports a broad range of research and education efforts on cerebral palsy and related disabilities.

The Arc is the national organization of and for people with mental retardation and related developmental disabilities and their families. It is devoted to promoting and improving supports and services for people with mental retardation and their families. The Arc also fosters research and education regarding the prevention of mental retardation in infants and young children.

We urge all Senators to join you and Senator Harkin to support inclusion of your

amendment, S. AMDT. 991, in the Medicare Prescription Drug bill.

Sincerely,

LYNNE CLEVELAND,
Co-Chair.
LEON TRIEST,
Co-Chair.

OREGON PARALYZED VETERANS OF
AMERICA
Salem, OR, June 25, 2003.

Hon. GORDON SMITH,
U.S. Senate, Russell Senate Office Building,
Washington, DC.

DEAR SENATOR SMITH: on behalf of the Oregon Chapter of the Paralyzed Veterans of America and other disabled citizens of the state of Oregon, we thank you for joining Senator Harkin in introducing Amendment 991 ("Money Follows the Person"), to the Prescription Drug and Medicare Improvement Act of 2003 (S. 1). This amendment would authorize an initiative contained in the President's proposed FY 2004 budget, a critical part of the administration's New Freedom Initiative to integrate people with disabilities into the community.

Amendment 991 includes fiscal offsets of \$1.75 billion over five years to fund Medicaid demonstrations to assist states in developing and implementing cost-effective choices between institutional and community services. Financing Medicaid services for individuals who transition from institutions to the community is a major part of this effort.

When enacted, the Federal Government would fully reimburse states (100% Federal match) the cost of one year of Medicaid home and community-based services for people with disabilities who leave institutions. After the initial year, states would be responsible for matching payments at their usual Medicaid matching rate. \$350 million would be available in FY 2004 and in each of the following four years to implement these changes.

PVA believes that this amendment is essential to enable Oregon and other states to comply with the Americans with Disabilities Act and the Supreme Court's Olmstead decision. People with disabilities must have a meaningful choice to receive long term services and supports in their home or community.

Again, thank you for introducing Amendment 991 during the prescription drug and Medicare debate.

Sincerely,

SAM LEAM
President.
PATRICK E. ROGERS
Government Relations
Director.

(At the request of Mr. DASCHLE, the following statement was ordered to be printed in the RECORD.)

● Mr. KERRY. Mr. President, I have been a long-standing supporter of the Olmstead decision to end the institutional bias in care for people with disabilities. Unfortunately, States have been slow to implement this landmark decision. To better help States in this effort, I am proud to say that I am an original cosponsor of Senator HARKIN'S MiCASSA legislation, S. 971, the Medicaid Community-Based Attendant Services and Supports Act of 2003, a bill to ensure that "the money follows the people" and that true choice is granted for people with disabilities to decide whether they wish to live in their own communities instead of being institutionalized. The bill also provides major Federal resources to assist

States with the costs of paying for community-based attendant and support services. Had I been present for the vote, I would have voted against the motion to table the Harkin amendment and would have voted in favor of its inclusion in the Medicare prescription drug bill. ●

The PRESIDENT pro tempore. The Senator from Pennsylvania is recognized for 1½ minutes.

Mr. SANTORUM. Mr. President, I think what the Senator from Iowa has done is a very worthy thing. The President has focused on this. Part of the President's plan is what the Senator from Iowa has before us. The problem with this is that this is a Medicaid proposal that is under the jurisdiction of the Finance Committee. The Finance Committee would like the opportunity, in the context of looking at the Medicaid Program, to work this through the structure. A, to have this amendment come to the floor, not having gone through the normal process, I think is inappropriate; B, this is a Medicare bill, not a Medicaid bill.

I say to the Senator from Iowa, I know Senator GRASSLEY has said to me he is willing to work with his colleague from Iowa on moving this forward. The legislation the Senator from Iowa has put forward has merit and will probably receive bipartisan support, but it does not belong on this bill.

So I ask my colleagues—by the way, it is \$1.75 billion. I understand there is an offset, but this is a Medicare bill and we should defeat this amendment.

I ask unanimous consent that the Senator from Colorado be recognized to lay down an amendment.

The PRESIDENT pro tempore. The Senator from Colorado.

Mr. ALLARD. Mr. President, I ask that the pending amendment be temporarily laid aside.

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

AMENDMENT NO. 1017

Mr. ALLARD. I send amendment No. 1017 to the desk.

The PRESIDENT pro tempore. The clerk will report.

The bill clerk read as follows:

The Senator from Colorado (Mr. ALLARD), for himself, Mr. FEINGOLD, Mr. KOHL, and Mr. LEAHY, proposes an amendment numbered 1017.

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

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

The amendment is as follows:

(Purpose: To provide for temporary suspension of OASIS requirement for collection of data on non-medicare and non-medicaid patients)

At the end of title VI, insert the following:

SEC. ____ . TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under

OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as "non-medicare/medicaid OASIS information").

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

Mr. ALLARD. Mr. President, Medicare home health providers are in a paperwork crisis. Current regulations of the Centers for Medicare and Medicaid Services, CMS, requires that caregivers administer voluminous paperwork to patients when they administer care.

These paperwork requirements are too excessive for both patients and caregivers. Caregivers must administer numerous forms including data collection, patient privacy information, a plan of care, advance directives, a visit schedule, a comprehensive assessment, and more.

One of these requirements, called OASIS, or the Outcome and Assessment Information Set, is 94 questions long and takes a few hours to fill out. Before a nurse or physical therapist administers care, she and the patient must sit down and answer questions and fill out this paperwork. Colorado providers have told me they spend more time filling out paperwork than they do caring for patients.

As a result of this excessive data collection and dissemination, home health caregivers are leaving the home health industry. Two weeks ago a home health administrator in Colorado Springs came to share with me the situation in her agency. On her plane trip here, three of her newly-home health physical therapists called to tell her they were leaving the agency because of ex-

cessive paperwork requirements. They said they were going to leave the home health industry and return to the hospital industry.

We cannot afford this. Home health care is a vital player in health care for seniors and all individuals. If this paperwork crisis continues, home health care will continue to lose caregivers and bloat its current caregiver shortage.

Currently CMS requires that home health caregivers administer OASIS to Medicare patients, to Medicaid patients, and to patients who have private health insurance. The problem with this regulation, however, is that the data collected for private health insurance patients is not even used. This data literally sits in the offices of home health agencies with no current purpose.

The fact is CMS requires that home health agencies encode the OASIS data for Medicare and Medicaid patients only and to transmit it to their States. Then the information is transmitted into the Federal OASIS Repository.

For all private insurance patients, the home health agencies do not have to encode or transmit the data. So these nurses, physical therapists, occupational therapists, and nurse practitioners are required to collect this data for no reason.

It is my understanding CMS intends to require the transmission of data for private health patients at some point. But it has been 4 years and they have not done it yet.

In the meantime there are still many problems with OASIS. Until CMS issues the improved regulation, caregivers should be allowed to stop collecting unused data that ends up in the filing cabinets of home health agencies.

The amendment I am offering with Senators FEINGOLD, COLLINS, KOHL, and LEAHY would suspend the CMS requirement of collecting OASIS data for private insurance patients, non-Medicare and non-Medicaid patients, until an outcome by CMS's two OASIS working groups is reached.

Specifically, OASIS would be suspended until the 2 months immediately after HHS issues its regulations about OASIS. The regulations will be based on the information collected from and the recommendations of CMS's two working groups that are determining over the course of 3 years ways to improve OASIS data collection and quality assurance.

Our amendment is supported by caregivers in home health who administer OASIS, including physical therapists, nurses, nurse practitioners, occupational therapists, and speech therapists. Congresswoman NANCY JOHNSON, chairwoman of the Oversight Subcommittee of the House Committee on Ways and Means, also strongly supports this amendment. In addition, our language was included in Medicare reform bills in the Senate in the last 2 consecutive years. Further, I commend

Senator FEINGOLD for introducing legislation last Congress to reform OASIS and I commend Senator MURKOWSKI and Senator KERRY for their work on the MARCIA regulatory reform legislation, which included an OASIS suspension.

My colleagues and I believe OASIS data collection is helpful and should be applied. Even providers and patients, who must comply with the law, believe this. Yet the requirements to collect data should be achievable and inexcusive.

I am pleased to offer this amendment and urge my colleagues to support this effort for caregivers and patients.

Mr. ALLARD. Mr. President, I ask unanimous consent that the two additional cosponsors be added to the amendment, Senator KOHL and Senator LEAHY.

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

The Senator from Pennsylvania.

VOTE ON AMENDMENT NO. 991

Mr. SANTORUM. Mr. President, I move to table the Harkin amendment and ask for the yeas and nays.

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID, I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would each vote "nay".

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

The result was announced—yeas 50, nays 48, as follows:

[Rollcall Vote No. 247 Leg.]

YEAS—50

Alexander	Craig	Lugar
Allard	Crapo	McCain
Allen	DeWine	McConnell
Baucus	Dole	Murkowski
Bennett	Domenici	Nickles
Bond	Enzi	Roberts
Breaux	Fitzgerald	Santorum
Brownback	Frist	Sessions
Bunning	Graham (SC)	Shelby
Burns	Grassley	Snowe
Campbell	Gregg	Stevens
Chafee	Hagel	Sununu
Chambliss	Hatch	Talent
Cochran	Hutchison	Thomas
Coleman	Inhofe	Voinovich
Collins	Kyl	Warner
Cornyn	Lott	

NAYS—48

Akaka	Dorgan	Landrieu
Bayh	Durbin	Lautenberg
Biden	Edwards	Leahy
Bingaman	Ensign	Levin
Boxer	Feingold	Lincoln
Byrd	Feinstein	Mikulski
Cantwell	Graham (FL)	Miller
Carper	Harkin	Murray
Clinton	Hollings	Nelson (FL)
Conrad	Inouye	Nelson (NE)
Corzine	Jeffords	Pryor
Daschle	Johnson	Reed
Dayton	Kennedy	Reid
Dodd	Kohl	Rockefeller

Sarbanes Schumer Smith Specter Stabenow Wyden

NOT VOTING—2

Kerry Lieberman

The motion was agreed to. Mr. SANTORUM. Madam President, I move to reconsider the vote.

Mr. GRASSLEY. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1052

Mr. BAUCUS. Madam President, will the Chair state the regular order?

The PRESIDING OFFICER. There will be 2 minutes evenly divided before the vote on the next amendment.

Mr. BAUCUS. I thank the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. The Senator from North Carolina.

Mr. EDWARDS. Madam President, yesterday we voted on the Edwards-Harkin amendment which had two provisions. The first provision dealt with the FDA approval process for "me too" drugs. There were concerns expressed by the Members of the Senate about that provision. Even though I disagreed with those concerns, I don't think it would have slowed down the FDA approval process. Because of those concerns, we have removed those provisions from this amendment.

The amendment we are about to vote on deals only with advertising. It in no way bans advertising. All this amendment does is require that the advertising engaged in by drug companies and pharmaceutical companies be evenhanded. The only thing this amendment requires is that the information be accurate and evenhanded. In other words, you can't have kids dancing in a field as the image on television and in small print at the bottom saying the drug can cause strokes or have other side effects.

We want to make sure the American people in these advertisements get accurate information and which is not misleading. This amendment does exactly that. We have eliminated the provision so many were concerned about yesterday.

I urge my colleagues to support this amendment. Let us make sure the American people get true and accurate information in the advertising they are seeing on drugs on television.

The PRESIDING OFFICER. Who yields time?

Mr. ENZI. Madam President, I rise in opposition to this amendment submitted by my colleague from North Carolina, Senator EDWARDS. Yesterday, the Senate defeated an amendment offered by my colleague that would have restricted direct-to-consumer advertising of prescription medicines.

This new amendment continues this effort by offering similar advertising provisions to those already defeated.

I have a list of 14 organizations which I ask unanimous consent be printed in the RECORD.

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

JUNE 26, 2003

To: Members of the United States Senate:

The undersigned organizations are writing in opposition to the amendment offered by Senator EDWARDS regarding changes to Direct to Consumer advertising of pharmaceutical products. This amendment would impose serious restrictions on information which is of considerable value to the millions of patients we represent.

Our organizations are advocates for millions of Americans who suffer from a broad range of illnesses. Early detection and treatment of these illnesses is an important factor in helping those individuals lead longer and healthier lives. Communication, public education and awareness are key components in the outcomes American patients can hope to achieve. Limiting access to credible information is bad healthcare policy and we urge you to oppose the Edwards amendment and any other efforts to deny Americans information.

Respectfully,

- The National Alliance for the Mentally Ill.
- The National Mental Health Association.
- The American Association of Diabetes Educators.
- The American Foundation for Urologic Disease.
- The American Lung Foundation.
- The National Health Council.
- The Interamerican College of Physicians and Surgeons.
- The Kidney Cancer Association.
- The Society for Womens Health Research.
- The National Headache Foundation.
- The National Coalition for Women with Heart Disease.
- The National Osteoporosis Foundation.
- The American Liver Foundation.
- The National Stroke Association.

Mr. ENZI. Madam President, these are organizations that are advocates for millions of Americans who suffer from a broad range of illnesses. Early detection and treatment of these illnesses is more communication. Public education and awareness are key components. Advertising is the key component of it.

This amendment would require the Secretary of Health and Human Services to promulgate new rules that would require advertisements to provide information about a drug's effectiveness in comparison to other drugs for "substantially the same condition." In other words, you have to advertise with your competitors as well. The unfortunate effect would be to make the advertisements even more complex, not less, for consumers. It would force ads to drop other information that would be beneficial to consumers.

I ask that you reject the amendment.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

Mr. SANTORUM. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The clerk will call the roll.

The bill clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "Yea".

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

The result was announced—yeas 39, nays 59, as follows:

[Rollcall Vote No. 248 Leg.]

YEAS—39

Akaka	Durbin	Lincoln
Bayh	Edwards	Mikulski
Bingaman	Feingold	Miller
Boxer	Feinstein	Murray
Byrd	Graham (FL)	Nelson (FL)
Cantwell	Harkin	Pryor
Clinton	Inouye	Reed
Conrad	Johnson	Reid
Corzine	Kennedy	Rockefeller
Daschle	Kohl	Sarbanes
Dayton	Landrieu	Schumer
Dodd	Leahy	Stabenow
Dorgan	Levin	Wyden

NAYS—59

Alexander	Crapo	Lugar
Allard	DeWine	McCain
Allen	Dole	McConnell
Baucus	Domenici	Murkowski
Bennett	Ensign	Nelson (NE)
Biden	Enzi	Nickles
Bond	Fitzgerald	Roberts
Breaux	Frist	Stantorum
Brownback	Graham (SC)	Sessions
Bunning	Grassley	Shelby
Burns	Gregg	Smith
Campbell	Hagel	Snowe
Carper	Hatch	Specter
Chafee	Hollings	Stevens
Chambliss	Hutchison	Sununu
Cochran	Inhofe	Talent
Coleman	Jeffords	Thomas
Collins	Kyl	Thomas
Cornyn	Lautenberg	Voinovich
Craig	Lott	Warner

NOT VOTING—2

Kerry Lieberman

The amendment (No. 1052) was rejected.

Mr. GRASSLEY. Madam President, I move to reconsider the vote.

Mr. BAUCUS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1092, AS MODIFIED

Mr. GRASSLEY. Madam President, I send to the desk a modification of the Grassley benchmark amendment filed last night. I ask that I have a right to modify my amendment.

The PRESIDING OFFICER. Without objection, the amendment is modified. It is not the pending amendment at this time.

The modification is as follows:

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

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—Section 1858 (as added by section 211(b)) is amended by adding at the end the following new subsection:

"(i) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

"(1) ANNUAL DETERMINATION AND DESIGNATION.—

"(A) IN 2008.—In 2008, prior to the date on which the Secretary expects to publish the

risk adjusters under section 1860D-11, the Secretary shall designate a limited number (but in no case fewer than 1) of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions.

"(B) SUBSEQUENT YEARS.—For each year (beginning with 2009) the Secretary may designate a limited number of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions in addition to any region designated as a highly competitive region under subparagraph (A).

"(C) CONSIDERATIONS.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

"(i) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

"(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

"(iii) Whether the Secretary expects that Medicare Advantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

"(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

In considering the matters described in clauses (i) through (iv), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

"(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region under subparagraph (A) or (B) of paragraph (1)—

"(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmarks for preferred provider regions; and

"(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to paragraph (5)(B)(ii).

"(3) SUBMISSION OF BIDS.—

"(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1854(a)(2)(A)(i), the plan bid for a highly competitive region shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of only the benefits described in section 1852(a)(1)(A) to an individual enrolled in the plan that resides in the service area of the plan for a month.

"(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting a preferred provider organization plan not to provide coverage for the benefits described in section 1852(a)(1)(C).

"(4) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE AREAS.—With respect to highly competitive regions, the following rules shall apply:

"(A) IN GENERAL.—Notwithstanding subsection (c), of the plans described in subsection (d)(1)(E), the Secretary shall substitute the second lowest bid for the benchmark applicable under subsection (c)(4).

"(B) IF THERE ARE FEWER THAN THREE BIDS.—Notwithstanding subsection (c), if

there are fewer than 3 bids in a highly competitive region for a year, the Secretary shall substitute the lowest bid for the benchmark applicable under subsection (c)(4).

"(5) FUNDING LIMITATION.—

"(A) IN GENERAL.—

"(i) IN GENERAL.—The total amount expended as a result of the application of this subsection during the period or year, as applicable, may not exceed the applicable amount (as defined in clause (ii)).

"(ii) APPLICABLE AMOUNT DEFINED.—In this paragraph, the term 'applicable amount' means—

"(I) for the period beginning on January 1, 2009, and ending on September 30, 2013, the total amount that would have been expended under this title during the period if this subsection had not been enacted plus \$6,000,000,000; and

"(II) for fiscal year 2014 and any subsequent fiscal year, the total amount that would have been expended under this title during the year if this subsection had not been enacted.

"(B) APPLICATION OF LIMITATION.—If the Secretary determines that the application of this subsection will cause expenditures to exceed the applicable amount, the Secretary shall—

"(i) take appropriate steps to stay within the applicable amount, including through providing limitations on enrollment; or

"(ii) rescind the designation under subparagraph (A) or (B) of paragraph (1) of 1 or more preferred provider regions as highly competitive regions.

"(C) TRANSITION.—If the Secretary rescinds a designation under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(ii) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition from the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

"(D) APPLICATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in subparagraph (A)(ii)(I) begins, the Secretary may designate appropriate regions under such paragraph.

"(6) LIMITATION OF JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).

"(7) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

"(A) a detailed description of—

"(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

"(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

"(iii) amounts remaining within the funding limitation specified in paragraph (5); and

"(iv) the steps that the Secretary will take under clauses (i) and (ii) of paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed

the applicable amount described in paragraph (5)(A); and

“(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under clauses (i), (ii), (iii), and (iv) of subparagraph (A) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

“(8) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the designation of highly competitive regions under this subsection and the application of the payment system under this subsection within such regions. Each report shall include—

“(A) an evaluation of—

“(i) the quality of care provided to beneficiaries enrolled in a Medicare Advantage preferred provider plan in a highly competitive region;

“(ii) the satisfaction of beneficiaries with benefits under such a plan;

“(iii) the costs to the medicare program for payments made to such plans; and

“(iv) any improvements in the delivery of health care services under such a plan;

“(B) a comparative analysis of the benchmark system applicable under the other provisions of this section and the payment system applicable in highly competitive regions under this subsection; and

“(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

“(9) REPORT ON BUDGET NEUTRALITY FOR FISCAL YEARS AFTER 2013.—

“(A) IN GENERAL.—If the Secretary intends to designate 1 or more regions as highly competitive regions with respect to calendar 2014 or any subsequent calendar year, the Secretary shall submit a report to Congress indicating such intent no later than April 1 of the calendar year prior to the calendar year in which the applicable designation year begins.

