adopt its business models to new technologies. The industry is now responding to such concerns by developing new products and new distribution channels. The EnFORCE Act will ensure that Federal law allows the music industry to negotiate fair compensation for these innovative products and services.

Second, the EnFORCE Act will also resolve two narrow issues relating to statutory damages in copyright infringement litigation. Some accused infringers have tried to avoid liability for statutory damages by challenging the accuracy of the information in copyright registrations; this bill clarifies that courts should resolve such challenges by applying the existing judicial doctrine of fraud-on-the-Copyright-Office. In other cases, disputes have arisen about how many ‘works’ have been infringed for purposes of computing statutory damages. These disputes are important for the music industry, which has received inconsistent adjudications about whether an album consisting of ten songs counts as one or ten works for statutory-damages computation. The bill gives courts discretion to conform the law of statutory damages to changing market realities.

Third, and finally, the EnFORCE Act will also enhance both the enforcement and oversight of federal intellectual property law. The bill authorizes appropriations to ensure that all Department of Justice units that investigate intellectual property crimes have the support of at least one agent specifically trained in the investigation of such crimes. The bill also requires the Department of Justice to report to Congress detailed information about the scope of its efforts to investigate and prosecute crimes involving the sexual exploitation of minors or intellectual property.

For the above reasons, I urge my colleagues to support the Enhancing Federal Rights for Music Act or the Copyright Enforcement of the 21st Century Act or the Strengthening the Rights of the Music Industry of the 21st Century Act of 2003. I look forward to working with my colleagues in the Senate and the affected public to ensure that this bill achieves its important objectives.

PRIVILEGES OF THE FLOOR

Mr. HATCH. I ask unanimous consent that Grace Becker, a detailee from the Federal Obscenity Reporting and Copyright Enforcement Act of 2003, be granted the privilege of the floor for the duration of the 108th Congress.

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

Mr. GRASSLEY. Mr. President, I ask unanimous consent that Grant menke and Brett Swearingen be granted floor privileges throughout the debate on the conference report on H.R. 1.

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

Mr. BONAKDIN. Mr. President, I ask unanimous consent that Jeneile Krishnamoorthy be granted the privilege of the floor for the remainder of the debate today, and the remainder of the debate on this conference report. The PRESIDING OFFICER. Without objection, it is so ordered.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003—CONFERENCE REPORT—Continued

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, this debate so far has been very illuminating, in a way fascinating, to see how different Members of the Senate view the bill that is before us. I hope that America’s seniors are watching this debate. I hope they are listening. I hope they will make up their own minds.

There are many groups out there who are going to give their opinions, and I do. But people look to you if you just go to the debate and you listen to all sides of it, seniors will come up with their own conclusions. As a matter of fact, I also hope people in their fifties and forties are watching this debate because maybe the changes that will be made, if this bill becomes law, are going to impact people in their fifties, people in their forties.

Let’s face it, Medicare is a program that impacts all families because the children of our seniors oftentimes bear the burden, if there are health problems. Of course, they care deeply about their families.

We know that Medicare is a nationwide health care program for citizens and certain disabled Americans, and it was created 40 years ago for seniors to offer them access to good quality health care. There was a huge debate at that time about whether this was the right thing to do.

But Medicare has saved many lives and has made the golden years golden for a lot of our seniors. That is why they feel so strongly about it.

I have been listening to some of the call-in shows. I have heard seniors identify themselves as Republicans, Democrats, and Independents. They are worried about the changes that are about to hit the system, and so am I.

The one thing I think everyone agrees on is that we are going to see a significant reduction in prescription drug benefit. At least I think most of us believe that from both sides of the aisle. We know this cost is heavy on our seniors. We know drug prices are skyrocketing because, unfortunately and very sadly, we don’t allow drug reimburishment from places like Canada and Mexico, although I have to tell you that in my State, people are going to Mexico.

I received a letter from a constituent of mine from San Marcos, CA, earlier this year. She told me that her annual cost for prescription drugs this year will top $10,000. Think about that, $10,000. How do our seniors deal with this when they are retired? The retired physician from Marina del Rey told me that a pill he takes for his heart disease went up 600 percent, from $15 a month to $95. For seniors who have to take an assortment of medicines to manage their chronic diseases, this is really serious.

Very sad to say, in this bill there is virtually no cost containment. Even though the House version said re-importation from Canada was a good idea, this has not happened. We will continue to pay the highest drug prices in the world. It is very sad, indeed. The provisions on generic drugs were watered down a bit. We have some in there but not what they should be.