“(B) REQUIREMENTS.—A report submitted under subparagraph (A) shall—

“(i) specify the steps (if any) that the Secretary will take pursuant to paragraph (5)(B) to ensure that the total amount expended as a result of the application of this subsection during the year will not exceed the applicable amount for the year (as defined in paragraph (5)(A)(ii)(II)); and

“(ii) contain a certification from the Chief Actuary of the Centers for Medicare and Medicaid Services that such steps will meet the requirements of paragraph (5)(A) based on an analysis using generally accepted actuarial principles and methodologies.”

(b) CONFORMING AMENDMENT.—Section 1858(c)(3)(A)(i) (as added by section 211(b)) is amended to read as follows:

“(i) Whether each preferred provider region has been designated as a highly competitive region under subparagraph (A) or (B) of subsection (i)(1) and the benchmark amount for any preferred provider region (as calculated under paragraph (2)(A)) for the year that has not been designated as a highly competitive region.”

SEC. 232. FEE-FOR-SERVICE MODERNIZATION PROJECTS.

(a) ESTABLISHMENT.—

(1) REVIEW AND REPORT ON RESULTS OF EXISTING DEMONSTRATIONS.—

(A) REVIEW.—The Secretary shall conduct an empirical review of the results of the demonstrations under sections 442, 443, and 444.

(B) REPORT.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the empirical review conducted under subparagraph (A) which shall include estimates of the total costs of the dem-

onstrations, including expenditures as a result of the provision of services provided to beneficiaries under the demonstrations that are incidental to the services provided under the demonstrations, and all other expenditures under title XVIII of the Social Security Act. The report shall also include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such estimates are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(2) PROJECTS.—Beginning in 2009, the Secretary, based on the empirical review conducted under paragraph (1), shall establish projects under which medicare beneficiaries receiving benefits under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act are provided with coverage of enhanced benefits or services under such program. The purpose of such projects is to evaluate whether the provision of such enhanced benefits or services to such beneficiaries—

(A) improves the quality of care provided to such beneficiaries under the medicare program;

(B) improves the health care delivery system under the medicare program; and

(C) results in reduced expenditures under the medicare program.

(2) ENHANCED BENEFITS OR SERVICES.—For purposes of this section, enhanced benefits or services shall include—

(A) preventive services not otherwise covered under title XVIII of the Social Security Act;

(B) chronic care coordination services;

(C) disease management services; or

(D) other benefits or services that the Secretary determines will improve preventive health care for medicare beneficiaries, result in improved chronic disease management, and management of complex, life-threatening, or high-cost conditions and are consistent with the goals described in subparagraphs (A), (B), and (C) of paragraph (1).

(b) PROJECT SITES AND DURATION.—

(1) IN GENERAL.—Subject to subsection (e)(2), the projects under this section shall be conducted—

(A) in a region or regions that are comparable (as determined by the Secretary) to the region or regions that are designated as a highly competitive region under subparagraph (A) or (B) of section 1858(i)(1) of the Social Security Act, as added by section 231 of this Act; and

(B) during the years that a region or regions are designated as such a highly competitive region.

(2) RULE OF CONSTRUCTION.—For purposes of paragraph (1), a comparable region does not necessarily mean the identical region.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) only to the extent and for such period as the Secretary determines is necessary to provide for enhanced benefits or services consistent with the projects under this section.

(d) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter for as long as the projects under this section are being conducted, the Comptroller General of the United States shall submit to the Secretary and Congress a report that evaluates the projects. Each report shall include—

(1) an evaluation of—

(A) the quality of care provided to beneficiaries receiving benefits or services under the projects;

(B) the satisfaction of beneficiaries receiving benefits or services under the projects;

(C) the costs to the medicare program under the projects; and

(D) any improvements in the delivery of health care services under the projects; and

(2) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(e) FUNDING.—

(1) IN GENERAL.—Payments for the costs of carrying out the projects under this section shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), as determined appropriate by the Secretary.

(2) LIMITATION.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the period or year, as applicable, may not exceed—

(A) for the period beginning on January 1, 2009, and ending on September 30, 2013, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus \$6,000,000,000; and

(B) for fiscal year 2014 and any subsequent fiscal year, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of such title during the year if the projects had not been conducted.

(3) MONITORING AND REPORTS.—

(A) ONGOING MONITORING BY THE SECRETARY TO ENSURE FUNDING LIMITATION IS NOT VIOLATED.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(I) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the previous year compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(II) the projections of the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the year in which the report is submitted compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(III) amounts remaining within the funding limitation specified in paragraph (2); and

(IV) how the Secretary will change the scope, site, and duration of the projects in subsequent years in order to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under subclauses (I), (II), (III), and (IV) of clause (i) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(C) REPORT ON BUDGET NEUTRALITY FOR FISCAL YEARS AFTER 2013.—

(i) IN GENERAL.—If the Secretary intends to continue the projects under this section for fiscal year 2014 or any subsequent fiscal year, the Secretary shall submit a report to Congress indicating such intent no later than April 1 of the year prior to the year in which the fiscal year begins.

(ii) REQUIREMENTS.—A report submitted under clause (i) shall—

(I) specify the steps (if any) that the Secretary will take pursuant to paragraph (4) to ensure that the limitations described in paragraph (2)(B) will not be violated for the year; and

(II) contain a certification from the Chief Actuary of the Centers for Medicare and Medicaid Services that such steps will meet the requirements of paragraph (2) based on an analysis using generally accepted actuarial principles and methodologies.

(4) APPLICATION OF LIMITATION.—If the Secretary determines that the projects under this section will cause the limitations described in subparagraphs (A) and (B) of paragraph (2) to be violated, the Secretary shall take appropriate steps to reduce spending under the projects, including through reducing the scope, site, and duration of the projects.

(5) AUTHORITY.—Beginning in 2014, the Secretary shall make necessary spending adjustments (including pro rata reductions in payments to health care providers under the medicare program) to recoup amounts so that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

Mr. BAUCUS. Mr. President, on behalf of Senator CONRAD, I ask unanimous consent that a letter from the Congressional Budget Office be printed in the RECORD.

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 26, 2003.

Hon. KENT CONRAD,
*Ranking Member, Committee on the Budget,
U.S. Senate, Washington, DC.*

DEAR SENATOR: The Congressional Budget Office has reviewed a proposed amendment (GOE03.597) by Senators Grassley and Baucus to S. 1, a bill 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. That amendment would add subtitle D to title II, establishing an alternative payment system for preferred provider organizations in highly competitive regions and fee-for-service modernization projects.

CBO estimates that the amendment would add \$12 billion in outlays to the cost of the bill over the 2009–2013 period—\$6 billion for payments to preferred provider organizations and \$6 billion for the fee-for-service modernization projects. The amendment would allow the programs to continue after 2013, but under the rules the amendment specifies for the Secretary of Health and Human Services, CBO estimates that those programs would incur no additional net costs after that time.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT A. SUNSHINE

(For Douglas Holtz-Eakin, Director.)

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BAUCUS. Madam 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. 1054

Mr. BAUCUS. Madam President, I ask unanimous consent that all pending amendments be set aside so that I might call up amendment No. 1054 on behalf of Senator FEINGOLD, with respect to Medicare beneficiaries.

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

The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. FEINGOLD, proposes an amendment numbered 1054.

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

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

The amendment is as follows:

(Purpose: To establish an Office of the
Medicare Beneficiary Advocate)

At the end of subtitle D of title I, add the following:

SEC. 133. OFFICE OF THE MEDICARE BENEFICIARY ADVOCATE.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish within the Department of Health and Human Services, an Office of the Medicare Beneficiary Advocate (in this section referred to as the "Office").

(b) DUTIES.—The Office shall carry out the following activities:

(1) Establishing a toll-free telephone number for medicare beneficiaries to use to obtain information on the medicare program, and particularly with respect to the benefits provided under part D of title XVIII of the Social Security Act and the Medicare Prescription Drug plans and Medicare Advantage plans offering such benefits. The Office shall ensure that the toll-free telephone number accommodates beneficiaries with disabilities and limited-English proficiency.

(2) Establishing an Internet website with easily accessible information regarding Medicare Prescription Drug plans and Medicare Advantage plans and the benefits offered under such plans. The website shall—

(A) be updated regularly to reflect changes in services and benefits, including with respect to the plans offered in a region and the associated monthly premiums, benefits offered, formularies, and contact information for such plans, and to ensure that there are no broken links or errors;

(B) have printer-friendly, downloadable fact sheets on the medicare coverage options and benefits;

(C) be easy to navigate, with large print and easily recognizable links; and

(D) provide links to the websites of the eligible entities participating in part D of title XVIII.

(3) Providing regional publications to medicare beneficiaries that include regional contacts for information, and that inform the beneficiaries of the prescription drug benefit options under title XVIII of the Social Security Act, including with respect to—

(A) monthly premiums;

(B) formularies; and

(C) the scope of the benefits offered.

(4) Conducting outreach to medicare beneficiaries to inform the beneficiaries of the

medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(5) Working with local benefits administrators, ombudsmen, local benefits specialists, and advocacy groups to ensure that medicare beneficiaries are aware of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(c) FUNDING.—

(1) ESTABLISHMENT.—Of the amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures, \$2,000,000 may be used to establish the Office in accordance with this section.

(2) OPERATION.—With respect to each fiscal year occurring after the fiscal year in which the Office is established under this section, the Secretary may use, out of amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures for such fiscal year, such sums as may be necessary to operate the Office in that fiscal year.

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

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

Mr. GRASSLEY. Madam President, I ask that the pending amendments be set aside and that the Senator from Washington be recognized for an amendment.

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

The Senator from Washington.

AMENDMENT NO. 942

Ms. CANTWELL. Madam President, I ask unanimous consent that amendment No. 942 be the pending business.

The PRESIDING OFFICER. Without objection, it is so ordered. The amendment is the pending business.

AMENDMENT NO. 942, AS MODIFIED

Ms. CANTWELL. Madam President, I ask unanimous consent that the amendment be modified with the changes I send to the desk.

The PRESIDING OFFICER. The Senator has a right to modify her amendment. The amendment is so modified.

The amendment (No. 942), as modified, is as follows:

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. (a) PROHIBITION.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, an eligible entity offering a Medicare Prescription Drug plan under this part or a Medicare Advantage organization offering a Medicare Advantage plan under part C shall not enter into a contract with any pharmacy benefit manager (in this section referred to as a "PBM") that is owned by a pharmaceutical manufacturing company.

“(2) PROVISION OF INFORMATION.—A PBM that manages prescription drug coverage under this part or part C shall provide the following information, on an annual basis, to the Assistant Attorney General for Antitrust of the Department of Justice and the Inspector General of the Health and Human Services Department:

“(A) The aggregate amount of any and all rebates, discounts, administrative fees, promotional allowances, and other payments received or recovered from each pharmaceutical manufacturer.

“(B) The amount of payments received or recovered from each pharmaceutical manufacturer for each of the top 50 drugs as measured by volume (as determined by the Secretary).

“(C) The percentage differential between the price the PBM pays pharmacies for a drug described in subparagraph (B) and the price the PBM charges a Medicare Prescription Drug Plan or a Medicare Advantage organization for such drug.

“(b) FAILURE TO DISCLOSE.—

“(1) CIVIL PENALTY.—Any PBM that fails to comply with subsection (a) shall be liable for a civil penalty as determined appropriate through regulations promulgated by the Attorney General. Such penalty may be recovered in a civil action brought by the United States.

“(2) COMPLIANCE AND EQUITABLE RELIEF.—If any PBM fails to comply with subsection (a), the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General.

“(c) DISCLOSURE EXEMPTION.—Any information filed with the Assistant Attorney General under subsection (a)(2) shall be exempt from disclosure under section 552 of title 5, and no such information may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.”

Ms. CANTWELL. Madam President, I rise today to offer the Cantwell-Lincoln Prescription drug transparency amendment to S. 1, the medicare prescription drug bill. I thank my cosponsor, Senator LINCOLN, for working with me on this important amendment that will help protect consumers against high prescription drug prices.

This amendment does three things.

First, it requires any PBM contracting with Medicare to disclose to the Department of Justice how much of the rebates and discounts negotiated for Medicare are being passed back.

Second, the disclosure of these financial arrangements to the Department of Justice provides an incentive for PBMs to return as much of that savings as possible to Medicare, which will in turn, help reduce the high cost of prescription drugs.

Finally, it prohibits a pharmaceutical company from owning a pharmacy benefit manager, an inherent conflict of interest.

By requiring transparency, the Cantwell-Lincoln amendment works to prevent collusion on pricing and helps ensure seniors are not paying unnecessarily high prices for their medications.

PBMs have been the target of numerous lawsuits filed in recent years by

health plans, employers and governments. The allegations in these lawsuits are always the same: overinflated drug prices, price collusion between PBMs and manufacturers, failure of PBMs to share discounts and rebates, and switching patients to more expensive drugs without the consent of the patient or the doctor.

The PBMs have denied wrongdoing and have settled in many cases.

Last year, Merck agreed to pay \$42.5 million to settle lawsuits over allegations that Medco improperly promoted higher priced Merck drugs when less expensive options from other pharmaceutical companies were available.

In 1998, Merck signed a settlement agreement with the Federal Trade Commission stating that, “Medco has given favorable treatment to Merck drugs.”

This admission is proof that pharmaceutical companies and PBMs have engaged in collusion on drug pricing in the past, extracting excessive profits from people who rely on these drug services. The Cantwell-Lincoln amendment is needed to help prevent price gouging in the future.

Other governments have struggled to keep a close watch on PBM practices.

In 2000, one of the big four PBMs, Advance PCS, was hired by the state of Arkansas to provide coverage for the state's 135,000 employees. A recent audit found that the PBM was overcharging the state for numerous drugs. During one 4-month period, the PBM overcharged the state \$479,000 on generic drugs alone.

PBM executives say that my amendment makes turning a profit impossible. It is true that PBMs are not charities but private companies with a duty to their shareholders to earn a profit.

Let's not forget, however, that these are also private companies charged with providing a Government-funded benefit in the best interests of 40 million senior citizens. These private companies also are duty bound to get the most for the Government's \$400 billion investment.

Traveling in my home State of Washington, I hear regularly from senior citizens about the high cost of prescription drugs. While seniors in my State, like elsewhere in the country, want a Medicare prescription drug benefit, they also desperately want some relief from high prescription drug prices. They say, “Stop the price gouging. Do something to make sure that prescription drugs are reasonably affordable for everyone.”

PBMs have come to dominate the prescription drug benefit market. Nearly 210 million Americans are served by one of the four largest PBMs.

According to the Centers for Medicaid and Medicare Services, national prescription drug spending increased by 15.7 percent in 2001. Despite promises from pharmacy benefit managers to lower costs, prescription drugs continue to be the fastest growing sector of health care spending in this country.

Soaring in tandem with prescription drugs prices are PBM profits. St. Louis-based Express Scripts—one of the four largest PBMs—provides coverage to 40 million people. The company reported that its net income grew 63 percent last year to \$202.8 million.

Another one of the big four, Advance PCS, which covers 75 million people, was ranked by Fortune Magazine as the ninth fastest growing company in the nation based on its profits over the past 5 years.

Unfortunately, it has been near impossible to find out whether PBMs are fairly sharing rebates and other savings with patients or simply using it to boost the bottom line.

Even the General Accounting Office has been unable to find out how rebates are being divided between PBMs and the Federal Employees Health Benefits Plan. A GAO requested by Senator DORGAN last year failed to discover if the PBMs were passing along the savings because none of the PBMs financial documents were available for review.

Several private companies and employee groups that contract with PBMs have resorted to lawsuits to get access to this information.

The Cantwell-Lincoln amendment requires the PBM to disclose to the Department of Justice the financial arrangements that dictate what percentage of rebates and other savings are being passed back to the client.

This disclosure creates a major incentive for PBMs to return as much as possible of the rebates and spread back to the Medicare program. This incentive also will help reduce prescription drug prices.

The PBMs have argued that reporting this financial information would kill their ability to continue to negotiate low drug prices. I am a businesswoman, and I understand the need to keep financial agreements confidential. That is why my amendment mandates the information be handed over to the Department of Justice, where it remains confidential.

Department of Justice oversight also allows for regular review of these financial arrangements to weed out any potential collusion on pricing. This added protection also will help lower drug costs for seniors.

The Cantwell-Lincoln amendment also prohibits PBMs from being owned by pharmaceutical manufacturers. This cross-ownership is problematic because it could allow for pharmaceutical companies to collude with PBMs to favor the manufacturers more expensive drugs over less expensive alternatives.

A report on PBMs by the National Health Policy Forum points out the concerns raised by close relationships between PBMs and drug manufacturers. Close ties between the two could lead to a lack of drug choice for consumers, with one manufacturer's drugs getting preferential treatment by the PBM.

Actions taken this week by the U.S. attorney in Philadelphia reinforce the

need for greater PBM oversight as outlined in the Cantwell-Lincoln amendment.

Madam President, I ask unanimous consent that articles from the Washington Post and Wall Street Journal be printed in the RECORD.

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

[From the Wall Street Journal, June 24, 2003]

U.S. IS JOINING LAWSUIT THAT SAYS MEDCO PUT PROFITS BEFORE PATIENTS

(By Barbara Martinez)

The Justice Department is joining a lawsuit that alleges Merck & Co.'s Medco pharmacy-benefits subsidiary adopted an "aggressive profits-before-patients policy." Medco's approach resulted in a potentially dangerous lack of oversight in filling prescriptions and increased pharmaceutical costs for the federal government, the suit says.

The department's involvement in the suit, brought by two former Medco pharmacists, doesn't necessarily mean that it believes all the allegations. But it signals that the government investigated the accusations and found at least some of them worth pursuing in court. The government, which also joined a second lawsuit against Medco Monday that made similar allegations, intends to file its own complaint within 90 days. Justice Department investigators have been examining Medco and other pharmacy-benefit managers, or PBMs, for several years, but this is the first time they have indicated that any suit would be filed. PBMs handle prescription-drug-card benefits for millions of employees.

The complaint alleges that after Merck—one of the world's largest drug companies—purchased Medco in 1993, the PBM began to make systemic changes in its mail-order prescription-filling system—disregarding safety and instead promoting higher profits per prescription.

In a statement, Medco said, "We are confident that when all the facts are presented they will show that our business has one focus, providing the highest quality of prescription health care to our clients and members." It added: We are prepared to present a rigorous defense and believe that we will prevail. We will prove that the allegations in the complaint "are absolutely untrue or reflect years-old isolated issues that were identified and corrected and in no way and at no time compromise the quality of patient care."

The airing of previously sealed allegations in the suit comes at a difficult time for both Merck and PBMs. Merck plans to spin off Medco as a publicly traded company this year, while PBMs have been angling to get a piece of a Medicare drug benefit currently being debated in Congress. Medco provides drug benefits to more than 60 million Americans, including millions of federal and state employees. Medco's annual revenue totals about \$30 billion.

The case could have repercussions on Capitol Hill, too, where PBMs are locked in a fierce lobbying battle, especially with the retail-pharmacy industry, over details of Medicare legislation. The measure would create a drug benefit that PBMs would have a prominent role in providing. Already Monday, the National Community Pharmacists Association, which represents about 25,000 owners of independent drugstores, stepped up its lobbying efforts. The group is pushing for stricter disclosure requirements for PBMs.

In the newly unsealed complaint, which was filed in U.S. District Court in Philadel-

phia, the two former Medco pharmacists make detailed charges that enormous pressure was placed on employees to falsify orders to meet goals and to disregard complaints by patients and doctors about drug switching or pill shortages.

Daily internal publication of prescription-error rates to help pharmacists measure their own safety standards were eliminated, the suit asserts. Instead, daily loudspeaker messages announced prescription-filling costs, as well as the stock price of parent company Merck, the suit says. Many Medco employees are compensated in part with Merck stock options.

To save money, the suit alleges, Medco reduced licensed pharmacists' role in the filling and supervising of prescription drugs at its mail-order facilities. In addition, the job of calling a physician to discuss a potential drug interaction—once the job of only pharmacists—ultimately fell to employees who "seldom have college degrees, and have no prior training in pharmacy services other than limited on-the-job training." And as a result of being pressured to meet quotas on how many doctors to call, employees regularly lied on physician call records to indicate they alerted doctors about problems when they really had not, according to the lawsuit.

The lawsuit was filed under the Federal False Claims Act. In such lawsuits, the plaintiff, often a former employee of a company that does business with the government, alleges that the company has defrauded the government. If the government considers the allegations valid, it joins the complaint, litigates the case and shares any recovery or damages with the person who filed the suit.

Medco has a significant amount of legal government business, providing mail-order prescriptions to millions of federal employees through the Federal Employee's Health Benefit Program.

Many of the allegations in this complaint relate to Medco's mail-order business, where patients mail in a prescription and Medco fills it and sends it back. PBMs such as Medco have been pushing hard to promote their mail-order facilities as a cost-effective alternative to retail stores.

According to the suit, Medco "boasts to its clients nationwide that licensed pharmacists check each mail-order prescription before it is sent out, with as many as three or four quality checks." The suit says such scrutiny only happened prior to Merck's 1993 acquisition of Medco.

After the acquisition, Medco automated more of its prescription-filling capabilities and "significant changes" were instituted that "marked a shift from prudent pharmacy practices" to a "focus on profit maximization," the complaint said.

One of Medco's largest and most technologically advanced mail-order facilities is in Las Vegas, where the two former Medco pharmacists who filed the complaint worked. According to the suit, after Medco upgraded its Las Vegas facility in the mid-1990s, "pharmacists were no longer reading and verifying mailed prescriptions prior to entry into a computer." Instead, upon arrival, the prescriptions were entered by "data-entry clerks with no formal pharmacy training" and who were supervised by nonpharmacist managers.

The suit also alleges that under a special program, touted by Medco as promoting the most cost-effective drugs, Medco called doctors to get them to change their prescriptions because of undisclosed payments to Medco from drug manufacturers. The suit said patient and physician complaints about switching prescriptions were "common" but that "Medco routinely ignores these com-

plaints, including the health risks associated with inappropriate drug switches."

In addition, Medco, like other PBMs, provides "drug utilization reviews" of prescriptions and patients. The process aims to prevent adverse drug interactions, verifies appropriate drug strength, catches drug allergies or duplicate medications.

Until 1995, such calls to physicians to alert them to possible problems were made by pharmacists who could fully explain the situation and suggest alternatives. Subsequently, the suit says, these calls were being made only by "cheaper, non-pharmacists employees." The pharmacist was only brought in at the end of a call, to verify information.

But with workers having quotas of 20 to 25 calls an hour, the pharmacist was handling as many as 100 calls within 60 minutes. As a result of pressures to meet the quotas, the complaint said, employees regularly fabricated records documenting that they called doctors to alert them to potential safety issues, among other matters, when they really hadn't. Sometimes, the suit says, the employees would change prescriptions without the pharmacist's intervention.

In other areas of the mail-order facility, the complaint says, employees "permanently delete, cancel or otherwise falsify prescriptions orders" to reduce back-order size. As a result, the complaint says, many patients didn't get the medications they needed.

[From the Washington Post, June 24, 2003]

U.S. JOINING SUIT AGAINST MEDCO

(By Charles Duhigg)

The U.S. attorney in Philadelphia announced yesterday that he is joining a complaint against Medco Health Solutions Inc. that alleges the nation's second-largest pharmacy-benefit manager improperly canceled prescriptions, switched medications without physician approval and sent patients partially filled orders.

The U.S. attorney's office has been investigating whistle-blower allegations against the company since 1999 and intends to file its own complaint in September, said Associate U.S. Attorney James G. Sheehan.

The government has decided to intervene in two lawsuits brought by three whistle-blowers. Those suits allege that Medco changed prescriptions without a physician's approval to favor more expensive drugs produced by Merck & Co. and induced physicians with false information to switch to higher cost Merck drugs. Medco also destroyed mail order prescriptions without filling them and in other cases mailed patients less than the number of pills ordered but charged for the full amount, the lawsuits allege.

Medco is a subsidiary of Merck.

"We know from industry studies that almost half of mail order participants will run out of medicine within two days if they fail to receive their new prescriptions," said Patrick L. Meehan, the U.S. attorney for the eastern district of Pennsylvania.

Medco officials contend that the allegations are untrue or "reflect years-old isolated issues that were identified and corrected," said Ann Smith, director of public affairs at Medco. At no time was the quality of patient care compromised, Smith said.

Most Americans know pharmacy benefit managers, or PBMs, from the plastic cards they hand over at local pharmacies when filling a prescription. Major employers and health plans hire these companies to negotiate with drug companies to control drug costs for plan enrollees, and to oversee the complex paperwork associated with filling prescriptions.

The Senate is considering plans to provide prescription drug coverage to the elderly

that may enhance the clout of pharmacy-benefit managers, industry analysts say. The companies are expected to administer government drug spending under some plans, according to congressional testimony offered by the National Association of Chain Drug Stores, and to receive a larger share of government reimbursements for prescription drugs.

More than 62 million Americans get prescriptions processed through Medco, according to the company. Medco handles pharmacy benefits totaling nearly \$30 billion per year, including \$1.2 billion from Blue Cross/Blue Shield as part of the Federal Employees Health Benefits Program.

George Bradford Hund and Walter W. Gauger, who both worked as pharmacists in Medco's Las Vegas processing facility, and Joseph Piacentile, a physician, allege in their complaints that on busy days Medco would cancel or destroy prescriptions to avoid penalties for delays in filling orders. Customers would be told that the prescriptions had never been received, Sheehan said.

The company is also accused of fabricating records and, when the handwriting on prescriptions was unclear or difficult to read, simply guessing at what they said, according to Sheehan. The government's suit against Medco could ask for damages in the millions of dollars and new oversight systems.

Merck acquired Medco in 1993 at a time when other drugmakers were purchasing pharmacy-benefit managers. By the end of the 1990s, all pharmaceutical manufacturers but Merck had sold their units amid concerns that the drug companies would use the benefit managers to push their own drugs, rather than doing what was best for clients.

I 1998 Merck signed a settlement agreement with the Federal Trade Commission stating that "Medco has given favorable treatment to Merck drugs." Last December, Medco agreed to pay \$42.5 million to settle a class-action lawsuit alleging that the company improperly promoted higher priced Merck drugs rather than seeking the best price from alternative pharmaceutical companies. Merck announced it intended to spin off Medco last year, but delayed the initial public offering of shares because of the depressed stock market.

Yesterday's announcement marks the first significant legal action by a federal agency against a pharmacy-benefit manager. Previously, attorneys general of at least 25 states have opened inquiries into Medco to determine whether it has violated state laws, and New York State Attorney General Eliot L. Spitzer said last Friday that his office was investigating another company, Express Scripts Inc., for allegedly overbilling state health plans.

Shares of Merck closed yesterday at \$62.11, down 78 cents, or 1.24 percent.

[From the Washington Post, June 24, 2003]

MEDCO ACCUSED OF FAVORING MERCK DRUGS

(BY DAVID B. CARUSO)

Federal prosecutors on Monday said a company that was supposed to help health plans find low-cost prescription drugs instead pressured doctors to switch patients to medications made by its owner, pharmaceutical giant Merck & Co.

U.S. Attorney Patrick Meehan said his office has joined a pair of civil "whistleblower" lawsuits against Medco Health Solutions, accusing the Merck subsidiary of providing misleading information to the government in connection with its contract to manage drug benefits for federal employees.

More than 1,000 companies have hired Medco to coordinate prescription drug coverage for employee health plans, making it the nation's largest manager of pharmacy

benefits, and the company is supposed to use its bulk-purchasing power to lower drug costs.

But the suits say Medco routinely induce physicians to switch patients to Merck drugs, even if a patient had been doing well on another medication that cost less.

The government also says the company failed to call doctors to explain prescriptions that were unclear, and fabricated records to make it appear as if calls from pharmacists to physicians had been made.

The three whistleblowers—a New Jersey doctor and two Nevada pharmacists who once worked for Medco—claim the firm also misled clients about its practice of accepting cash rebates from pharmaceutical companies in exchange for promoting their products. The suits claim the payments amount to kickbacks.

Medco spokesman Jeffrey Simek said the charges are "either absolutely untrue, or they reflect years-old isolated issues that were identified and corrected."

He denied the firm gives preferential treatment to Merck, or any other drug company.

"Our policy is that we will never make a drug interchange that will not result in a benefit for either our clients, or the members of their health plans," he said. "If we improperly favored any drug by any single company, we could never succeed."

Several health plans have previously sued Medco, claiming that it improperly accepted \$3.56 billion in payments from drug companies in the late 1990s to promote their products, but Monday's filing by the U.S. Attorney in Philadelphia is the first such action by a federal prosecutor.

Medco, like other pharmacy benefit companies, acknowledges participating in rebate programs. Simek said the company took in \$2.5 billion in rebates in 2001. But he said the payments work like coupons and ultimately lower medication costs for clients.

The suits also accuse Medco, of Franklin Lakes, N.J., of shortchanging patients by mailing them fewer than the number of pills they paid for. They say the company tried to avoid penalties for delays in filling mail orders by destroying prescriptions on days when the order volume was heavy.

Simek said the company investigated the allegations and determined they were isolated incidents that didn't affect patient care. Two employees were fired, he said.

Court filings identified the whistleblowers as Dr. Joseph Piacentile, of New Jersey, and George Bradford Hunt and Walter W. Gauger, two pharmacists who previously worked for Medco in Las Vegas.

Attorneys general in several states have said they are also investigating whether the company, and other pharmacy benefit firms, broke the law.

Merck has been trying to spin off its Medco business. It canceled an initial public offering for the company in July after revealing that it had misstated its revenues by \$12 billion in recent years by counting prescription copayments made to pharmacies as Medco revenue. Merck said in May that the firm would be spun off instead to Merck shareholders.

Ms. CANTWELL. Madam President, it was reported this week that U.S. Attorney Patrick Meehan plans to join a pair of lawsuits filed by three former Medco Health employees. The employees—two pharmacists and a doctor—allege that Medco provided misleading information to the Government related to a contract to provide drug coverage for Federal employees. The lawsuits accuse Medco of switching patients to more expensive drugs and fabricating

records to make it look as if the prescription changes were made by doctors and not by Medco.

These are serious allegations resulting from an investigation that began in 1999. This is the first such action taken by a U.S. attorney against a PBM and is a strong signal that all is not right with this industry.

U.S. Attorney Patrick Meehan told the Newark Star Ledger:

The kind of conduct alleged in the complaints threatens not only the integrity of the system as a whole, but also the well being of the very patients it is designed to benefit. These allegations suggest that, somewhere along the line, the focus became the profit instead of the patient.

The possibility of profitability trumping patient care has promoted a number of consumer groups to favor the accountability system outlined in my amendment. Consumers Union, Public Citizen, Families USA, AFSCME, the National Community Pharmacy Association and the Washington State Pharmacy Association all support my amendment.

Mr. President, I ask unanimous consent that letters of support be printed in the RECORD.

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

CONSUMERS UNION,

Washington, DC, June 25, 2003.

DEAR SENATOR: As the Senate continues to debate S. 1, the "Prescription Drug and Medicare Improvement Act of 2003," Consumers Union urges you to redouble your efforts to improve the legislation so that it better meets the needs of seniors and people with disabilities, many of whom are in dire need of meaningful protection from the devastating impact of spiraling prescription drug costs.

Some of Consumers Union's most serious concerns about S. 1 are:

The amount set aside in the Congressional budget resolution for a Medicare prescription drug bill, \$400 billion over 10 years, is inadequate for the task and limits coverage to 22 percent of the projected prescription drug expenditures over this time period;

Prescription drug coverage provided by S. 1 is skimpy, leaving many beneficiaries who lack coverage in 2003 actually paying more out of their own pockets for prescription drugs in 2007, when they have coverage. (For more information, please see our report, *Skimpy Benefits and Unchecked Expenditures: Medicare Prescription Drug Bills Fail to Offer Adequate Protection for Seniors and People with Disabilities*, at www.consumersunion.org);

The bill lacks a standard, uniform benefit, does not guarantee the availability of a prescription drug benefit through the Medicare program, and leaves all beneficiaries uncertain about what coverage will be available to them (and uncertain about the premium they will be charged);

While the Senate has approved helpful amendments that would accelerate the introduction of generics and possibly provide beneficiaries access to lower-priced drugs from Canada, the bill's reliance on hundreds of private insurance companies and HMOs precludes the possibility of the federal government using its purchasing power to negotiate deep discounts for consumers. It does too little, therefore, to rein in spiraling prescription drug expenditures;

The bill creates confusion for Medicare beneficiaries, forcing them to sort out the

options in the drug-only marketplace and options in the HMO/PPO marketplace, and it further complicates the "comparison shopping" task by allowing the prescription drug benefits to vary from the basic parameters (e.g., deductible, cost-sharing, doughnut, catastrophic coverage). Simply put, the confusing options that will face Medicare beneficiaries flunks the "kitchen table" test;

S. 1 will leave many Medicare beneficiaries worse off since employers will cut back their retiree coverage because any coverage is not counted toward retirees' out-of-pocket costs; and

While the bill provides for a relatively generous subsidy for low-income consumers, it requires them to get their prescription drug benefit through Medicare instead of the currently universal Medicare program, even though they qualify for Medicare coverage by virtue of their age or disability.

We are deeply troubled by discussions that are underway that would undermine the traditional fee-for-service Medicare program—the very program that assures beneficiaries that they have the freedom to go to the doctor of their choice—by providing extra subsidization to private PPOs and HMOs. By enriching the benefits available in the private marketplace, PPOs and HMOs will attract relatively healthy people; the traditional fee-for-service Medicare option will erode over time, because of the design of the subsidies and desire to cut costs. The sickest and most vulnerable will be severely disadvantaged.

There are several amendments that would help address some of the problems with S. 1. We urge you to support amendments that would:

Expand the prescription drug benefits so that they are comparable to prescription drug coverage in employer-based health insurance plans;

Rein in prescription drug expenditures through the use of the federal government's buying power to negotiate deep discounts;

Provide for scientific study of the comparative effectiveness of alternative prescription drugs;

Guarantee that beneficiaries would have access to a prescription drug benefit through the Medicare program at a set premium;

Count the contributions made by employers toward beneficiaries' out-of-pocket costs;

Maintain a level-playing field so that benefits in PPOs and HMOs are not more generous than benefits available in traditional fee-for-service Medicare;

Instruct the National Association of Insurance Commissioners to adjust medigap benefit packages to allow beneficiaries to buy additional coverage;

Increase the transparency of transactions by pharmaceutical benefit managers;

Cut the time before the prescription drug benefits begin.

The current debate about a Medicare prescription drug benefit has led seniors and persons with disabilities to believe that relief is in sight. In its present form, S. 1 will be a big disappointment to beneficiaries when it is implemented in 2006. We urge you to amend S. 1 so that it is more effective in providing meaningful relief to Medicare beneficiaries while addressing the pressing need to curb prescription drug expenditures.

Sincerely,

GAIL E. SHEARER,
Director, Health Policy Analysis,
Washington Office.

SOCIETY OF PROFESSIONAL ENGINEERING EMPLOYEES IN AEROSPACE,

Seattle, WA, June 5, 2003.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: As you know, union members and retirees in Washington are very concerned about the current activities involving prescription drug benefits for Medicare seniors. We thought you should know that we are part of a national delegation of unions that met with Secretary Tommy Thompson to express our opposition to any PBM-based alternative to our local pharmacies.

PBMs own much of the mail order drug service in this country. For the past 2 years, we have been warning congressional members that a PBM-based benefit would potentially harm many local pharmacies that serve our communities. Still however, lawmakers almost passed a PBM-based benefit in the 107th Congress.

Since last year, the reputation of PBMs has grown worse. Now they are being sued by a California based union, AFSCME. Allegedly, four of the largest PBMs have been pocketing money that is meant for the consumer.

SPEEA urges you and your fellow Senators to look into this lawsuit before passing any PBM-based legislation. In this day and age, transparency must be part of any program set up by the United States government.

Sincerely,

CHARLES BOFFERDING,
Executive Director.

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO,

Washington, DC, June 24, 2003.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: On behalf of AFSCME's 1.4 million members, I am writing to express my strong support for your amendment to S. 1, the Medicare prescription drug bill, that would make certain that costs savings generated by Pharmacy Benefit Managers (PBM) on behalf of the Medicare program are returned to the program. We believe that this is a critical means of controlling costs for this new benefit.

PBMs create most of their cost savings and their profits by negotiating with drug manufacturers to receive favorable rates on a pharmaceutical company's drugs in exchange for including the drugs on the PBM's formulary of preferred medicines. This bill would require that all contracts with PBMs to provide the Medicare benefit with a private insurer or the government itself include language that would ensure that all savings negotiated with a pharmacy be passed back to the government or the private insurer administering the benefit on behalf of the government.

We believe it is crucial that PBMs be required to disclose the percentage of rebate they have negotiated with the pharmaceutical companies that are passed onto their clients. Your amendment would do precisely that—giving some assurance to consumers and the government that the savings achieved by the PBMs are being shared.

I believe that your amendment goes a long way toward ensuring that Medicare beneficiaries will receive their fair share of the cost savings produced by contracts with PBMs, and AFSCME strongly supports its adoption.

Sincerely,

CHARLES M. LOVELESS,
Director of Legislation.

JUNE 18, 2003.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: Families USA, the national consumer health advocacy organization, strongly endorses your amendment to ensure that the conflicts of interest, which can occur in the delivery of a Medicare prescription drug benefit, are minimized or avoided.

Everyone agrees that whether Medicare directly administers the benefit or whether it is administered through private plans, Pharmacy Benefit Managers (PBM) will be used. They have the expertise and knowledge necessary to help administer this program. But in the recent past, there have been examples of abuse in this sector, particularly troubling has been the steering of patients to a particular prescription drug product because it was more profitable for the administering company and not because it was better for the patient! In a very real sense, that is malpractice. It is inexcusable. It must be stopped. At least one major PBM has announced a code of ethics to prevent such abuses. But these important consumer protections should not depend on company-by-company internal codes of ethics. Your amendment is needed.

Your amendment requires the confidential disclosure of the type of information that will enable the Department of Health and Human Services to protect against rebates and kickbacks that would cause a company to steer people toward profitable medicine rather than needed medicine. Your amendment helps ensure that those who will surely be called on to help administer the new benefit provide good health care to the beneficiaries and not just profitable health care to their owners.

Sincerely,

RONALD F. POLLACK,
Executive Director.

WASHINGTON STATE
PHARMACY ASSOCIATION,
Renton, WA, June 23, 2003.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: The Washington State Pharmacy Association, representing pharmacy practitioners from all practice arenas in the State of Washington, strongly endorses your amendment to ensure that the conflicts of interest, which can occur in the delivery of a Medicare prescription drug benefit through a PBM, are minimized or avoided.

Pharmacy Benefit Managers (PBM) are an integral part of the health care delivery system. Efficient plan administration and timely claims processing are mandatory components of a successful health care benefit which are important to patients, payers and providers. However, in recent years the PBM industry has expanded their role to include benefit design that has created significant conflicts of interest and ethical questions of appropriate health care delivery versus profitable health care delivery.

Your amendment, as proposed, provides the necessary transparency that will provide patients, payers, and regulators the necessary information to appropriately monitor PBM business practices. Your amendment is a significant step toward insuring that the health care provided to the citizens of this country is focused on improving the patient's health and wellbeing and not the fiscal wellbeing of the pharmacy benefit managers.

Sincerely,

ROD SHAFER, R.Ph.,
CEO.

Ms. CANTWELL. Madam President, these groups and others have been trying to call attention to problematic PBM practices. These groups rightly point out that strong consumer protections are needed in any Medicare drug benefit.

The American Association of State, County and Municipal Employees agrees that these protections provide "a critical means of controlling costs."

A national coalition of workers representing more than 20 states also are supportive of efforts to monitor PBMs. Many in this coalition currently use PBMs to provide benefits and many of them are wondering why drug costs continue to rise.