For all the reasons that I talked about, the fact that the House of Representatives, instead of the Senate, decided to have this legislation, it is not enough.

It had about six things that it did that I thought were really important.

First, there was a modest benefit for seniors that were hardest hit by the costly prescription drugs. The benefit was $4,020, which is a lot better than the benefit that is currently before us. I will go into the differences. The benefit that is before us is so weak, it barely has a pulse. It is barely worth filling out the forms. It is barely worth your time. You could probably do better if you become friendly with your pharmacy down the road. They will probably give you a better deal.

The benefit before us, unlike the benefit we voted on, is this: If you have $5,000 worth of drugs, you pay a $2,000 deductible, but you pay $4,020 for those drugs. In the meanwhile, you will have to figure out what are your deductibles, what are your copays, filling out the forms, being nervous, getting notified that you no longer have the drug benefit because there is a benefit shutdown, which I will get into later. So think about it. You have a $5,000 drug bill, and you are paying $4,000. And you are going through probably bureaucratic hell to get the thousand dollars of your benefit.

So the benefit, when we got the bill, we voted it out. I voted for it. I wanted it. It was a modest benefit but a decent benefit. It was much better than this one. We will get into that later.

Second, all seniors were guaranteed a Medicare prescription drug benefit if they didn’t have two private plans in their area. So you had a good fallback. If you didn’t have two private drug plans competing for your business, you could say: Forget this. I can go to Medicare.

Third, Medicare could have bargained for lower prescription drug costs. Now, why is this important? I just look at the
Veterans' Administration. They can get way lower costs for the drug ben-
fits for their veterans because they rep-
resent millions of veterans. Therefore, they have bargaining power. It is not like if I walked into a pharmacy myself and say I am a veteran, can you lower my drug prices. And the phar-
macist looks at me and says: Well, no. But if I bring millions of people into the store, the pharmacist is going to say: You know, now I can talk to you about some bargain prices.

This is what it says. When I think about competition, I don't think about paying people to compete. I didn't think that is what capitalism is. I was a stockbroker. That is news to me. To me competition is what we agree on, and you come in, you see you have a chance to make a profit, and you compete.

Well, we were giving them $6 billion. I wasn't happy about it, but I felt that, all in all, because we balanced it and gave $6 billion to Medicare, to add pres-
cription drug benefits and some other very important benefits, it was worth it.

So just sum that up. I want to be clear here. I supported the Medicare prescription drug bill that was before the Senate because it was a decent ben-
efit for seniors. It gave them a third off their drugs. So it gave you a third off of your drugs. I thought that was a good benefit. You paid two-thirds and you got a third off. Again, I thought it should have been better. It was modest. I wasn't thrilled with it. I tried to have amendments to close the benefit shutdown, to bring the benefit up to 50 percent, but I did not succeed in that effort.

All seniors were guaranteed a Medi-
care drug benefit, that fallback, if they didn't have two private drug plans competing. Frankly, I wanted a Medi-
care fallback for everybody. I remem-
ber the debate. But they convinced me to compromise, I wasn't thrilled, but I voted for it. Medicare could have bar-
gained for lower prices for drugs. I as-
sumed that would be part of what we would do. We didn't prohibit it. The steps to privatize Medicare, to incent-
ize HMOs to stay in the Medi-
care business, were balanced by $6 bil-
lion added to Medicare for some impor-
tant new benefits.

The last thing is, for the lowest in-
come seniors, they got prescription drugs at a third off. That was a very big thing in the Senate bill. The poorest of the poor people who worked all their lives and found themselves in a hor-ible situation today would have got-
ten drugs at no cost. For all those rea-
sions, I was very pleased in the end that I was able to move that bill forward.

I want to show you something I hope you can appreciate, as I hold this bill up for a minute. The bill itself that has had so much heavy lifting. Here it is. This is the bill that is before us today. This bill I am holding is 678 pages. How much of this is the pre-
scription drug benefit? It is 181 pages. What does that tell you? It tells you that most of this bill has nothing to do with prescription drug benefits. Think about it. We sent a prescription drug bill into the conference committee to come back to us, and here it is. This yellow tab shows me where it is. This is the prescription drug benefit. It is 181 pages. The balance of this bill is way more, 5 times more.