There is a balance to be had here, and the Cantwell-Lincoln amendment makes sure the scale is not tipped too far one way. It is a good amendment that will lower prescription drug prices, provide much needed consumer protections and ensure strong government oversight. I urge my colleagues to support it.

Mr. GRASSLEY. Is the amendment before us now?

The PRESIDING OFFICER. The amendment is before us.

Mr. GRASSLEY. We have looked at the amendment on this side. It has been modified, and I urge we accept it on a voice vote.

Mr. BAUCUS. We have looked at this amendment. I agree with Senator GRASSLEY. We accept the amendment.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 942, as modified.

The amendment (No. 942), as modified, was agreed to.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. BAUCUS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

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

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

Mr. BYRD. Madam President, I ask unanimous consent that I may speak out of order.

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

Mr. BYRD. I thank the Chair. (The remarks of Mr. BYRD are printed in today's RECORD under "Morning Business.")

AMENDMENT NO. 1095

The PRESIDING OFFICER. The Senator from Nevada.

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

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

Mr. REID. On behalf of the Senator from South Dakota, Senator JOHNSON, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. JOHNSON, for himself and Mr. COCHRAN, proposes an amendment numbered 1095.

Mr. REID. I ask unanimous consent the 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 1-year medication therapy management assessment program)

At the end of subtitle A of title I, add the following:

SEC. ____ . MEDICATION THERAPY MANAGEMENT ASSESSMENT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish an assessment program to contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 geographic areas, each containing not less than 3 sites, at which to conduct the assessment program under this section. At least 2 geographic areas designated under this paragraph shall be located in rural areas.

(3) DURATION.—The Secretary shall conduct the assessment program under this section for a 1-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the program not later than January 1, 2005, but may not implement the assessment program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as an assessment site under subsection (a)(2) may participate in the assessment program under this section if such beneficiary identifies a qualified pharmacist who agrees to furnish medication therapy management services to the eligible beneficiary under the assessment program.

(c) CONTRACTS WITH QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—The Secretary shall enter into a contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries residing in the area served by the qualified pharmacist.

(2) NUMBER OF QUALIFIED PHARMACISTS.—The Secretary may contract with more than 1 qualified pharmacist at each site.

(d) PAYMENT TO QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—Under a contract entered into under subsection (c), the Secretary shall pay qualified pharmacists a fee for providing medication therapy management services.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The Secretary shall, in consultation with national pharmacist and pharmacy associations, design the fee paid under paragraph (1) to test various payment methodologies applicable with respect to medication therapy management services, including a payment methodology that applies a relative value scale and fee-schedule with respect to such services that take into account the differences in—

(A) the time required to perform the different types of medication therapy management services;

(B) the level of risk associated with the use of particular outpatient prescription drugs or groups of drugs; and

(C) the health status of individuals to whom such services are provided.

(e) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the assessment program under this section.

(2) BUDGET NEUTRALITY.—In conducting the assessment program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the assessment program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the assessment program under this section.

(g) AVAILABILITY OF DATA.—During the period in which the assessment program is conducted, the Secretary annually shall make available data regarding—

(1) the geographic areas and sites designated under subsection (a)(2);

(2) the number of eligible beneficiaries participating in the program under subsection (b) and the level and types medication therapy management services used by such beneficiaries;

(3) the number of qualified pharmacists with contracts under subsection (c), the location of such pharmacists, and the number of eligible beneficiaries served by such pharmacists; and

(4) the types of payment methodologies being tested under subsection (d)(2).

(h) REPORT.—

(1) IN GENERAL.—Not later than 6 months after the completion of the assessment program under this section, the Secretary shall submit to Congress a final report summarizing the final outcome of the program and evaluating the results of the program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The final report submitted under paragraph (1) shall include an assessment of the feasibility and appropriateness of the various payment methodologies tested under subsection (d)(2).

(i) DEFINITIONS.—In this section:

(1) MEDICATION THERAPY MANAGEMENT SERVICES.—The term "medication therapy management services" means services or programs furnished by a qualified pharmacist to an eligible beneficiary, individually or on behalf of a pharmacy provider, which are designed—

(A) to ensure that medications are used appropriately by such individual;

(B) to enhance the individual's understanding of the appropriate use of medications;

(C) to increase the individual's compliance with prescription medication regimens;

(D) to reduce the risk of potential adverse events associated with medications; and

(E) to reduce the need for other costly medical services through better management of medication therapy.

(2) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) receiving, in accordance with State law or regulation, medication for—

(i) the treatment of asthma, diabetes, or chronic cardiovascular disease, including an individual on anticoagulation or lipid reducing medications; or

(ii) such other chronic diseases as the Secretary may specify.

(3) QUALIFIED PHARMACIST.—The term “qualified pharmacist” means an individual who is a licensed pharmacist in good standing with the State Board of Pharmacy.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that immediately following Senator KENNEDY’s comments I be recognized to offer an amendment regarding cancer. I further ask unanimous consent that this morning the Senate proceed to a vote in relation to the McConnell amendment, to be followed immediately by a vote in relation to the Boxer amendment numbered 1036, to be followed immediately by a vote in relation to the Bingaman amendment numbered 1065, with no second degrees in order to the three above amendments prior to the vote, with 2 minutes equally divided prior to the vote, and with 10 minutes equally divided before the first vote.

Mr. REID. Mr. President, it is my understanding that as soon as Senator KENNEDY finishes his speech Senators MCCONNELL and BOXER will be recognized for 10 minutes with the time equally divided, and then we go into the series of votes. Is that right?

Mr. MCCONNELL. That is my understanding.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from Massachusetts is recognized.

AMENDMENT NO. 1092

Mr. KENNEDY. Mr. President, we will have a chance to have greater discussion and debate on one of the important amendments that is before the Senate. But I wanted to bring to the attention of our Members as we go through the course of the day the Grassley-Baucus amendment, which has two different parts to it. I would like to address the part of the amendment which I find enormously compelling and which deserves the broad support of all the Members of this body.

This amendment provides equal funding for Medicare and the private plan demonstration plans. That is effectively what will be in the Grassley-Baucus amendment. The Republicans say the private sector can do a better job providing health care for seniors and we say Medicare can do a better job. This amendment tests both. This amendment improves the coordination of care for seniors with multiple chronic conditions who remain in Medicare. Republicans have said we need to move seniors into private plans if we want to provide chronic care coordination, disease management, or enhanced preventive services.

I am confident this demonstration program will show Medicare can do an even better job than private plans in providing preventive health services and ensuring care coordination. Care for patients with chronic conditions is

especially critical. These patients account for 95 percent of Medicare spending, according to “Care Coordination for People with Chronic Conditions”, an analysis published this year by Johns Hopkins University.

Currently, 60 million Americans have multiple chronic conditions, and that number is expected to grow to 157 million by the year 2020.

Sixty-two percent of seniors have multiple chronic conditions, but their care is often fragmented. A senior citizen may get treatment for her diabetes from one doctor, care for her arthritis from a second doctor and attention for her high blood pressure from a third.

Study after study shows that improving the coordination of care for those with multiple chronic conditions can improve outcomes and reduce costs.

For example, in Laconia, NH, the Home and Community Based Care program improved disease management for seniors with multiple conditions. This program saved an average of \$8,100 in health care costs for each senior served and decreased admission to nursing homes.

In Georgia, the Service Options Using Resources in a Community Environment—SOURCE—program improved disease management for 1,600 beneficiaries in 80 counties. The costs of caring for those seniors in the SOURCE program over two years was over \$4,000 lower than for those who were not in the program.

My own state of Massachusetts is part of the New England States Consortium, a multi-state effort funded by the Robert Wood Johnson Foundation to study the improvements that can be made in health care through better care coordination.

Expert groups in health care have said that care coordination should be one of the highest priorities for our health care system. For example, in its recent report, Priority Areas for National Action: Transforming Health Care Quality, the Institute of Medicine identified 20 “priority areas” for improving health care.

The Institute of Medicine has carefully examined the issue of care quality. The Institute’s recent report, “Priority Areas for National Action” has a series of recommendations on improving the quality of health care in America. We have included in our amendment 13 of the 20 priority items that have been identified by the Institute of Medicine that will make a significant difference in quality. The amendment will have an important impact in reducing costs by improving care coordination and providing needed preventive services.

A recent study funded by the Robert Wood Johnson Foundation reaches the same conclusion. The study examined the effect of care coordination on outcomes for patients with diabetes. Care coordination and simple preventive services dramatically improved the outcome for patients with diabetes in

terms of their blood glucose levels. Elevated blood glucose is a major concern for patients with diabetes, and preventive services are effective in keeping blood glucose levels down. As we know, diabetes is one of the principal health concerns for our country, and is of particular concern for our seniors.

A decrease of even one percentage point in the blood glucose level of a patient with diabetes can have a profound effect on health. That seemingly small decrease results in a 21 percent drop in mortality from the disease, a 12 percent decrease in strokes, a 24 percent decrease in renal failure, and a remarkable 43 percent drop in the amputations that so many patients face as a result of this cruel disease. More effective management of blood glucose levels is also effective in keeping patients out of hospitals or nursing homes and thus reducing costs. A reduction in blood glucose levels of just one percent reduces health care costs by \$800 per patient.

These kinds of extraordinary improvements in health care quality are what this amendment is all about. We are going to provide some \$6 billion nationwide over a 5-year period to give life to these kinds of quality improvement efforts, and we are going to challenge the private sector to do it as well.

We believe that the kinds of quality improvement initiatives included in this amendment will be a major factor for the support for this legislation. Health care quality and its impact on health care costs is an aspect of the health care debate that has not received sufficient attention.

This amendment will give us an opportunity to take dramatic steps forward in Medicare which will strengthen and improve the quality of health care for our seniors. The amendment will also have a very positive impact in terms of cost reductions.

This amendment also addresses the whole question of prevention which is equally critical to keeping people healthy. Immunizations, managing high blood pressure, cancer screening, and patient education can all have an enormous impact on keeping people healthy and reducing costs. Too often Medicare pays huge amounts to care for people who are sick but fails to invest adequately in keeping them healthy.

Failure to invest adequately in preventive services is a tragic consequence of the repayment system we now have under the Medicare system. When the original Medicare system was established, we did not have the knowledge, awareness, and understanding of the importance of prevention nearly to extent we have it today. Preventive care was not reimbursed the way it should be.

Under this amendment, we will have the opportunity to provide the kinds of real, effective support for prevention programs they deserve. Increased support for preventive services will mean

lower costs and better quality of care for our seniors under Medicare.

As I mentioned, too often we pay huge amounts to care for people who are sick, but fail to invest in keeping people healthy. This amendment gives Medicare the tools to invest in keeping people healthy. Too often the care for people with the highest cost, the most serious illnesses, such as cancer and stroke, is not optimal.

This demonstration will help Medicare assure the highest quality care for the sickest patients. Medicare is a fine program. It has kept our senior citizens secure for 40 years. Today let us make Medicare even better with this amendment.

I will include the selective parts of the studies I referred to previously in the RECORD. I ask unanimous consent that the selective parts be printed in the RECORD at the conclusion of my remarks.

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

(See exhibit 1).

Mr. KENNEDY. Mr. President, as I mentioned, the New England Journal of Medicine—in a major study published just today—focuses on the issue of quality. The study demonstrates that the problem most likely to occur in our health care system is not overutilization of services, but underutilization. This point bears repeating. Patients all over America are not receiving the services they need to keep them healthy. 46 percent of patients did not receive the recommended care, while only 11 percent received care that was not recommended and was potentially harmful. That means that four times as many patients did not receive the care they needed as received care they did not need. The problem in our health care system is not overutilization of services, but underutilization.

The problem of not receiving needed care is particularly acute for some of the most serious disorders that affect seniors. The New England Journal article states that less than a quarter of patients with diabetes received recommended blood tests. Fewer than two-thirds of patients with high blood pressure received the recommended care. These two diseases alone take an extraordinary toll on the lives of our citizens. Nearly 600,000 seniors die each year from heart disease, and complications of diabetes kill over 50,000 seniors. We could dramatically reduce the serious toll of these diseases—and many others—by improving access to preventive services and enhancing the quality of care.

Modern medicine—and a strong Medicare program—have been effective in allowing seniors to live with chronic conditions that once were fatal. Millions of seniors are alive today because of advances in the treatment of heart disease, high cholesterol, cancer and other serious illnesses. As a result of this success, however, millions of seniors have multiple chronic conditions which put them at higher risk for ill-

ness and hospitalization. The Institute of Medicine reports that only 0.7 percent of seniors with just one chronic condition require hospitalization in any given year. 6.2 percent of seniors with 4 chronic conditions are hospitalized, and over 25 percent of those with 10 or more chronic conditions require a hospital stay. Currently, 60 million Americans have multiple chronic conditions, and that number is expected to grow to 157 million over the next two decades.

Improving the coordination of care for those with multiple chronic conditions can markedly improve outcomes. Yet the average Medicare beneficiary sees more than six different doctors in a year. Clearly, we need to do more to see that seniors receive the most appropriate care for all their conditions—not just the one that any particular doctor among these six is treating individually. Study after study cited by the Institute of Medicine indicates that care is inadequately coordinated for patients with some of the most serious diseases.

Our health care system also fails to provide adequate preventive services. Survival rates for many forms of cancer increase dramatically if the disease is detected early—yet far too few patients receive the type of early screening that can literally mean the difference between life and death. For example, early diagnosis of colon cancer results in a survival rate of 90 percent, but that survival rate drops precipitously if the cancer spreads or grows before it is detected. Early detection not only saves lives—it reduces costs too. Proper screening can save up to \$25,000 for every patient who avoids painful and lengthy treatment through early detection of cancer. Despite this compelling evidence of the value of preventive services, only a third of patients receive the recommended form of colon cancer screening.

The story is the same with adult immunization. Pneumonia and influenza are the seventh leading cause of death in the United States, and the fifth leading cause of death among seniors. Over a third of seniors with invasive pneumonia will die of the disease. Many cases of these diseases are preventable with a simple immunization—yet one-third to one-half of all seniors do not receive needed immunizations. Coverage rates for high-risk seniors are particularly poor. Tragically, only about a quarter of seniors with chronic disease receive a flu shot.

This very important amendment will address these challenges which the Institute of Medicine, the Robert Wood Johnson Foundation, and the New England Journal of Medicine have all commented on as being critical if we are going to strengthen quality and begin to get a greater handle on costs.

I will refer to the part of the amendment that addresses these questions. Page 13 of the amendment describes the enhanced benefits that will now be available to beneficiaries in terms of

care coordination, disease management and preventive services not otherwise covered under section 18 of the Social Security Administration. I ask unanimous consent to include the section of the bill containing this provision in the RECORD.

The amendment provides chronic care coordination services, disease management services and other benefits that the Secretary will determine to improve preventive health care for Medicare beneficiaries. These services will improve chronic disease management and management of complex life-threatening or high-cost conditions. The amendment will make a real difference in improving the health of millions of seniors.

This is really a historic opportunity. I can say, having been here for some period of time, the idea that you would get \$6 billion over 5 years to be able to support prevention and the coordination of care for our seniors—I didn't believe it would ever be realized. We have that chance with this amendment.

I think one of the most important aspects of this legislation is its emphasis on the area of prevention, which is so important, as I have just described. Increased support for preventive health care services will improve and strengthen the quality of health care and also result in savings for the Medicare system. We have seen how these services help the intensely ill and sick and fragile elderly. And we will increase the coordination of services as well. All of this makes a great deal of sense. And we have the evidence—ample evidence—to show that action in this area can make a very important difference to the elderly.

I will let others describe the other part of the amendment dealing with private plans. But we challenge them, after the 5 years in which the resources will be spent—with a GAO study that will report back how the money has been spent—we challenge them to see which will make the greatest difference in terms of quality of care for our senior population and will make a difference in terms of the savings in the Medicare system. There is no question in my mind—no question in my mind—what that GAO report will demonstrate. We have clear documentation and scientific information that talks about the various studies that have been done to date, and also the conclusions that have been reached by the thoughtful, nonpartisan groups in this very area.

We welcome the opportunity to show to the American people which system is really going to work effectively. At the end of that period of time, we will have the chance to enhance and improve on that, to make sure the future generations' health care will be strengthened.

So I hope this amendment, which will be before us very soon, will receive overwhelming support because I think it will have a real chance to evaluate the different approaches and see what

is going to be most effective in terms of quality and cost.

BLOOD GLUCOSE—REDUCTIONS PAY OFF

Longitudinal studies demonstrate that a one percentage point reduction in Hemoglobin A1C (blood glucose) results in: 14% decrease in total mortality; 21% decrease in diabetes-related deaths; 14% decrease in myocardial infarction; 12% decrease in strokes; 43% decrease in amputations; 24% decrease in renal failure; and \$800 reduction in health care costs.

PROBLEMS WITH QUALITY OF CARE

The problem with quality that is most likely to occur, is underuse: 46.3 percent of participants did not receive recommended care. With overuse, 11.3 percent of participants received care that was not recommended and was potentially harmful.

VARIATIONS IN QUALITY

There is substantial variability in the quality-of-care patients receive for the 25 conditions for which at least 100 persons were eligible for analysis. Persons with senile cataracts received 78.7 percent of the recommended care; persons with alcohol dependence received 10.5 percent of the recommended care. The aggregate scores for individual conditions were generally not sensitive to the presence or absence of any single indicator of quality.

DISCUSSION

Overall, participants received about half of the recommended processes involved in care. These deficits in care have important implications for the health of the American public. For example, only 24 percent of participants in our study who had diabetes received three or more glycosylated hemoglobin tests over a two-year period. This routine monitoring is essential to the assessment of the effectiveness of treatment, to ensuring appropriate responses to poor glycemic control, and to the identification of complications of the disease at an early stage so that serious consequences may be prevented.

In our study, persons with hypertension received 64.7 percent of the recommended care. We have previously demonstrated a link between blood-pressure control and adherence to process-related measures of quality of care for hypertension. Persons whose blood pressure is persistently above normal are at increased risk for heart disease, stroke, and death. Poor blood-pressure control contributes to more than 68,000 preventable deaths annually.

FINAL LIST OF PRIORITY AREAS

The committee's selection process yielded a final set of 20 priority areas for improvement in health care quality. Improving the delivery of care in any of these areas would enable stakeholders at the national, state, and local levels to begin setting a course for quality health care while addressing unacceptable disparities in care for all Americans. The committee made no attempt to rank order the priority areas selected. The first 2 listed—care coordination and self-management/health literacy—are cross-cutting areas in which improvements would benefit a broad array of patients. The 17 that follow represent the continuum of care across the life span and are relevant to preventive care, inpatient/surgical care, chronic conditions, end-of-life care, and behavioral health, as well as to care for children and adolescents (see boxes ES-1 to ES-6). Finally, obesity is included as an "emerging area" that does not at this point satisfy the selection criteria as fully as the other 19 priority areas.

Recommendation 3: The committee recommends that DHHS, along with other public and private entities, focus on the fol-

lowing priority areas for transforming health care:

Care coordination (cross-cutting);
Self-management/health literacy (cross-cutting);

Asthma—appropriate treatment for persons with mild/moderate persistent asthma;

Cancer screening that is evidence-based—focus on colorectal and cervical cancer;

Children with special health care needs;

Diabetes—focus on appropriate management of early disease;

End of life with advanced organ system failure—focus on congestive heart failure and chronic obstructive pulmonary disease;

Fraility associated with old age—preventing falls and pressure ulcers, maximizing function, and developing advanced care plans;

Hypertension—focus on appropriate management of early disease;

Immunization—children and adults;

Ischemic heart disease—prevention, reduction of recurring events, and optimization of functional capacity;

Major depression—screening and treatment;

Medication management—preventing medication errors and overuse of antibiotics;

Nosocomial infections—prevention and surveillance;

Pain control in advanced cancer;

Pregnancy and childbirth—appropriate prenatal and intrapartum care;

Severe and persistent mental illness—focus on treatment in the public sector;

Stroke—early intervention and rehabilitation;

Tobacco dependence treatment in adults; and

Obesity (emerging area).

CARE COORDINATION—RATIONALE FOR SELECTION

Impact

Nearly half of the population—125 million Americans—lives with some type of chronic condition. About 60 million live with multiple such conditions. And more than 3 million—2.5 million women and 750,000 men—live with five such conditions (Partnership for Solutions, 2001). For those afflicted by one or more chronic conditions, coordination of care over time and across multiple health care providers and settings is crucial. Yet in a survey of over 1,200 physicians conducted in 2001, two-thirds of respondents reported that their training was not adequate to coordinate care or education for patients with chronic conditions (Partnership for Solutions, 2001).

More than 50 percent of patients with hypertension (Joint National Committee on Prevention, 1997), diabetes (Clark et al., 2000), tobacco addiction (Perez-Stable and Fuentes-Afflick, 1998), hyperlipidemia (McBride et al., 1998), congestive heart failure (Ni et al., 1998), chronic atrial fibrillation (Samsa et al., 2000), asthma (Legorreta et al., 2000), and depression (Young et al., 2001) are currently managed inadequately. Among the Medicare-eligible population, the average beneficiary sees 6.4 different physicians in a year, 4.6 of those being in the outpatient setting (Anderson, 2002a).

CANCER SCREENING THAT IS EVIDENCE-BASED—RATIONALE FOR SELECTION

Impact

Colorectal cancer is the third most common cancer among men and women in the United States, with an estimated incidence of 148,300 cases annually. In 2002, 56,600 Americans died from colorectal cancer, making it the nation's second leading cause of cancer-related death. Lifetime risk for developing colorectal cancer is approximately 6 percent with over 90 percent of cases occurring after

age 50 (American Cancer Society, 2002). The estimated long-term cost of treating stage II colon cancer is approximately \$60,000 (Brown et al., 2002).

Cervical cancer is the ninth most common cancer among women in the United States, with an estimated incidence of 13,000 cases annually. Cervical cancer ranks thirteenth among all causes of cancer death, with about 4,100 women dying of the disease each year (American Cancer Society, 2002). The incidence of cervical cancer has steadily declined, dropping 46 percent between 1975 and 1999 from a rate of 14.8 per 100,000 women to 8.0 per 100,000 women (Ries et al., 2002). Despite these gains, cervical cancer continues to be a significant public health issue. It has been estimated that 60 percent of cases of cervical cancer are due to a lack of or deficiencies in screening (Sawaya and Grimes, 1999).

PREVENTION—CANCER SCREENING

Improvement

Early diagnosis of colorectal cancer while it is still at a localized state results in a 90 percent survival rate at 5 years (Ries et al., 2002). The American Cancer Society's (ACS) guidelines recommend screening for colorectal cancer beginning at age 50 for adults at average risk using one of the following five screening regimens: fecal occult blood test (FOBT) annually; flexible sigmoidoscopy every 5 years; annual FOBT plus flexible sigmoidoscopy every 5 years; double contrast barium enema every 5 years; or colonoscopy every 10 years (American Cancer Society, 2001). The United States Preventive Services Task Force strongly recommends screening for men and women 50 years of age and older for colorectal cancer. Screening has been found to be cost-effective in saving lives, with estimates ranging from \$10,000 and \$25,000 life-year saved.

IMMUNIZATION (ADULT)—RATIONALE FOR SELECTION

Impact

Pneumonia and influenza are the seventh leading cause of death in the United States (The Commonwealth Fund, 2002). Pneumococcal disease causes 10,000 to 14,000 deaths annually; influenza causes an average of 110,000 hospitalizations and 20,000 deaths annually (United States Department of Health and Human Services, 2000). Approximately 30-43 percent of elderly people who have invasive pneumonia will die from the disease (United States Preventive Services Task Force, 1996). The elderly are also at increased risk for complications associated with influenza, and approximately 90 percent of the deaths attributed to the disease are among those aged 65 and older (Vishnu-Priya et al., 2000).

To decrease the burden of these diseases, including incapacitating malaise, doctor visits, hospitalizations, and premature deaths, experts recommend vaccination. Yet one-third to one-half of older adults (aged 65 and over) do not receive these vaccinations (The Commonwealth Fund, 2002). Coverage rates for high-risk adults who suffer from chronic disease are especially poor, with only 26 percent receiving an influenza vaccination and 13 percent a pneumococcal vaccination (Institute of Medicine, 2000).

Mr. KENNEDY. 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. MCCONNELL. 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. 1097

Mr. MCCONNELL. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Kentucky [Mr. MCCONNELL] proposes an amendment numbered 1097.

Mr. MCCONNELL. 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 protect seniors with cancer)

At the end of subtitle A of title I, add the following:

SEC. ____ . PROTECTING SENIORS WITH CANCER.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cancer shall be protected from high prescription drug costs in the following manner:

(1) **SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.**—If the individual is a qualified medicare beneficiary (as defined in section 1860D-19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(1) of such Act.

(2) **SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.**—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D-19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D-19(4)(C) of such Act) who is diagnosed with cancer, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D-17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(2) of such Act.

(3) **SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.**—If the individual is a subsidy-eligible individual (as defined in section 1860D-19(a)(4)(D) of such Act) who is diagnosed with cancer, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only \$50;

(B) only a percentage of the monthly premium (as described in section 1860D-19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D-19(a)(3)(A).

(4) **ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.**—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cancer,

such individual shall have access to qualified prescription drug coverage (as described in section 1860D-6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of \$275;

(B) the limits on cost-sharing described section 1860D-6(c)(2) of such Act up to, for 2006, an initial coverage limit of \$4,500; and

(C) for 2006, an annual out-of-pocket limit of \$3,700 with 10 percent cost-sharing after that limit is reached.

(5) **CONSTRUCTION.**—Notwithstanding the preceding provisions of this section, nothing in this section shall be construed in a manner that would provide an individual who is diagnosed with cancer with benefits under part D of title XVIII of the Social Security Act (as added by section 101) that are different from the benefits that the individual would have been eligible for if such individual was not diagnosed with cancer.

Mr. MCCONNELL. Mr. President, the amendment I just sent to the desk ensures protection of seniors diagnosed with cancer from the high prescription drug costs associated with that illness.

My amendment states specifically that any senior in Medicare and diagnosed with cancer shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, no more than a 2.5-percent copayment for any drug spending up to \$4,500 a year, no more than a 5-percent copayment for drug spending between \$4,500 and \$5,800 a year, and no more than a 2.5-percent copayment for any drug spending over \$5,800 if their income is below the poverty level.

My amendment states that any senior in Medicare who is also diagnosed with cancer, with an income between 100 percent and 135 percent of the poverty level, shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, no more than a 5-percent copayment for drug spending up to \$4,500, no more than a 10-percent copayment for drug spending between \$4,500 and \$5,800, and no more than a 2.5-percent copayment for any drug spending over \$5,800.

My amendment provides that any senior in Medicare diagnosed with cancer, with an income between 135 percent and 160 percent of the poverty level, shall have the right to a drug plan in which the beneficiary shall pay no more than a \$50 deductible, an average monthly premium not greater than \$35, no more than a 10-percent copayment for drug spending up to \$4,500, no more than a 20-percent copayment for drug spending between \$4,500 and \$5,800, and no more than a 10-percent copayment for any drug spending over \$5,800.

My amendment also provides that any senior in Medicare and diagnosed with cancer, with an income above 160 percent of the poverty level, shall have the right to a drug plan in which the beneficiary shall pay no more than a \$275 deductible, an average monthly premium not greater than \$35, no more than a 50-percent copayment for drug spending up to \$4,500, and no more than a 10-percent copayment for drug spending over \$5,800.

With this amendment, which conforms to the provisions within the bill,

all seniors with cancer get help with prescription drug costs, especially the poor and moderate-income seniors.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. Two minutes.

Mr. MCCONNELL. Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

The Senator from Nevada.

Mr. REID. Mr. President, the Boxer amendment is very simple. It says if a person is receiving cancer drugs and they come to a period of time—as this bill is written—where they run out of the ability to get help from the Medicare Program, that they, in effect, are covered.

We want a cancer patient to have no donut hole, no gap in coverage. That is what the Boxer amendment is all about.

Mr. KENNEDY. Mr. President, do we have any time?

Mr. REID. We have at least 4 minutes.

Mr. KENNEDY. Will the Senator yield me a minute?

Mr. REID. Of course.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. REID. Mr. President, I yield 2 minutes to the Senator from Massachusetts.

Mr. KENNEDY. Mr. President, the Boxer amendment provides the additional resources for the treatment of cancer. I think all of us understand the importance of the continuity of care in the treatment of disease generally. That is why I am going to continue to vigorously fight for additional resources to fill in this gap in the future for all diseases. But it is particularly important to fill this gap for people who are afflicted with the disease of cancer. They are waiting for Congress to fill in this gap.

It does seem to me, because of the compelling reasons for the continuity of care in terms of diseases generally we ought to be able to find the additional resources to fill this gap.

The Boxer amendment does not replace the fundamental structure of this legislation. It finds the additional resources to be able to make sure there will be continuity of care for what is, for many families, their Number 1 health concern. So that is a very compelling reason. I hope the amendment will be favorably considered.

I suggest the absence of a quorum.

Mr. REID. Mr. President, I ask the Senator to withhold the suggestion of a quorum.

Mr. KENNEDY. I withhold.

The PRESIDING OFFICER. Who yields time?

If no one yields time, time will be charged equally to both sides.

Who yields time?

The minority leader.

Mr. DASCHLE. Mr. President, I ask unanimous consent that all time be yielded back.

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

The question is on agreeing to the McConnell amendment No. 1097.

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

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

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

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

The result was announced—yeas 97, nays 1, as follows:

[Rollcall Vote No. 249 Leg.]

YEAS—97

Akaka	Dodd	Lugar
Alexander	Dole	McCain
Allard	Domenici	McConnell
Allen	Dorgan	Mikulski
Baucus	Durbin	Miller
Bayh	Edwards	Murkowski
Bennett	Enzi	Murray
Biden	Feingold	Nelson (FL)
Bingaman	Feinstein	Nelson (NE)
Bond	Fitzgerald	Nickles
Boxer	Frist	Pryor
Breaux	Graham (FL)	Reed
Brownback	Graham (SC)	Reid
Bunning	Grassley	Roberts
Burns	Gregg	Rockefeller
Byrd	Hagel	Santorum
Campbell	Harkin	Sarbanes
Cantwell	Hatch	Schumer
Carper	Hollings	Sessions
Chafee	Hutchison	Shelby
Chambliss	Inhofe	Smith
Clinton	Inouye	Snowe
Cochran	Jeffords	Specter
Coleman	Johnson	Stabenow
Collins	Kennedy	Stevens
Conrad	Kohl	Sununu
Cornyn	Kyl	Talent
Corzine	Landrieu	Thomas
Craig	Lautenberg	Thomas
Crapo	Leahy	Voinovich
Daschle	Levin	Warner
Dayton	Lincoln	Wyden
DeWine	Lott	

NAYS—1

Ensign

NOT VOTING—2

Kerry Lieberman

The amendment (No. 1097) was agreed to.

AMENDMENT NO. 1036

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). By previous order, there are 2 minutes evenly divided prior to the vote on the Boxer amendment.

The Senator from California is recognized.

Mrs. BOXER. The Senator from Kentucky and I agreed to an extra 30 seconds each, so I ask unanimous consent for that.

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

Mrs. BOXER. Mr. President, I want to speak to the hearts and the minds of each and every one of my colleagues and friends, so I will speak straight from the shoulder.

The amendment we just voted for did nothing, not one thing, for cancer patients, except reiterate what is already in the underlying bill.

What my amendment does, and why I hope we will rise to the occasion and support it, is to send a strong message to anyone diagnosed with cancer, and to their families, friends, and loved ones, that if and when they are diagnosed with cancer, they will not face the benefit shutdown that is now in this bill.

I will show my colleagues on this chart that at \$4,500 of drug costs, the benefit shuts down. I want my colleagues to think about someone they know with cancer, someone who is battling cancer. Do we want to put this burden on them? They must take their drugs. They cannot cut their pills in half in order to survive.

The Cancer Society tells us that 6 million to 7 million Medicare beneficiaries are battling some form of cancer, and 380,000 of them will die of cancer. Please, let us relieve this burden of them having to pay 100 percent of their drug costs during this benefit shutdown. I beg my colleagues to take a stand. I beg my colleagues to be compassionate. I beg my colleagues to be independent for once on an amendment and support the cancer patients who are counting on us today to at least relieve them of this terrible financial burden that will hit them just when they are the sickest.

I urge an aye vote.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Before I use my time, I have a unanimous consent request. That unanimous consent request is that the time lapse between the next two votes be 10 minutes instead of 15 minutes.

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

Mr. GRASSLEY. Mr. President, first, from a parliamentary point of view, this amendment, if adopted, would subject the entire bill to a budget point of order. We have enough people in this body who maybe do not want a prescription drug bill that could take down the whole bill.

The other reason is, all the concerns the Senator has mentioned we have taken into account within the \$400 billion capability of our legislation. We have before us this \$400 billion to provide prescription drug benefits to our seniors. We have used that \$400 billion to help low-income seniors with prescription drug costs if they have cancer, diabetes, or anything else for which they need drugs.

We have used the \$400 billion to limit the catastrophic costs of prescription drugs to all seniors. We do not create two drug classes for the sick and the ill, and that is why we should move forward with this amendment so it does not bring down the whole bill on a potential budget point of order.

I move to table the amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. All time has expired. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The bill clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

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

The result was announced—yeas 54, nays 44, as follows:

[Rollcall Vote No. 250 Leg.]

YEAS—54

Alexander	Crapo	McCain
Allard	DeWine	McConnell
Allen	Dole	Miller
Baucus	Domenici	Murkowski
Bennett	Ensign	Nickles
Bond	Enzi	Roberts
Breaux	Fitzgerald	Santorum
Brownback	Frist	Sessions
Bunning	Graham (SC)	Shelby
Burns	Grassley	Smith
Campbell	Gregg	Snowe
Chafee	Hagel	Specter
Chambliss	Hatch	Stevens
Cochran	Hutchison	Sununu
Coleman	Inhofe	Talent
Collins	Kyl	Thomas
Cornyn	Lott	Voinovich
Craig	Lugar	Warner

NAYS—44

Akaka	Durbin	Levin
Bayh	Edwards	Lincoln
Biden	Feingold	Mikulski
Bingaman	Feinstein	Murray
Boxer	Graham (FL)	Nelson (FL)
Byrd	Harkin	Nelson (NE)
Cantwell	Hollings	Pryor
Carper	Inouye	Reed
Clinton	Jeffords	Reid
Conrad	Johnson	Rockefeller
Corzine	Kennedy	Sarbanes
Daschle	Kohl	Schumer
Dayton	Landrieu	Stabenow
Dodd	Lautenberg	Wyden
Dorgan	Leahy	

NOT VOTING—2

Kerry Lieberman

The motion was agreed to.

AMENDMENT NO. 1065

The PRESIDING OFFICER. There are now 2 minutes equally divided prior to the vote on the amendment offered by the Senator from New Mexico.

The Senate will please be in order. The Senator from New Mexico will suspend until the Senate is in order.

The Senator from New Mexico.

Mr. BINGAMAN. I ask unanimous consent that the RECORD reflect we are updating the asset test to a limit of \$10,000 per individual and \$20,000 per couple.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Reserving the right to object, have we seen this? We do not seem to know about this.

The PRESIDING OFFICER. The Senate will be in order.

Mr. GRASSLEY. Reserving the right to object, we do not know about the

modification—or do we? We do not seem to.

Mr. BINGAMAN. Mr. President, this is what the bill was intended to say. It is exactly what we have shared with your staff. It is just that there was a typo in it.

Mr. GRASSLEY. I withdraw the reservation.

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

The Senator from New Mexico.

Mr. BINGAMAN. I ask unanimous consent that the Senator from Florida, Mr. GRAHAM, be added as a cosponsor.

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

Mr. BINGAMAN. I also ask unanimous consent that we be allowed 2 minutes to advocate for the amendment and the opposition get 2 minutes as well.

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

Mr. BINGAMAN. Mr. President, I will take one of those 2 minutes and Senator DOMENICI the other.

This is a Bingaman-Domenici amendment. The purpose of it is not to eliminate the asset test. That was an earlier amendment I offered and then withdrew. Instead, it is to update the asset test, where you would still be required to demonstrate that your income was below poverty or in that range, but instead of having to demonstrate that your total combined assets were only \$4,000, you would be able to show that they were less than \$10,000.

This also eliminates the paperwork burden that currently is imposed in most States on people who are required to itemize their assets and essentially provide a full financial statement to get the full low-income benefit.

We think this is a needed update on the asset test. It will allow a lot more people to get the full benefit.

I yield the remaining time to Senator DOMENICI.

Mr. DOMENICI. Mr. President, this is a very simple amendment. I believe it is absolutely fair and nothing more than simple equity. We have had an asset test under Medicaid, which applies here, since 1988. It is \$4,000. That means there is an income test and an asset test of \$4,000. I believe the time has come to change that \$4,000 to something more reasonable—not gigantic, just \$10,000. It says the income test still applies, but you can own assets up to \$10,000.

It also says you do not have to fill out all kinds of forms. You can sign an affidavit under penalty of felony, as to what your assets are, and that suffices. If there is anything this bill needs it is simplicity. So this adds simplicity to this form. But most of all, for the poor people, it permits them to own a car today. You know, hardly any cars are worth less than \$4,000. I think you can be poverty stricken and still own an automobile.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. DOMENICI. I believe the amendment should be adopted.

The PRESIDING OFFICER. The Senate will come to order.

The Senator from Maine.

Ms. SNOWE. Mr. President, I urge my colleagues to vote against the amendment offered by Senator BINGAMAN. We are not here to alter the guidelines for the Medicaid Program because it certainly would have an impact on the underlying Medicaid Program.

Let me be clear. We did not create a new asset test for this benefit. We followed the asset test that exists in current law and that governs existing low-income assistance programs under Medicaid and Medicare.

Actually, we learned our lesson from the last debate last fall on the tripartisan bill. We realized in constructing that approach that we excluded 40 percent of low-income Medicare beneficiaries. So this time we built on the existing Medicaid and Medicare Programs. We created a new program for those under 160 percent of the poverty level that has no asset test. By doing so, we capture 8.5 million more Medicare beneficiaries for a total of 17.5 million Medicare beneficiaries or 43 percent of the overall program.

We target our assistance, the most assistance to those most in need. So it is important for our colleagues to understand, we are using asset tests that already exist in current law to maximize the most assistance to those most in need of this benefit.

Mr. President, 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 the amendment.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

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

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

The result was announced—yeas 69, nays 29, as follows:

[Rollcall Vote No. 251 Leg.]

YEAS—69

Akaka	Chambliss	Feinstein
Alexander	Clinton	Graham (FL)
Allen	Coleman	Graham (SC)
Baucus	Collins	Hagel
Bayh	Conrad	Harkin
Bennett	Corzine	Hollings
Biden	Daschle	Hutchison
Bingaman	Dayton	Inouye
Boxer	DeWine	Jeffords
Breaux	Dodd	Johnson
Brownback	Domenici	Kennedy
Byrd	Dorgan	Kohl
Campbell	Durbin	Landrieu
Cantwell	Edwards	Lautenberg
Carper	Ensign	Leahy
Chafee	Feingold	Levin

Lincoln	Nelson (NE)	Schumer
Lugar	Pryor	Smith
McCain	Reed	Specter
Mikulski	Reid	Stabenow
Miller	Roberts	Stevens
Murray	Rockefeller	Warner
Nelson (FL)	Sarbanes	Wyden

NAYS—29

Allard	Fitzgerald	Nickles
Bond	Frist	Santorum
Bunning	Grassley	Sessions
Burns	Gregg	Shelby
Cochran	Hatch	Snowe
Cornyn	Inhofe	Sununu
Craig	Kyl	Talent
Crapo	Lott	Thomas
Dole	McConnell	Voinovich
Enzi	Murkowski	

NOT VOTING—2

Kerry Lieberman

The amendment (No. 1065) was agreed to.