Think about it. If the folks who brought you this bill were sincere about giving you a prescription drug benefit, why did they then use that as an excuse to begin changing Medicare in ways that are perplexing, that are going to be dif-
cult to understand, and the rest?

Now, I am not, generally speaking, someone who is paranoid about things. But I have to tell you, I am when I hear Newt Gingrich, that fellow, 606 pages of this bill, who said in 1995:

Now, we don't get rid of it [Medicare] in round one because we don't think that's politically smart, and we don't think that's the right way to go through a transition. But we believe Medicare is going to wither on the vine, because we think people are volun-
tarily going to leave it.

Voluntarily. If you mess up Medicare and you make it confusing and start doing the things that they do in this bill, Newt Gingrich will be proven right. Why do you think he went over to the caucus on the other side, in the House, and talked to the Republicans who didn't like the bill? Because they thought it was going to hurt seniors.

He said: No, it is not. Trust me. I would lead you astray.

That is Newt Gingrich. The senior citizens in this country, in my view, are the smartest of the folks when it comes to Medicare. They know it. They get it. They understand Social Secu-
rit y and they understand Medicare. They understand when Newt Gingrich said that Medicare should "wither on the vine, and that this isn't some-
thing they were going to use.

Well, folks, please listen. "We don't have to get rid of it in round one," Newt said, "because we don't think it's politically smart." So what did they do? They take a prescription drug ben-
efit that is popular—by the way, it is voluntary, but I will talk about that because it is not voluntary if you are on MedicaId, and it is not voluntary when you find out that your pension plan has dropped your prescription drug coverage because they will have nothing else forced into it. It is not voluntary for those folks.

But I can tell you that this is just what Newt Gingrich planned. You can-
not do it all at once. Not in round 1. We have to go through a "transition." Re-
member that word because it shows up in this bill—"transition." So here is prescription drugs, and here is the withering on the vine.

A lot of the people who fought Medi-
care, the beginning are embracing this bill. Do you think they had a change of heart? Do you think those of us who built our careers on protecting seniors have somehow gone wacko on you by saying that this bill does more harm than good? Think about the Sen-
ators who are standing up here and ex-
tolling the virtues of this bill. One of 
them was here before and he said that people on the other side are saying we are trying to destroy Medicare. How ri-
diculous, he said. That's crazy. We would never do that. Then he launched into a harsh criticism of Medicare and how it needs to change.

Another, I thought, belied his point of view when he stood up and said—it is hard for me to say this after the Senator and asked him or her a question about it, not one of them would pass the test of understanding every acronym—not even close. So the Senate bill benefited seniors. What we have before us is quite different. That is the saddest thing about this bill is that it turned a modest, but de-
cent, benefit for seniors into an enor-
mous benefit for the largest pharma-
ceutical companies and HMOs in Amer-
ica. Here is what we have now in the 
toll.

This is the headline on the front page of the Congress-
ional Record from this afternoon—

"Re-

Washington Post that tries to explain 
the saddest thing about this bill? It is that turned a modest, but de-
cent, benefit for seniors into an enor-
mous benefit for the largest pharma-
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ica. Why do you think that is the case?

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November 22, 2003

This is the selling of America. I want to quote from this article...

More than three dozen of President Bush’s major fundraisers are affiliated with companies that stand to benefit from the passage of two central pieces of the administration’s legislative agenda: the energy and Medicare bills.

We stopped the Energy bill. I don’t know how long we will be able to hold that, but the Energy bill is a clear-cut case. We know where the money is going. It is going out of the Federal Treasury to the fat cats. Face it. Unfortunately for the folks around here, we know now. We have it.

How about this? We know about that before. Medicare on Medicare price negotiation. I talked to one of the executives of companies or lobbyists working for them, including eight who have clients affected by both bills.

Talk about hitting the lottery. They benefit from the Energy bill and this bill. We know where the money is going. It is going out of the Federal Treasury to the fat cats. Face it. Unfortunately for the folks around here, we know now. We have it.

He may be a lovely man; this is not a personal attack on him—chairman and CEO of Pfizer, has pledged to raise at least $200,000 for Bush’s reelection, although he is not yet listed as a Pioneer or Ranger. Pioneer Munr Kazmir, who runs a direct-mail drug company called Direct Meds Inc., estimates that he has about 100,000 customers, who have qualified as either “Pioneers” or “Rangers”—

That is what they call the big fat cats, Pioneers or Rangers—

as well as to the clients of at least 15 lobbyists and their spouses who have achieved similar status as fundraisers. At least 24 Rangers and Pioneers could benefit from the Medicare bill—

Twenty-four Rangers and Pioneers, and those are the people who give the most money—

could benefit from the Medicare bill as executives of companies or lobbyists working for them, including eight who have clients affected by both bills.