Mr. BINGAMAN. Mr. President, I move to reconsider the vote.

I move to lay that motion on the table.

The motion to lay on the table was agreed to.

CHANGE OF VOTE

Ms. LANDRIEU. Mr. President, on rollcall vote No. 251, I voted nay. I intended to vote yea. It does not change the outcome of the vote. I ask unanimous consent that the RECORD reflect as I have stated.

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

(The foregoing tally has been changed to reflect the above order.)

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

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

Mr. FRIST. Mr. President, I ask unanimous consent that at 2:30 the Senate proceed to a vote in relation to a McConnell or designee amendment regarding Alzheimer's, to be followed immediately by a vote in relation to the Durbin amendment on the same subject, again, with no second degrees in order to either amendment prior to the votes; provided further that the Senate then proceed to a vote in relation to the Dorgan second-degree amendment on premiums to the Grassley-Baucus amendment No. 1092. Finally, I ask unanimous consent that following disposition of the Dorgan amendment, the Senate then proceed to a vote in relation to the underlying Grassley-Baucus amendment, with no other amendments in order to amendment No. 1092 other than the mentioned Kyl and Dorgan amendments. I also ask unanimous consent that there be 2 minutes equally divided for debate between each of the votes in this series as well.

Mr. REID. Reserving the right to object, everyone here is working in the best of faith to try to work through

this situation. We don't have the actual document of the Durbin amendment. I have been told what is in that. I related that to the majority and to the two managers of the bill. It is very similar to the Boxer amendment. If it is anything different than that, I will make sure that we vitiate this agreement.

Mr. MCCONNELL. So if the Durbin amendment is other than we anticipate, I will obviously reserve the right to modify mine as well.

Mr. REID. Absolutely.

Mr. DORGAN. Mr. President, reserving the right to object, I ask the majority leader if in the period between now and when the first vote occurs, there will be provided 30 minutes for the offering and discussion of my amendment. I had previously talked with the Senator from Nevada. Senator PRYOR and I wish to be recognized for 30 minutes to offer our amendment. I simply ask if that timeframe allows that opportunity so that we have 30 minutes of debate.

Mr. MCCONNELL. Mr. President, I would like to make sure I am protected to lay down my amendment now.

The PRESIDING OFFICER. The Senator from Nevada has the floor.

Mr. REID. Mr. President, we have approximately an hour and a half. I would ask, as Senator DORGAN asked earlier, that he and Senator PRYOR be given 30 minutes of that hour and a half, and Senator DURBIN be given a half hour.

The PRESIDING OFFICER. The majority leader has the floor.

Mr. FRIST. Mr. President, I yield to the Senator from Kentucky.

Mr. MCCONNELL. Mr. President, we are talking about how to divide up an hour and a half. How about a consent that we divide the time equally?

Mr. REID. That will be fine. I ask unanimous consent that the agreement give each side an extra 5 minutes, so the vote would occur at 2:40, rather than 2:30, and the time be divided equally.

The PRESIDING OFFICER. Is there objection?

Mr. DORGAN. Reserving the right to object, I don't care what the vote is. Senator PRYOR and I wish to speak for 30 minutes. If that is not provided for in the unanimous consent, I will object.

Mr. REID. That is fine on this side.

Mr. FRIST. Mr. President, we have no objection.

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

The PRESIDING OFFICER. The Senator from Kentucky is recognized.

AMENDMENT NO. 1102

Mr. MCCONNELL. Mr. President, pursuant to the consent agreement just entered into, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Kentucky [Mr. MCCONNELL] proposes an amendment numbered 1102.

Mr. MCCONNELL. 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 protect seniors with Alzheimer's disease)

At the end of subtitle A of title I, add the following:

SEC. —. PROTECTING SENIORS WITH ALZHEIMER'S DISEASE.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with Alzheimer's disease shall be protected from high prescription drug costs in the following manner:

(1) **SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.**—If the individual is a qualified medicare beneficiary (as defined in section 1860D-19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(1) of such Act.

(2) **SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.**—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D-19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D-19(4)(C) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D-17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(2) of such Act.

(3) **SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.**—If the individual is a subsidy-eligible individual (as defined in section 1860D-19(a)(4)(D) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only \$50;

(B) only a percentage of the monthly premium (as described in section 1860D-19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D-19(a)(3)(A).

(4) **ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.**—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with Alzheimer's disease, such individual shall have access to qualified prescription drug coverage (as described in section 1860D-6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of \$275;

(B) the limits on cost-sharing described section 1860D-6(c)(2) of such Act up to, for 2006, an initial coverage limit of \$4,500; and

(C) for 2006, an annual out-of-pocket limit of \$3,700 with 10 percent cost-sharing after that limit is reached.

Mr. MCCONNELL. Mr. President, very briefly, the amendment I just sent to the desk ensures protection of seniors diagnosed with Alzheimer's from the high prescription drug costs associated with that illness.

My amendment states specifically that any senior on Medicare diagnosed with Alzheimer's shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, no more than a 2.5-percent copayment for drug spending up to \$4,500, no more than a 5-percent copayment for drug spending between \$4,500 and \$5,800, and no more than a 2.5-percent copayment for any drug spending over \$5,800 if their income is below the poverty level.

My amendment states that any senior on Medicare diagnosed with Alzheimer's with an income between 100 and 135 percent of the poverty level shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, and no more than a 5-percent copayment for drug spending up to \$4,500, no more than a 10-percent copayment for drug spending between \$4,500 and \$5,800, and no more than a 2.5-percent copayment for any drug spending over \$5,800.

My amendment provides that any senior in Medicare diagnosed with Alzheimer's with an income between 135 percent and 160 percent of the poverty level shall have the right to a drug plan in which the beneficiary shall pay no more than a \$50 deductible, an average monthly premium not greater than \$35, no more than a 10-percent copayment for drug spending up to \$4,500, no more than a 20-percent copayment for drug spending between \$4,500 and \$5,800, and no more than a 10-percent copayment for any drug spending above \$5,800.

My amendment also provides that any senior on Medicare diagnosed with Alzheimer's with an income above 160 percent of the poverty level shall have the right to a drug plan in which the beneficiary shall pay no more than a \$275 deductible, an average monthly premium not greater than \$35, no more than a 50-percent copayment for drug spending up to \$4,500, and no more than a 10-percent copayment for drug spending over \$5,800.

With this amendment, which conforms to the provisions within the bill, all seniors with Alzheimer's get help with drug costs, especially the poor and moderate-income seniors.

I yield the floor.

The PRESIDING OFFICER. Who yields time? The Senator from Iowa.

AMENDMENT NO. 1093 WITHDRAWN

Mr. GRASSLEY. Mr. President, I ask unanimous consent, on behalf of Senator KYL, to withdraw the Kyl amendment to the Grassley amendment.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent that the Dorgan amendment be offered now and the pending amendment be set aside.

The PRESIDING OFFICER. Is there objection? Without objection.

The Senator from North Dakota.

AMENDMENT NO. 1103 TO AMENDMENT NO. 1092

Mr. DORGAN. Mr. President, 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 North Dakota [Mr. DORGAN] for himself and Mr. PRYOR, proposes an amendment numbered 1103.

Mr. DORGAN. 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 reduce aggregate beneficiary obligations by \$2,400,000,000 per year beginning in 2009)

In lieu of the matter proposed to be inserted, insert the following:

SEC. ____ . AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D-17, as added by section 101, is amended by adding at the end the following:

“(d) AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall for each year (beginning with 2009) determine a percentage which—

“(1) shall apply in lieu of the applicable percent otherwise determined under subsection (c) for that year, and

“(2) will result in a decrease of \$2,400,000,000 for that year in the aggregate monthly beneficiary obligations otherwise required of all eligible beneficiaries enrolled in a Medicare Prescription Drug Plan or a Medicare Advantage plan that provides qualified prescription drug coverage.

This subsection shall not apply in determining the applicable percent under subsection (c) for purposes of section 1860D-21.”.

Mr. DORGAN. Mr. President, this is an amendment that deals with the question of what to do about the \$12 billion of remaining available out of the \$400 billion Congress set aside for a prescription drug benefit plan in the Medicare Program. According to CBO, the underlying bill is \$12 billion of that \$400 billion, so what do we do with that \$12 billion? If the bill on the floor of the Senate to add prescription drugs to the Medicare Program costs \$388 billion, and we have allocated \$400 billion, the question is, what do you do with the other \$12 billion? So we had a group of people—I am not quite sure who they were—negotiate over a period of time, and they have now developed a plan for what to do with the \$12 billion.

By far, the simplest, most direct, and most appropriate use of the \$12 billion would be to improve the prescription drug benefit for Medicare recipients. After all, that is why we are here. That is the purpose of this discussion and debate. That is the purpose of writing this legislation—to provide a prescription drug benefit to the Medicare Program that serves the interests of our senior citizens.

Regrettably, the Grassley amendment before us, to which I have just offered a second-degree amendment, does not accomplish those goals. So I offer an amendment that is very simple. It says let's try to improve this prescription drug benefit plan for senior citizens with the \$12 billion that is available.

Let me just mention a word generally about Medicare. We have people on the floor of the Senate who don't like Medicare. They don't say it, I know. One of their colleagues said it yesterday in New York City. It is the only flash of candid comment that I have seen recently. Congressman THOMAS, in the New York Times, dated 6/26, says:

Some of our friends on the other side of the aisle are saying that if this bill becomes law [meaning the Medicare prescription drug bill] it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so.

Let me read it again so we understand what he is saying: “Some of our friends [Democrats, he means] . . . are saying if this bill becomes law, it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so.”

When I was a young boy in a town of 400 people, my dad asked me to drive an old fellow to the hospital in Dickinson, ND. He was a man with a very serious health problem, and he had no relatives, had no vehicle, had no resources. So I was a teenager just about out of high school. I got him in my car and drove him to St. Joseph's Hospital in Dickinson, ND, and dropped him off there to be treated. He had a serious health problem but no insurance, no money, nothing.

The fact is, that was at a period of time in the late 1950s and early 1960s when a good many senior citizens had no capability to get health care. They had no insurance coverage. It wasn't the case that insurance companies were running after old folks to ask them: Can we please sell you a health insurance policy? They want to insure 22-year-olds—healthy, vibrant, young 22-year-olds.

That is where they make money. They don't make money by chasing 75-year-old people and selling them health insurance policies. Back in the early 1960s, one-half of America's elderly had no health insurance—none. None at all.

Then along came Medicare. The Congress had a real debate about that. I wasn't here then, but you know there were naysayers who say no to everything for the first time. They said no, no, no; you cannot create Medicare. Well, we did create Medicare, and now 99 percent of the senior citizens in this country don't have to go to bed at night worrying about whether they can get medical care because they have health care coverage under Medicare. God bless them for that. They needed it, they deserved it, and this country provided it through the Medicare Program.

Some say: We have incredible problems financing this program. Yes, we have some financial problems, no question about that. Do you know how we solve those problems? Go back to the old life expectancy. Go back 100 years and, on average, you were expected to live to 48 years of age in this country. Now people live to 76 to 77 years of age.

Life expectancy has increased dramatically in this country. That is good news. Our financing problems with Medicare are born of good news. People are living longer. Good for them. Good for us. Good for our country.

Is it a problem to have good news? I do not think so. We will solve these issues. But even as we have done that, even as people are living longer and better lives, these new miracle medicines that have been created since Medicare was created are very expensive but very necessary for people to continue their lifestyle. And we have no prescription drug coverage in the Medicare Program.

Clearly, if we wrote Medicare starting from scratch today, we would have prescription drug coverage. That is clear to everyone. But prescription drugs were not a key medical expense when Medicare was created, so now we have to put that coverage in the Medicare Program.

Because some people do not like the Medicare Program—to wit my colleague, Congressman THOMAS who said, “certainly we hope this will be the end of Medicare as we know it,”—they want to privatize Medicare. Now, keep in mind that the private sector is the sector that would not insure old people in the first place, which is the reason why Congress had to develop the Medicare Program.

That brings us back to this question of what to do with the \$12 billion. We are struggling to put together a benefit that means something to the people who need it. This is not theory. It is not a debate in the abstract. It is about some 85-year-old widow who, today, is going to the pharmacy in the back of a grocery store and trying to figure out how much her prescription drugs are going to cost so she can figure out how much money she has left for groceries. That is happening in a real sense today all across this country.

We have \$12 billion. We also have a bill that says to senior citizens: You pay \$35 a month on an optional basis if you want this program of ours, and after \$35 a month, you pay the first \$275 in prescription drugs. Between \$275 and \$4,500, the Federal Government will help you by paying 50 percent of your prescription drug costs. And then between \$4,500 and \$5,800, there is what is famously called the donut hole, which means you receive no coverage.

So you are not covered until you spend \$275, then you are partially covered, then you are not covered again, and then you get catastrophic coverage. This is the most byzantine, complicated system we could possibly put together. It clearly is done by committee. We could not have done this so

badly if it were done without a committee.

Having said all of that, the question is, What do we do with the \$12 billion? We are told today, with the Grassley amendment, that we will provide \$6 billion of the \$12 billion to test a new alternative bidding system for paying PPOs—and if this is not complicated enough, just stay with me—that would reimburse these PPOs based on the median amount of the three lowest bids. There is nothing here that protects American taxpayers by ensuring we are not paying private health plans substantially more than traditional Medicare costs.

Here is what it means in English. It means we are going to have an experiment with private sector delivery, but we are going to incentivize insurance companies. We are going to provide them some of this money so that they will actually want to offer this plan, so we can say at the end of it that somehow the plan is a good plan.

We already know that does not work. My colleague, Senator HOLLINGS, says there is no education in the second kick of a mule. We know this does not work. We know what happens. We know the Medicare Payment Advisory Committee, MedPAC, which is a non-partisan committee that advises Congress on Medicare payment policies, says private plans cost 15 percent more than traditional Medicare. We know that. We do not have to spend \$6 billion giving money to private insurers to do an experiment. We know what does not work. We know the cost advantage of Medicare, and yet our colleagues continue to resist and continue to insist that we move Medicare beneficiaries into the private sector. And now with half of the \$12 billion, they say let's do this little experiment.

Will it enhance the health of senior citizens? No. Will it improve health care? No, not at all. Will it actually improve the underlying bill, improve the benefits, reduce the costs? No, not at all. This is just like a puppy dog following the master home. It is putting more and more money down this chute to pursue this dream of trying to demonstrate something we already know does not work.

Mr. DURBIN. Will the Senator yield?

Mr. DORGAN. I will be happy to yield.

Mr. DURBIN. Do I understand that senior citizens, given the choice between traditional Medicare and Medicare HMOs, have already voted and that 88 or 89 percent of them want traditional Medicare; that they do not want to put their medical fate in the hands of these HMO private insurers who are unreliable, who may or may not cover the procedures they need? Haven't the seniors of this country, with their experience, already voted on this issue we are considering?

Mr. DORGAN. Seniors have already made that judgment. They have already decided that. So we want to take \$6 billion and give it to private health

insurers at a time when Senators have been coming to the Chamber and saying we cannot improve this plan because we do not have any money. I have quotes of all the Senators, and I shall not name them all. I could read lots of quotes from the last 2 weeks of Senators. Why can't we improve it? Because we are limited by money. So now we have \$12 billion more? That is what happens when you go into a room, shut the door, make a little deal, and say this is how we want to use this money: We are going to take \$6 billion and try an experiment that we failed at previously. It makes no sense to me. It is a byzantine failure, in my judgment, to do it this way.

What I am proposing in my amendment is use the money to actually improve the program for senior citizens. We can drive down the cost of the prescription drug policies and improve the coverage.

Mr. DURBIN. I ask the Senator, if he will yield further, is the Senator aware of a recent survey of seniors—over 600 across the United States—where they were told what this plan, S. 1, is all about? They said the fact that the \$35 premium is not mandated in this law but is simply a suggestion; it may go higher; the fact private insurance companies that provide the prescription drug benefit may decide to change the benefit or go out of business every 2 years; the fact there is a \$275 deductible and a huge gap in coverage for the sickness of the senior citizens—when they looked at all those items, is the Senator aware of the fact that most of the seniors, when asked, said they did not believe that S. 1 really answered the need in America that seniors are looking for?

Mr. DORGAN. I know that is the case. I have seen the same survey to which the Senator referred. I think there are some provisions in this bill that have some merit. I prefer we do something rather than do nothing, but when we do something, let's do something right and something that benefits senior citizens. This is the case when you cite the polls, when you cite what our previous experience has been. It is a case, especially with respect to the use of this \$6 billion, of the old joke from the movies: What are you going to believe, me or your own eyes?

The fact is, we have already had these experiments. We understand how much additional costs are involved in the private sector delivery of this benefit, and we also know what Medicare does and how Medicare works. We know the private insurers have about a 14-percent overhead in administrative costs and delivering their service. We know that. We also know Medicare has about a 4-percent cost, a dramatic advantage.

For that reason alone, you would want to provide this benefit through the traditional Medicare delivery system. Against all odds, we have people in this Chamber who, I guess, although they do not say it, believe along with

Congressman THOMAS that this bill ought to be the end of Medicare as we know it. Congressman THOMAS said: Our answer to that is, we certainly hope so.

Mr. DURBIN. I ask the Senator, is it possible Halliburton is going to pay some of these services with the six—I will withdraw that question. I ask the Senator, if one believes in privatization and competition, why does the private sector need a \$6 billion subsidy to compete with Medicare? If they are good, if they are efficient, if they are customer friendly, why do they need this Federal subsidy of \$6 billion to offer an attractive health care package to seniors?

Mr. DORGAN. First, they do not need it, and no subsidy is warranted. The point of my amendment is to say if you have \$12 billion, and they say let's take \$6 billion and use it for an experiment that we know does not work, let's instead use that money to help seniors. Then the underlying amendment says let's take another \$6 billion and test whether focusing on wellness will work, which we know it does work. We do not exactly have to have an experiment on that. Do things that promote wellness and the fact is you save money on the acute care side by not having people go into the hospital because they are taking care of themselves and have the kind of preventive care that is necessary to take care of themselves.

I have another amendment pending. It has been pending for nearly a week. I hope it will be approved by the end of this process. It is a very inexpensive amendment that deals with that very kind of wellness approach.

If senior citizens have heart disease, Medicare covers cholesterol screening. It makes sense, does it not? But Medicare does not cover cholesterol screening if one does not know they have heart disease. It does not make sense.

Heart disease is our biggest killer in this country. We ought to cover cholesterol screening across the board. That is the way one can discover who is at risk for heart disease at a point when steps can be taken to prevent it. Yet Medicare does not cover that screening unless a person already has evidence of heart disease.

There are many things we should do to improve Medicare's preventive coverage. My hope is that perhaps we will have that amendment approved before the end of this process.

My colleague from Illinois talked about HMOs a moment ago. We are not in the trenches of the HMO debate as it was first envisioned by the White House, which said to senior citizens, here is a Faustian bargain: we will give you a prescription drug benefit but only if you enroll in an HMO. Talk about a goofy proposal; that is it.

I have been talking about HMOs. There were some HMOs that did some good things, held down some prices. I understand that. But we have all also heard the stories of HMOs not taking

good care of people. I guess we do not need to review the HMO stories about what happens to patients when profits were at stake. For instance, a woman falls off a cliff in the Shenandoah Mountains, sustains very serious head injuries and body injuries. She is hauled into an emergency room on a gurney in a coma. After a long convalescence, she finally gets out of the hospital only to be told by her HMO that they will not cover her emergency room treatment because she did not have prior approval to use the emergency room. This is a woman who is hauled in on a gurney in a coma.

I will not revisit all of those HMO stories because it will take too much time, but I will say this: With Medicare, we know what works. Some of my colleagues make the case that it costs too much. Do my colleagues really know what costs too much in Medicare? It costs too much because people are living too long. What a wonderful set of victories we have in this country. With great health care, people are living longer.

I probably should not talk about my uncle again, but I have an 81-year-old uncle who runs the 400 meter and 800 meter in the Senior Olympics. He is probably out running today. He runs 3 miles a day at 81 years old. Forty years ago, one reached 81 years old and they had to be in a chair someplace, but not any longer. People live longer, doing things no one ever expected them to do. And that includes my uncle. Good for them. Good for him. But because people live longer, Medicare costs more. That is not a sign of failure; it is a sign of success.