In this bill, we are going to be giving

$14 billion to the HMOs. I was not happy with that at all, but at least it gave $6 billion to traditional Medicare to help us do that. Now I give it to you. That is what happened. It is gone. The conference committee took it away. But they have added it to the $6 billion already there. They added $6 billion that was going to go to Medicare. They put it in the HMOs, and they added $2 billion just in case it was not enough money for their friends.

Secondly, this bill benefits drug companies and HMOs. There is a gag rule on Medicare price negotiation. I talked a little bit about that before. Medicare has its own limits. Think about the clout Medicare could have when they call a drug company and say that their drug X, Y, Z is a drug for arthritis and our patients like it; we are going to buy a lot of it for our patients; please give us a deal.

Oh, no, the conference said, Medicare has a gag rule. Watch out. They may do it to the veterans next. The VA can bargain, but Medicare cannot bargain. The drug companies and the HMOs can bargain efficiently and get a better bargain, and they can keep some of the profits that they bargain, but not Medicare. Medicare cannot bargain. There is a gag rule on Medicare.

They will stand up on the other side and say: We are not trying to destroy Medicare; we think it is a great program. Just remember Newt Gingrich: Let it wither on the vine.

Seniors are expected to spend $1.6 trillion on prescription drugs over the next decade. By the way, there are a lot of pharmaceutical companies and a lot of wonderful research companies in my State. I have a great relationship with them. I support them getting an R&D tax credit; in other words, a tax credit for every penny spent on research and development. Why? Because I think that is important. I support their patents—reasonably support their patent rights. I support research through the NIH very strongly, and a lot of that benefits the drug companies as well. So I work very closely with my biotech companies, with my pharmaceutical companies, but, by God, I do not believe in giving them welfare.

Fourteen billion dollars? Is that because we have so many millions? Is our deficit not big enough? It is only up to $500 billion in 2½ years or 3 years. Gee, we could do better. Why do we not make it $600 billion? Do I hear $700 billion?

I do not know what has happened, but it is not good. It took us 8 years to balance that budget. The other side said: We want a constitutional amendment to balance the budget. And our side said: Let’s just balance it. Why do we go to amendment? Let’s balance it. And President Clinton did that with us over 8 years.

Now it is gone. Now we have $14 billion to add to the deficit, and we are not going to let Medicare negotiate for us because, for whatever reason, they are tying Medicare’s hand. I think it is because they want Medicare to wither on the vine. That is what Newt Gingrich said. That is the only thing I can come up with.

The cost of drugs could be lowered if Medicare negotiated those drug prices. One might say, well, maybe, Senator Boxer; that would be highly unusual for Medicare to negotiate with the drug companies. I would say, not at all. Medicare negotiates payments to hospitals. They have done that for years. When the bill left the Senate, there was no prohibition, but now there is. Why? Because they do not want the Medicare drug plan to be able to negotiate prices. They have given the right to negotiate to the private sector. They are going to push seniors into those plans.

I just remember where I started from. I just remember, “wither on the vine,” and “follow the money.” These are some simple concepts. At the end of my statement, just put a little ribbon and tie the bow and everyone will get the picture as to why we are going down a very dangerous path.

Just remember, we are going to be giving to HMOs payments above their stated cost to deliver service. Has anyone ever heard of anything like that in their entire life? A firm bids on a contract.
They say: We can supply you with $X number of widgets for a thousand dollars. On the dot, you get it. You deliver the thousand widgets, I give you $1,000.

Here, HMOs are saying: We can deliver health care for patients at a cost of $X dollars per patient. In this conference committee, they said: Well, we are going to give them more money than they say they need. It is called a lot of different names, such as premium support. It is payment above and beyond what they said it would cost. So put together the slush fund and the payments above their cost of service and you are scratching your head, saying, maybe I ought to get into this business.

So to say to people all over the country, small businesses who work hard in their business, be it retail or wholesale, you do not have a deal like this. You open up your doors, you go into business. Look, suddenly Uncle Sam is knocking on the door: Hey, I got a check for you HMOs, $14 billion over 7 years just to stay in the business; and, by the way, we love you so much, we are going to give you dollars above and beyond what it costs. And by the way, no one will catch on. We are going to call these names different things. We are not going to call it a slush fund.