Now we are trying to add to Medicare that which should have been added some long while ago: The miracle drugs that do provide miracles but only if one can afford them. We are talking about covering the drugs that keep seniors out of the hospital and they do not have to go into an acute care hospital bed. That is what we are dealing with.

With this amendment, we are dealing with \$12 billion. Instead of bifurcating it into two different experiments, one of which failed and one of which we do not need because we know the answer, what I propose we do is use that \$12 billion to reduce from \$43 to \$38 the premium our senior citizens will have to pay for this prescription drug benefit, starting in 2009.

There are people who live on \$350 or \$450 a month, their total income from their miserable little Social Security payment, who are living alone in a small town, are struggling to buy food, struggling to buy the necessities of life. There are people who have been told by their doctor: Oh, by the way, you have heart disease and diabetes, and here are the prescription drugs you need; and they sit at home knowing they do not have a penny to pay for those prescription medicines. Talk to those seniors and understand how important this coverage is. The coverage

ought to be good and extensive coverage, and it ought to provide what we know we should provide for senior citizens.

Second, it ought to be done in an affordable way. Unfortunately, another weakness of this plan is that there is no defined benefit, which means the premiums can vary. The monthly premiums will increase year after year because we have not done enough to put downward pressure on prescription drug prices—and as prescription drug prices increase, the monthly premium will increase. The expectation is that the monthly premium starts at \$35 and goes to \$60 in a 10-year period. My amendment proposes about a \$6 reduction in the monthly premium for senior citizens. That is a more effective way to use this \$12 billion. Either that, or I would propose we extend the coverage through the \$1,300 gap that exists in coverage, which I think would also represent a meritorious way of using this amount of money.

My colleague, Senator PRYOR from Arkansas, is in the Chamber and he may wish to address this issue as well. I have offered this amendment on behalf of myself and my colleague Senator PRYOR, so I yield the floor in the hope that Senator PRYOR will wish to make some comments as well.

Mr. GRASSLEY. Mr. President, it is unfair for Members of the other side of the aisle to give us statistics that say 89 percent of the seniors are in for-fee-for-service Medicare and only 11 percent are in Medicare+Choice and that is a nationwide average. It is an accurate statistic, but it does not speak to the seniors of America who like Medicare+Choice and I have figures from four cities—Miami, New York, San Francisco, and Chicago.

In Miami, 45 percent of the senior citizens have chosen managed care, the Medicare+Choice option, as opposed to fee-for-service; New York, 22 percent; San Francisco, 29 percent. In Chicago, it was only 6 percent. That may be one reason why Senator DURBIN keeps bringing this up quite regularly. This data is from the Congressional Research Service, and it is as recent as March 2003.

When people, wherever they are in the Senate, want to denigrate Medicare+Choice by saying only 11 percent of the people in this country join in and that is such a small percentage and that these figures are evidence it is not liked, go to Miami and ask 45 percent of the citizens who belong to Medicare+Choice why they like it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. PRYOR. Mr. President, last night was a difficult night for me because I was lying in bed worrying about the insurance companies and how we were not getting them enough money during this Congress. Of course, I am being facetious because I think we have a very clear choice.

I commend Senator DORGAN, Senator DURBIN, and a number of others who

have shown national leadership on this effort to try to make this bill better. I think there is a broad consensus that we want to add a prescription drug benefit to Medicare. We want to help seniors all over this country, but at the same time we have to make sure it is set up the right way. It has to make sense.

Quite frankly, one of the things that to me does not make sense, and probably to most people around the country does not make sense, is that we might give a pretty healthy sum of money to the insurance industry.

All over the country—and I know it is certainly true in my State—insurance companies are raising premiums. It may be health care premiums—everybody knows those are going up. It may be property and casualty; it may be homeowners policies, auto policies, medical malpractice, legal malpractice. You name it, across the board, as far as I know, the price of every single kind of insurance in this country is going up.

Nonetheless, there are some in this Congress who want to actually give them a sizable chunk of money that could go to people who really need the help.

I take my hat off to Senator DORGAN for his leadership. One thing he has figured out is a way to make the monthly premium less for people. Now, saving \$6 a month to someone at my income level, and all of our income levels, that is not a lot of money, but for those senior citizens all over this country who live below the poverty level—the only money they get every month is Social Security, maybe a little help from the family—\$6 is a lot of money. Six dollars may make this program affordable for them. It is real money. It is money that at the end of the year, if you add it up, is only \$72 a year, but that is real money to so many Americans all over this country.

The purpose of the bill, not just this amendment but the whole bill, is to help Americans afford their prescription drugs. I know that Senator DURBIN, who is in the Chamber, and Senator DORGAN and a number of others in this Chamber have tried to make prescription drugs more affordable in this legislation. There have been different efforts tried in different ways. One of the things I tried was to strengthen reimportation from Canada to try to make prescription drugs more affordable, but certainly making the premiums more affordable makes the program more accessible to more Americans. That is a win/win/win for everybody.

So I thank the Senator from North Dakota for yielding me some of his time. I know he is frantically talking to colleagues to try to have them adopt this amendment when we vote on it this afternoon.

Let's run through the numbers very quickly one more time so we understand clearly what we are talking about. This amendment expends \$2.4

billion per year to make premiums cheaper. It will reduce the typical premium—this is average—by \$6 a month.

I take my hat off to the folks in this Chamber who worked out compromise after compromise after compromise trying to come up with solutions to make this bill something that will become law, something that the majority of Members can vote for, not just in this Chamber but the House, something the President can sign.

I believe strongly people in this country deserve to have access to these wonderful prescription medications that are in many ways miracle drugs. It is a shame for this country to have these drugs available on the marketplace but so expensive that people cannot afford them. That is what we are trying to accomplish.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I thank my colleague from Arkansas as well as my colleague from North Dakota. They have come to the floor and said to the Members of the Senate, look, we found \$12 billion. Imagine \$12 billion over a period of time. We are in the middle of debating a prescription drug bill. What would the Senate do with new found money, \$12 billion worth?

We took a look at the underlying bill, the prescription drug bill. There are a lot of problems with it. There is no guaranteed monthly premium. It has a deductible. It has a period of time when there is no coverage. You are paying prescription drug bills and you have no protection, no coverage. There are a lot of uncertainties in this bill.

You would think the first thing you would do with the \$12 billion is make this a stronger bill, try to take care of some of the weaknesses, the deficiencies.

Wrong. Given \$12 billion, an agreement has been reached not to give the money to the seniors to help them pay for prescription drugs but to give \$6 billion to HMOs and private insurance companies, a \$6 billion Federal subsidy so they can experiment with alternatives to Medicare.

I am like my colleague from Arkansas; I could not get a moment's rest last night for fear that we just were not going to give enough money to the insurance companies when this was all over with. I lost all my sleep the night before worried about the fact that maybe pharmaceutical companies would not get all the money that we could possibly throw their way. Then along comes this amendment. We can rest easy tonight because we will give \$6 billion to HMOs. This industry which manufactures the milk of human kindness for seniors and families across the America by denying basic health care coverage so they can run up profits is going to need a Federal subsidy.

What a delicious irony that we cannot help poor seniors trying to pay for prescription drugs because, Senator, we just do not have enough money. And we

cannot help our schools, we cannot pay for President Bush's No Child Left Behind, this unfunded mandate on everybody's local schools because, Senator, we just do not have enough money. But the \$6 billion we just found we are going to give to the HMO insurance industry.

When they write the history of this debate, this amendment will stand out. This amendment is a tribute to selfishness, a tribute to shortsightedness. Why in the world aren't we helping the people who need it the most? Why are we giving the money to the HMOs so they can experiment with an effort to end Medicare?

I just ran into BILL THOMAS in the hallway, chairman of the House Ways and Means Committee, most powerful man when it comes to Medicare in the House of Representatives. He said in today's New York Times:

Some of our friends on the other side of the aisle are saying if this bill becomes law, it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so.

Well, thank you, Congressman THOMAS, for your candor. And your candor is the reason why so many Senators have now come to the Senate and said the only way to end Medicare is to subsidize HMOs with even more money so they can be more profitable and try to force Medicare out of business. That is what it is all about.

My colleagues will have two choices. They can join me in voting with Senator DORGAN, Senator PRYOR, and others and say if you have \$12 billion, for goodness' sake, put it into this bill. Make this bill a little better for seniors. Reduce the cost for seniors. Give them some assurance of what they will pay. Provide more prescription drug coverage. That is one option. I will support it.

If it does not succeed, I will offer a second option. It reaches a point under the bill we are debating, during the course of a year, when there is a gap in coverage where the Federal Government will not help pay one penny on your prescription drugs, and about \$3,700 into the year out-of-pocket expenses for prescription drugs, this plan cuts off. The underlying plan says you are on your own until you get in the range of \$5,500. Then we will start paying you again. So there is a gap in coverage where that senior citizen, that widow living by herself, has to pay all of the prescription drug bills until she reaches the catastrophic coverage level.

This would not be a problem if you did not have over \$3,700 in prescription drugs a year. But a lot of seniors do. I have run into them, met them in Illinois, heard their testimony on Capitol Hill from across the country.

I will offer an alternative to my colleagues in the Senate that says simply this: We want to make sure people who suffer from some of the most expensive diseases that afflict senior citizens can pay for their medication. So we will take the \$12 billion and we will put it

into the basic bill and cover heart disease, cancer, Alzheimer's, diabetes and its complications.

We are not going to leave you high and dry. At the end of \$3,700 of subsidy from the Government, we are going to take the \$12 billion and put them back in there to try to keep helping you if you are afflicted with one of these diseases.

I will readily concede to my colleagues that I can think of a half a dozen other diseases where people have horrendous prescription drug bills and need help but I will try to appeal to my colleagues. Here is your choice. You have a parent or a grandparent, suffering from cancer, who has to buy expensive drugs to stay alive. The Government program that we are proposing stops paying for those drugs halfway through the year because they have reached a point where they spent \$3,700 and now they have to wait and spend another \$1,500 to \$1,800 of their own money before they have coverage. You can help them pay for those cancer therapies or you can send \$6 billion in Federal subsidies to HMO insurance companies.

That is the choice. It is a fairly straightforward choice.

According to a July 2002 study, heart disease and hypertension are the most expensive conditions to treat. Millions of Medicare beneficiaries are suffering from them and struggling to pay for their medications. That is one of the conditions we would help pay for with the \$12 billion, \$6 billion of which is headed for these private insurance companies' subsidy.

The majority of America's cancer patients are on Medicare. They are your parents and grandparents. They are struggling with all forms of cancer. Nearly 60 percent of new cancer diagnoses and 50 percent of all cancer-related deaths occur in people 65 years and older.

I am not identifying a problem that does not exist. It exists. Ask any family about cancer, my family included. We all have stories to tell. And you know how expensive it is now to keep that loved one alive to try to give them a chance to survive. This bill cuts them off and leaves them high and dry. My amendment gives them a chance.

More than 2 million of all Medicare beneficiaries will have cancer in 2003. Let me give an example of a couple who wrote to my office. They wrote a couple years ago from a downstate community, a small community. It is one of the letters that Senators get every day, one that we saved. It was sent to us in September of 2002.

Dear Senator DURBIN:

My wife has multiple myeloma, which is a cancer of the bone marrow. This disease, while controllable, is not curable. As a result, she has to take a great deal of drugs for physical as well as mental anxiety.

Last year our combined prescription drug bill [and this is the year 2000] was \$4,500. This year our regular prescription drug bills will be more.

Now my wife Marion has been put on Thalidomide. A great many multiple myeloma

patients are now on Thalidomide. Said drug is very expensive. With a low dose [and this is in the year 2000] it is \$455.99 a month.

Incidentally, we checked. That same low dose now costs \$645 a month. So in 3 years it has gone up over 40 percent. It costs them \$5,500 a year just for that drug. This is an elderly couple in their retirement on a fixed income, fighting cancer, putting every dollar in their savings into keeping one of them alive. Think about \$644 a month. Think about seniors trying to survive on \$1,100 a month on Social Security. And think about this bill which says to this family from Illinois and others just like them: I am sorry, but at some point we are going to stop paying.

Doesn't it make more sense for us to take the \$6 billion and not give it in a subsidy to these private insurance companies but instead give it to these seniors to help them pay these bills? I think it does.

I don't have to tell you the story of Alzheimer's. Is there a family in America that does not have a loved one or a friend who is struggling with some form of Alzheimer's? God bless us; we are living longer, but as we do life gets more complicated. Let me give an example of a gentleman in Maplewood, MN. His annual out-of-pocket drug costs for Alzheimer's are \$7,000—annual cost. This man is 78 years old. He pays as much out of pocket for prescription drugs as he does for all of his other household expenses combined. He is a World War II vet, father of three. He is a full-time caregiver for his wife. He hasn't had a vacation in 5 years. He has given up what he loves to do because he just can't afford them.

"I am managing the cost, but I'm pretty nervous about it," he says. Medicare can do something to help. Yes, it can. That is our choice. Are we going to do something to help these seniors facing the most expensive medical conditions or are we going to give \$6 billion to private HMOs in a Federal subsidy?

The last one I include is diabetes and its complications. I am sad to report to you, those who are following this debate, diabetes is reaching epidemic proportions in America. Over 6 percent of the American population suffers from some form of diabetes. In the late stages of diabetes, the complications become horrible: Amputations, blindness, severe problems.

Faced with this in your senior retirement years, depending on a prescription drug plan, do you really want to say to these people and these families battling diabetes and its complications: We are going to cut you off. We would love to give you more but frankly we have to help the HMO insurance companies. Those are the ones who really need a helping hand.

You couldn't take that argument to any town in America. You couldn't take it to any public meeting. You couldn't take it to any senior citizens. You couldn't take it to any family with a loved one struggling with one of these diseases.

So my friends on the floor of the Senate are going to have a choice: \$6 billion in Federal subsidies for HMOs or \$6 billion to help seniors struggling with these terrible, life-threatening, expensive conditions, to pay their prescription drug bills. I think that choice is easy. I hope the majority of the Senate agrees.

I reserve the remainder of my time. The PRESIDING OFFICER. Who yields time? The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might consume to address the issue of the amendment by the Senator from North Dakota and his attempt to take money from the \$12 billion that is the bipartisan compromise that is a major compromise on this amendment between Republicans and Democrats. The \$12 billion is being divided: \$6 billion to make the marketplace provider organizations more competitive, to save money, and to get people into organizations that will manage particularly chronic disease; and the other \$6 billion to go for Medicare demonstration projects to do the same, have about the same result, to have chronic disease management.

The reason for this compromise is both approaches deal with the issue that 5 percent of the sick people under Medicare are responsible for about 50 percent or 55 percent of the cost of Medicare. It is a small segment of people. If we were in business and we found 5 percent of our employees, or a certain problem we had with our business that was just 5 percent of it, but it was 50 percent of the cost of our business, we would hone in on that problem with the particular business.

The Federal Government is in the business of providing health care for our seniors. If we have 5 percent of our senior population who, for various reasons, are the cause of 50 percent of the costs of Medicare, then quite obviously we ought to concentrate on that 5 percent. We have plans to do that. This is how we use this \$12 billion, and we do it in a bipartisan way.

Honestly, the Senator from North Dakota is very open about it; he has a better idea how to use that money. He would take it to lower the monthly premium paid by beneficiaries in the new Part D prescription drug program.

I have at least two problems with that. First of all, the Congressional Budget Office's rule of thumb is that it costs around \$5 billion to lower the estimated \$35-a-month premium by just \$1. You spend \$5 billion and reduce the monthly premium from \$35 down to \$34. So if you take the \$12 billion that is available in the Grassley-Baucus amendment and use that to lower the premium for the people he wants to lower the premium for, instead of paying \$35 a month they will be paying \$32.50 a month.

My colleagues have to weigh that against the use of this money where we want to focus in on fee for service as well as the new Medicare Program, ze-

roing in on trying to save Medicare money by managing the chronic disease situations of the 5 percent of the most sick people under Medicare.

So the underlying Grassley-Baucus amendment, I remind my colleagues, authorizes the Secretary to establish a number of projects in fee-for-service Medicare Programs that would provide these enhanced services and benefits for beneficiaries. These enhanced services or benefits include preventive services, chronic care coordination, and disease management services. These are very worthwhile projects and have the potential to help many beneficiaries get better care and considerably reduce the cost in the Medicare Program.

I don't know how many Members on the other side of the aisle have worked with this issue we are trying to put \$6 billion toward, chronic disease management. A lot of people who have the same political philosophy as the Senator from North Dakota are very concerned about doing that. We are concerned on this side about doing it as well. That is why it is a bipartisan piece of legislation.

I don't know how, in good conscience, the Senator from North Dakota can take money that would reduce a monthly premium by \$2.50, still costing \$32.50, away from chronic disease management and a lot of other things that people on his side of the aisle are very concerned about.

It would not be possible to do these projects that we have in the underlying amendment. It seems to me that the Grassley-Baucus amendment with this bipartisan compromise of \$6 billion enhanced membership in PPOs as well as \$6 billion for chronic disease management in the older fee-for-service Medicare Program is preferable to the second-degree amendment offered by the Senator from North Dakota.

I urge my colleagues to not support the amendment by the Senator from North Dakota.

This is the second or third time I have heard that seniors have voted on whether they like fee for service or Medicare+Choice, the argument being 89 percent of the people in this country are in fee for service. Eleven are in managed care, Medicare+Choice, HMO, whatever you want to call it. That is true for the Nation as a whole.

But remember that in the vast geographical part of America HMOs are not available. In the State of Iowa, only 1 county out of 99 has an HMO for our seniors to join. We have 4,000 Iowans in Medicare+Choice. No place else in Iowa can my citizens get it. The Des Moines Register is always editorializing why more of Iowa cannot have Medicare+Choice so the seniors of our country have that opportunity.

But what is unfair about the 89 percent versus the 11 percent, and Senators making statements that it is so overwhelming that seniors do not like Medicare+Choice, is the fact that if more had that choice more would take it.

I use, as a basis for my statement, that in the larger cities of America a much higher percentage of seniors have decided to join Medicare+Choice. They do it voluntarily. They can go in one year and get out the next, if they don't like it. They have voted by a much higher percentage in favor of Medicare+Choice. They like it because they get more for their money. First, they do not have to pay Medigap insurance. Second, they might get things such as eye glasses and a better deal on prescription drugs than people who are in traditional Medicare fee for service. Where they have had a chance to have that option, a much higher percentage of seniors than 11 percent will join. All you have to do is talk to people in my State who go to Arizona, California, and Florida for maybe the winter and find out about what people in those States have when they join Medicare+Choice. They ask, Why can't we have that in more places in the country?

A couple of speakers on the other side of the aisle have talked about wasting money with Medicare+Choice. I think you ought to ask the seniors who join and who like it. That is a much higher percentage than 11 percent in a lot of the cities. It is not a fair comparison to imply that since only 11 percent of the people in the country have it and because such a high percentage can't get it that Medicare+Choice is not desired by seniors of America.

Our underlying legislation, the Grassley-Baucus bill, is going to make that opportunity more available for people down the road as we bring in new options. What we want to do in the underlying bill is give our seniors the right to choose. Not enough of them have a right to choose. They have a right to choose prescription drugs. They don't want to join for prescription drugs if they don't have to. They have a right to choose between traditional Medicare. If seniors say they are satisfied with what they have, I can say to those seniors that they can keep what they have. It is their choice. But if you want to go over here and join something that has more options, you will have that right to choose. You should have that right to choose.

One of the complaints people made about the President's program was that if you were going to get prescription drugs you had to go over to a new type of Medicare. In traditional Medicare, you could not get prescription drugs—or at least not much of a program; at least not equal to what you could get over here in the new program.

That is where Senator BAUCUS and I disagree with the President of the United States. We believe in equal benefits. If you want prescription drugs, if you want to join it voluntarily, and if you want to stay in traditional Medicare fee for service, you can have prescription drugs. If you want to go over here and choose a new form and have

prescription drugs with it, that is your choice.