So the bill left the Senate. It was a good benefit, a decent benefit, but a modest benefit. It was not perfect, but at least it was a bill on prescription drugs. It came back a benefit for drug companies and HMOs. Somebody said to me there was a hostile takeover in the conference committee of the Medicare bill, that the Senate passed, by the HMOs and the prescription drug companies.

If we look at Wall Street, follow the money, look at the prices of these stocks. They are going out of sight because people know this is a deal of a lifetime, that is for sure.

The last point I want to make is that this bill hurts our seniors. I am going to tell you, it hurts our seniors, and in the end I am going to show you how it hurts my seniors in California, the largest State in the Union.

These are facts. We have gotten them from the staff that worked on this conference bill. Six million seniors will pay more for prescriptions than they do now. Let me tell you who these people are. Six million low-income and disabled beneficiaries currently receive prescription drug benefits from the Medicaid Program, which is a matching Federal-State program administered by the State. These programs are more generous in coverage than the programs before us because they serve our very sickest Americans.

For example, a Medicare/Medicaid-eligible person in California can do, but does not have to, pay a $1 per prescription copayment. The copayment is voluntary. A dollar may sound like zero, nothing, to people. But if you are an inch away from owning nothing, every dollar counts.

Under the conference bill the same person will now be required to make a copayment, maybe, up to $5. Some will pay premiums of $50 and be subject to a strict asset test. Studies have shown that even small copayments for prescription drugs can make essential medicines unaffordable for low-income seniors, resulting in an 88-percent increase in hospitalizations and deaths, and a 78-percent increase in emergency room visits.

So they say to my State, now you can help up these poorest of the poor. Sorry. They gave that a name, too, which we will get into later. They give it a nice name, but the bottom line is the people, the poorest of the poor, the States that help them can no longer help them once they get into this program.

The copayments to these poorest of the poor are indexed for inflation. So they can and they will go up. Remember, most of these people don’t make much money. It will hit with inflation and you are on a fixed income. That takes food off the table. So we know there will be an increase in hospitalizations. That was in the background information, that 88-percent increase in hospitalizations and deaths because people will not take their medicine.

States are prohibited from covering the out-of-pocket costs of these dual eligibles, and the bill prohibits States from establishing more expansive drug lists for the mentally ill, disabled, and other groups.

That is important. They may be taking a drug that isn’t covered on this formulary.

I want to talk about people with AIDS. We have a high number in our State. People are suffering. Many of them are dual eligibles. They are eligible for Medicare disability and Medicaid. For them this bill is catastrophic. My phones are ringing off the hook with calls from them, their parents, their families. It is likely that they may not have access to or be able to afford all the drugs they need. So this is why this bill is opposed by the AIDS Medicare Project, San Francisco; AIDS Project, Los Angeles; Project Inform, San Francisco; San Francisco AIDS Foundation. But let’s face it, it is not just AIDS patients who are going to be harmed. Anyone with a life-threatening illness runs the risk of not having coverage, the drugs they need. If they are denied coverage for these drugs under Medicare, they can appeal the decision, but this doesn’t mean they can afford them.

So when it gets to the floor, I will show you later the numbers of people who will be worse off. It goes in the hundreds of thousands—the hundreds of thousands.

Now there is a very cruel asset test. When voted for the bill in the Senate that the Senator from Iowa worked so hard on with the Senator from Montana, that was a good bill. That bill would have allowed low-income seniors to receive assistance without forcing them to sell a car because it was worth over $4,500 and a ring that maybe was their most precious possession from their loved one or a family heirloom.

The conference bill imposes a Draconian asset test of $6,000 per person, $12,000 per couple, the poorest of the poor. As a result, 3 million low-income seniors nationwide, and 300,000 in California, will be deprived of assistance that would not only help them with their prescription drugs but help them pay the premium so they would receive the coverage in the first place.

In other words, the bill that is before us has some generosity towards the poorest of the poor, but they have added an asset test into it so if you have a family heirloom or you own a car worth more than $4,500 or you have a diamond ring and a gold wedding band that your husband may have given you when you were married, you have to sell it. You have to get rid of it. Otherwise you don’t get the benefit of this prescription drug coverage.

I don’t get that. I am sad the conference didn’t go with the bill that most of us voted for in the Senate.