The right to choose and fairness and equality and no pressure is the basis for this bipartisan Grassley-Baucus legislation. That is the basis for the compromise amendment that is before us which the Senator from North Dakota wants to detract from and use the money someplace else.

I think we need to keep this balanced approach. We need to keep the fairness, the equality, and no pressure and the right to choose. Seniors should have options just as other people have.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

AMENDMENT NO. 1108

Mr. DURBIN. Mr. President, I call up my amendment, which I send to the desk pursuant to the unanimous consent request.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Illinois [Mr. DURBIN] proposes an amendment numbered 1108.

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 provide additional assistance for certain eligible beneficiaries under part D)

At the appropriate place insert the following:

SEC. ____ ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES UNDER PART D.

Section 1860D-26, as added by section 101, is amended by adding at the end the following:“(d) ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES.—

“(1) PROGRAM.—Subject to paragraph (2), the Administrator shall implement a program (for the period beginning on January 1, 2009, and ending on September 30, 2013) to provide additional assistance to applicable eligible beneficiaries who have reached the initial coverage limit described in section 1860D-6(c)(3) for the year but have not reached the annual out-of-pocket limit under section 1860D-6(c)(4)(A) for the year in order to reduce the cost-sharing requirement during this coverage gap.

“(2) FUNDING LIMITATION.—The Administrator shall implement the program described in paragraph (1) in such a manner that will result in a decrease of \$12,000,000,000 in cost-sharing for covered drugs under part D by applicable eligible beneficiaries during the period described in such paragraph. The Administrator shall take appropriate steps to ensure that the costs of the program during such period do not exceed \$12,000,000,000.

“(3) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term ‘applicable eligible beneficiary’ means an eligible beneficiary with cardiovascular disease, diabetes and its complications, cancer, or Alzheimer's disease who is enrolled under part D.”

Mr. DURBIN. Mr. President, I will speak briefly because I have to go to another meeting and return for the vote.

I have great respect for the Senators from Iowa and Montana, but I struggle

to understand why we are giving a \$6 billion subsidy to the HMOs in America. If they are so good, if they are so efficient, if the free market is truly better than the Government-run Medicare system, why in the world do they need \$6 billion worth of the taxpayers' money? You know that of that \$6 billion hundreds of millions of dollars are going to go to them in profits. We are literally subsidizing the profits of these companies. We are creating this artificial environment that suggests these companies can do just as good a job or better than Medicare with the \$6 billion Federal subsidy to make it work.

I can't understand why my colleagues on the conservative side who are hidebound apostles of the free market system don't even wince when it comes to sending \$6 billion to the HMOs and the private insurance industry in order to let them play on the field for health care for seniors in America. I don't get it. I certainly don't understand why you wouldn't take that same money to protect the most vulnerable people in America—our senior citizens who are struggling with heart disease, cancer, Alzheimer's, and diabetes and its complications. Why is the money for the boardrooms of the HMOs a good expenditure of tax dollars and the money for the family rooms of senior citizens struggling with these deadly diseases not a good investment with taxpayer dollars?

The underlying bill is the biggest breakthrough for the American pharmaceutical industry since the establishment of patents in the Constitution. This amendment with \$6 billion in flatout tax subsidies to HMOs is the answer to the prayers of the insurance companies in America.

Is that what the Senate is all about? Are we supposed to come here to make certain that the wealthiest corporations in America get wealthier? I don't think so. They are doing quite well. The rate of return for pharmaceutical companies across America is 18 percent. The average for the S&P companies is 3 percent. These companies are immensely wealthy and profitable. We help them even more with this bill. We know how well the insurance companies are doing. We know the bonuses they give their executives and we are going to plow in \$6 billion to make it even wealthier.

There is something else wrong. We know that a lot of average citizens in America—particularly senior citizens—are struggling. Pick up the morning papers. Whether it is the Washington Post or the New York Times, they go to speak to seniors in their real-life environment and talk to them about how they survive. Some of them are well off. Some are lucky. They have saved a lot of money or they have a good and generous retirement but a lot of them do not. A lot of them are literally struggling month to month, some even week to week, just to get by.

This morning in the Washington Post there was a story about a widow lady who said: At the end of the month, I'm lucky if I have a dollar left over. At the end of the article she said: I wonder how many Senators have ever thought about trying to live on \$1,100 a month.

I don't know how she does it. I don't know how a lot of people do it in my State. Why wouldn't we want to help these people? Why is it the pharmaceutical companies and the HMOs are more important than the most vulnerable people in society? I don't get it.

Frankly, I think a lot of our colleagues, as I said earlier, ought to take these arguments, which sound so good on the floor of the Senate, back to the real world of the State they represent, take them into the town of their choice, the public meeting of their choice, and explain to people why HMOs need a subsidy but seniors do not need a helping hand. It just does not work.

So I will be offering an amendment that says we will take this \$12 billion and focus it on the elderly people who suffer from some of the worst and most demanding diseases.

I reserve the remainder of my time.

The PRESIDING OFFICER (Mr. ALEXANDER). Who yields time?

The Senator from Montana.

Mr. BAUCUS. Mr. President, I listened quite closely to the Senator from Illinois, as well as to the Senator from North Dakota. They are each offering a separate amendment, but they are both similar in an attempt, generally, to accomplish the same result.

I say to my good friend from Illinois, as well as my good friend from North Dakota, who is presently not in the Chamber, I am very sympathetic. If I had my way, we would be spending this newly found \$12 billion very much in the way the Senator suggested. In fact, there are a lot of good ways. It is not only helping those with Alzheimer's, but it is also lowering the premium. There are a lot of ways we could be spending dollars to help get more drug benefits to more seniors. There is no doubt about that. But, unfortunately, we are 100 Senators.

The Senator from Illinois, the Senator from North Dakota, and I have a view of how some of these dollars should be spent in a perfect world, but the world is not perfect. This is a democracy. It is messy. As Winston Churchill once said—I will paraphrase very poorly, but the Senator knows this quote—basically, Winston Churchill said: A democracy, for all its fits and starts and delays and inefficiencies and herky-jerky jolting, and all that, is the world's worst form of government, except for all the others.

Here we are, in a democratic process, trying to figure out how to get prescription drug benefits to seniors. We have 100 Senators. I don't know of very many timid Senators. We don't have many Senators who don't speak their views. I don't know very many Senators who don't have strong views

about subjects. I don't know of many Senators who are not thoughtful, articulate, and fighting hard for their constituents. And we have, as it turns out, Senators from two political parties: 51 Republicans, 48 Democrats, and 1 Independent; and at this time we are attempting to finally get prescription drug benefits to seniors.

This issue has been debated for 4 years, at least. It has been a politicized issue for 4 years. There has been a lot of talk for 4 years, a lot of rhetoric on both sides of the aisle for 4 years, and during all the talking there has not been any action; it has been all words, no deeds.

Well, here we are, at a time—after 4 years of just political posturing, to a large degree—where we are on the brink of getting prescription drug benefits passed for our seniors in our country.

Is it the best bill in the world? No. Could it be better? Yes. Do all Senators wish it could be better? Yes. But is it a good start? Is it a beginning? Is it a platform on which we can begin to build? Absolutely.

If we go back and look at the history of health care and assistance by the Government in providing health care to the needy and to Americans generally, it is a history of building, of starting somewhere, building on it, and making it better and better all the time.

Back in the 1930s it was the Wagner-Murray-Dingell legislation that was introduced to provide national health insurance for Americans. That was the idea: We need national health insurance for Americans.

Well, it was debated and debated. Not a lot more really happened. Then suddenly things changed in the 1960s. The idea of Medicare came along: Why not help at least our seniors? If we can't get national health insurance, the very least we can do is help our senior citizens get a break with respect to their health care bills. That is a good place to at least begin—by helping a good, solid segment of the population. And we did, back in 1965, by providing Medicare. And look what has happened since then. We have kept building on Medicare to make it better.

When Medicare was first enacted, 50 percent of a Part B premium was paid by the senior and the Government paid the other 50 percent of the premium for Part B. That is for doctor services. Now it is 25 percent. It has been improved over time. We also have added more benefits, some screening provisions. End-stage renal treatment has been added. There is a list of new additions to help our senior citizens.

Here we are now, on the brink of adding another major benefit: prescription drugs. After all these years, all the years of talking and talking and politicking and giving statements and speeches, we are finally on the brink of getting prescription drug benefits passed.

It has not been easy. Why has it not been easy? It has not been easy because

there are two competing philosophies on the floor of the Senate on how to get prescription drug benefits to seniors. Even though the two competing philosophies are very different from each other, Senators on both sides of the aisle—most Senators, maybe even all Senators, but certainly most Senators—still want to work as hard as they can to try to fit these competing philosophies together in order to pass legislation this year to begin finally getting prescription drug benefits to seniors.

Also, these two competing philosophies are very different. One is competition. The argument is: Let private companies, themselves, with assistance from the Government, design how they give prescription drug benefits to our senior citizens, make them available at a big discount for senior citizens. The other philosophy is: Medicare should be the agency that should be the way—traditional Medicare, basically—to provide discounts for senior citizens to get drugs.

Essentially, the competing philosophies are 50-50. You have 51 Republicans, 48 Democrats, and 1 Independent. What are we going to do? Well, all we can do, if we want to get this done, is to just try our best to put these two together in a fair, balanced way—and the private competition model gets a break, gets a fair chance to see the degree to which it might work—so that senior citizens really do get the benefits and are not taken advantage of during our efforts to pass legislation.

It is a balance. It is trying to find the right way to accomplish that balance. It has been extremely difficult. I do not have to tell the Presiding Officer just how hard this has been. But we are right on the brink.

We are limited to \$400 billion in providing the drug benefits for seniors over the next 10 years. Why are we limited to \$400 billion? Well, this body passed a budget resolution not too long ago—both the House and the Senate—saying we are going to set aside \$400 billion for prescription drug benefits for seniors. We never set aside anything like that in the past. So we have an opportunity now to use it. I don't think Senators want to miss this opportunity. I think they want to use the dollars that are there to get prescription drug benefits for seniors.

Well, as it turned out, when the Senate Finance Committee wrote this bill, trying its hardest to be balanced—and it is balanced; the best evidence of that is it passed by a large majority from both parties in the Finance Committee—we found it actually cost only about \$388 billion. There was \$12 billion remaining.

So the question before us is how we can spend that \$12 billion. That is the question. In an attempt to maintain a balance and to work on two competing models and in an attempt to get the legislation passed so we can provide a prescription drug benefit to seniors, we

have decided to split it, 6 and 6; \$6 billion to the PPOs, have it available potentially for PPOs, if that is needed for the bidding process, beginning in the year 2009. I don't know how many Senators are going to be here in 2009, but at least beginning then. The other \$6 billion, beginning in 2009, will then go, under Medicare fee for services, for disease management, chronic care, to help particularly seniors who really need that disease management and chronic care. It is really needed because there is very little disease management today under traditional Medicare. That is one of its shortcomings. That is what we have done.

Again it is a balance, a start, a beginning. I have a lot of sympathy with my friends on this side of the aisle. If I had my druthers and I were the only one writing this bill, I would take that \$12 billion and spend it along the lines they are suggesting. But I am not the only Senator here. I am one of 100. It is my job and that of the chairman of the committee, Senator GRASSLEY, to try to find a balance—not for the sake of balance but for the sake of getting legislation passed so we can finally get prescription drugs to seniors.

If the amendments offered by the Senators from North Dakota or Illinois were to pass, guess what would happen. First of all, those are killer amendments. If those amendments were to pass, that would mean this bill is in jeopardy of passage. That would mean senior citizens may not get the prescription drug benefits we are all trying to get; albeit just a first step, or it could also mean, on the other hand—and this is perhaps even more likely—if that amendment were to pass, I will bet you dollars to donuts—which is not a good phrase to use because we are trying to put dollars in the donut hole—the conservative part of this body, the Republican side of the aisle, would say: We are going to take that \$12 billion and spend it our way. And they have the votes. They have the White House. So this amendment puts in jeopardy a very delicate, very balanced kind of deal between competing philosophies, fairly and evenly, so that we can get prescription drug legislation passed, so that we are just not talking about it anymore and finally doing something about it.

If it were to pass or looked like it would pass, the other side, which has more votes than this side has, would say: We will spend it our way.

Then colleagues on my side of the aisle would be quite distressed. They would be forced to ask themselves if they would support on final passage a bill way off to the right for competition instead of the bill which currently exists, particularly with the underlying amendment. I wish we could do more but at least it is a first step. If the history of Medicare is any guide, in future years we will continue to make it better. We will work on that donut hole. We will fill in the gaps. We will make sure premiums are not too high.

We will try to help with Alzheimer's and all the other measures we desperately need to pay attention to as the days and years go by.

I implore my colleagues to think a little bit. Resist the siren song of doing something that sounds good but which very well could put the bill in real jeopardy. This is fair. It has \$6 billion which may or may not be used for PPOs, depending upon what the bids are. This bill cuts off after a 5-year period; no more \$6 billion can be spent. And \$6 billion for disease management under traditional Medicare which will be spent. That is the question. Do you want balance or do you want to try to get something else passed right now that you like in the short term but could very well jeopardize the whole bill, which means another year, year 5, Congress is talking about this issue, Congress is not doing anything about it. Rather, we want year 1, we have finally got it done.

We are very close to getting it done. It is not perfect, but we will keep working on it over the years.

The PRESIDING OFFICER. Who yields time?

AMENDMENT NO. 1037, AS MODIFIED

Mr. BAUCUS. Mr. President, on behalf of the Senator from New Jersey, Mr. CORZINE, I ask unanimous consent that amendment No. 1037 be modified with the text that I send to the desk.

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

The amendment, as modified, is as follows:

At the end of subtitle A of title I, add the following:

SEC. . CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

EXCLUSION FROM PER VISIT LIMIT.—Section 1833(a)(3) (42 U.S.C. 13951(a)(3)) is amended by inserting “(which regulations shall exclude any cost incurred for the provision of services pursuant to a contract with an eligible entity (defined in section 1860D(a)(4) operating a plan under Part D, for which payment is made by such entity)” after “including those authorized under section 1861(v)(1)(A)”.

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

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

AMENDMENT NO. 1110

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

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. LEVIN, proposes an amendment numbered 1110.

Mr. BAUCUS. 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 ensure that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan)

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan or entering private insurance under this act.

AMENDMENT NO. 1111

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside so that I may send to the desk on behalf of Senator LEVIN an amendment to ensure that current retirees who have prescription drug coverage, who will lose their coverage as a result of enactment of this legislation, would have the option of drug coverage under Medicare fallback.

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

The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. LEVIN, proposes an amendment numbered 1111.

Mr. BAUCUS. 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 ensure that current retirees who have prescription drug coverage who will lose their prescription drug coverage as a result of the enactment of this legislation have the option of drug coverage under the Medicare fallback)

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that the 37% of current retirees who have prescription drug coverage, estimated by the Congressional Budget Office who will lose their current employer retiree coverage as a result of the enactment of this legislation will have the option to enter either a Medicare backup plan or private insurance under this act.

Mr. BAUCUS. Mr. President, I ask unanimous consent that time under the quorum call be charged equally against both sides.

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

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. 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.

AMENDMENTS NOS. 1027 AND 1041, EN BLOC

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside and amendments numbered 1027 and 1041 be immediately considered.

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

The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS] proposes amendments numbered 1027 and 1041, en bloc.

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

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

The amendments are as follows:

AMENDMENT NO. 1027

(Purpose: To express the sense of the Senate regarding the implementation of the Prescription Drug and Medicare Improvement Act of 2003)

At the end of title VI, insert the following:

SEC. ____ . SENSE OF THE SENATE REGARDING IMPLEMENTATION OF THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003.

(a) IN GENERAL.—It is the sense of the Senate that the Committee on Finance of the Senate should hold not less than 4 hearings to monitor implementation of the Prescription Drug and Medicare Improvement Act of 2003 (hereinafter in this section referred to as the "Act") during which the Secretary or his designee should testify before the Committee.

(b) INITIAL HEARING.—It is the sense of the Senate that the first hearing described in subsection (a) should be held not later than 60 days after the date of the enactment of the Act. At the hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) The progress toward implementation of the prescription drug discount card under section 111 of the Act.

(2) Development of the blueprint that will direct the implementation of the provisions of the Act, including the implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(3) Any problems that will impede the timely implementation of the Act.

(4) The overall progress toward implementation of the Act.

(c) SUBSEQUENT HEARINGS.—It is the sense of the Senate that the additional hearings described in subsection (a) should be held in each of May 2004, October 2004, and May 2005. At each hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) Progress on implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(2) Any problems that will impede timely implementation of the Act.

AMENDMENT NO. 1041

(Purpose: To require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project)

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas of Alaska are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—
(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or
(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

AMENDMENTS NOS. 936, 938, 988, 1027 AND 1041 EN BLOC

Mr. BAUCUS. Mr. President, on behalf of the chairman of the committee, Senator GRASSLEY, I ask unanimous consent that the pending amendments be set aside and that the following amendments be agreed to en bloc, and that the motions to reconsider be laid on the table en bloc: Amendments Nos. 936, 938, 988, 1027, and 1041.

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

The amendments were agreed to en bloc.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the time I used be charged equally to both sides.

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

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. GRASSLEY. 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. GRASSLEY. I ask unanimous consent to proceed as in morning business.

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

AMENDING TITLE XXI OF THE SOCIAL SECURITY ACT

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 166, S. 312.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 312) to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program.

There being no objection, the Senate proceeded to consider the bill.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the managers' amendment be agreed to; that the bill, as amended, be read a third time and passed; that the motion to reconsider

be laid upon the table; and that any statements relating to the bill be printed in the RECORD.

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

The amendment (No. 1113) was agreed to, as follows:

(Purpose: To make a technical correction)

At the end, add the following:

SEC. 2. TECHNICAL CORRECTION.

(a) TEMPORARY INCREASE OF THE MEDICAID FMAP.—Section 401(a)(6)(A) of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108-027) is amended by inserting "after September 2, 2003," after "(42 U.S.C. 1315)".

(b) RETROACTIVE EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 401 of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108-027).

The bill (S. 312), as amended, was read the third time and passed, as follows:

S. 312

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENSION OF AVAILABILITY OF SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2001.

(a) EXTENDING AVAILABILITY OF SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2001.—

(1) RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEARS 1998 AND 1999.—Paragraphs (2)(A)(i) and (2)(A)(ii) of section 2104(g) of the Social Security Act (42 U.S.C. 1397dd(g)) are each amended by striking "fiscal year 2002" and inserting "fiscal year 2004".

(2) EXTENSION AND REVISION OF RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEAR 2000.—

(A) PERMITTING AND EXTENDING RETENTION OF PORTION OF FISCAL YEAR 2000 ALLOTMENT.—Paragraph (2) of such section 2104(g) is amended—

(i) in the heading, by striking "AND 1999" and inserting "THROUGH 2000"; and

(ii) by adding at the end of subparagraph (A) the following:

"(iii) FISCAL YEAR 2000 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2000 that were not expended by the State by the end of fiscal year 2002, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2004."

(B) REDISTRIBUTED ALLOTMENTS.—Paragraph (1) of such section 2104(g) is amended—

(i) in subparagraph (A), by inserting "or for fiscal year 2000 by the end of fiscal year 2002," after "fiscal year 2001,";

(ii) in subparagraph (A), by striking "1998 or 1999" and inserting "1998, 1999, or 2000";

(iii) in subparagraph (A)(i)—

(I) by striking "or" at the end of subclause (I),

(II) by striking the period at the end of subclause (II) and inserting "; or"; and

(III) by adding at the end the following new subclause:

"(III) the fiscal year 2000 allotment, the amount specified in subparagraph (C)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (C)(ii) for the State to the amount specified in subparagraph (C)(iii).";

(iv) in subparagraph (A)(ii), by striking "or 1999" and inserting ", 1999, or 2000";

(v) in subparagraph (B), by striking "with respect to fiscal year 1998 or 1999";