Now you come to seniors who are forced into demonstration projects that penalize them for staying in Medicare. That happens in 2010. You say we are just in 2003. We are almost in 2004—that is 6 years away, big deal. One thing I have learned, as long as I have lived, is that time goes fast. Six years will be here. If you are in one of those demonstration projects, what is going to happen is plain and simple: Your premiums are going to go up if you stay in Medicare-bottom line. Even though people say you are not forced into these other plans, the costs may force you into these other plans.

In six Medicare beneficiaries will be forced to participate in this experiment. In California, 12 of its metropolitan statistical areas will qualify for these demonstration projects. Let’s say two of the largest are chosen; one is in L.A. and the other is in San Francisco. That means what we will have to do is go to these areas and there will have to make a very tough choice. Do they stay in Medicare and pay more money or do they go into an HMO and lose the choice of their doctors?

We have already had some experimentation. We know the healthy people will choose the HMOs because they are cheaper. After all, they are healthy so they are not worried about getting messed up by an HMO. If they are not sick, you know, it is not a problem.

But the sicker seniors would be left in Medicare, and we know that we will see costs spiral out of control because there will be a sick pool of seniors, rather than spreading the risk, which is what insurance is all about.

We have a situation in California where premiums for middle and upper class people are going to go up. My colleagues say they are only going to go up if you earn $80,000 a year. I understand that is
quite a bit. That is not that many people. But this is the problem. This number of $80,000 a year is not indexed for inflation. So it looks like it is a lot now, but in the future it will not look like that big.

For example of this provision, the one that my colleague from Iowa supports, was in place in 1980, the equivalent level of income would be $33,000, and the person at that level would have to pay much more for their Medicare. So this has done this astounding thing: They have not indexed this, so in the end you will have people of very moderate incomes paying huge premiums to Medicare.

Now that is a big thing to happen. It will wither on the vine because people will say: I don’t want anything to do with this. It is too costly. I don’t need it. I will just go out and buy a catastrophic policy elsewhere.

I will tell you if you take that fact, along with the fact that this bill sets up health savings accounts for the wealthiest people, you are going to have middle-income people and wealthy people walk away from Medicare, and you will lose the class you have when you have a larger pool. That is just a fact of life. That is why we have when you have a larger pool. That is why we have a successful program—because insurance needs a very big pool. I am talking to put up a chart that I hope all of you who might be crazy enough to be watching this will remember. I know this isn’t exactly prime-time television. But I want to show you a chart of Fear and Confusion. That is Barbara Boxer home-made chart. This is the chaos and confusion that our seniors are going to be facing.

If any of you are watching this tonight, I am telling you to take note. I am telling you if you take that fact, along with the fact that this bill sets up health savings accounts for the wealthiest people, you are going to have middle-income people and wealthy people walk away from Medicare, and you will lose the class you have when you have a larger pool. That is just a fact of life. That is why we have a successful program—because insurance needs a very big pool. I am talking to put up a chart that I hope all of you who might be crazy enough to be watching this will remember. I know this isn’t exactly prime-time television. But I want to show you a chart of Fear and Confusion. That is Barbara Boxer home-made chart. This is the chaos and confusion that our seniors are going to be facing.

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with that, they are dropping coverage once they know their retirees have another option. Wait until those people get the clue that is happening.

Years ago we passed a catastrophic medical bill and I remember seniors were worried. They were not happy. But until they hear they get dropped—retirees who worked all their life, who like their plan and they get dropped. They do not have a choice. If they want prescription drugs they have to come with this plan. Wait until they have to deal with catastrophic situations.

Mr. President, 296,000 fewer low-income seniors will qualify for low-income protections than under the Senate bill because of the assets test that I talked about and lower-qualifying income levels. The poorest of the poor—when compared to what we did in the Senate, the bill I voted for—are worse off. These numbers are huge because I represent a big State. And 230,000 Medicare beneficiaries will pay higher Part B premiums because they are upper middle income and wealthy. That will happen to them.

Also, because they are in the MSA and metropolitan statistical area, that demonstration project, 1.4 million could be forced into the area as we understood because we have the big metropolitan areas, or be penalized for staying in traditional Medicare because the people who are healthy will go into those private plans and the people who are sick will stay in Medicare and the costs will go up.

We have fear and confusion. I don’t know how many of these figures are double-counted, so I cannot just add them up. Some of these figures may fit into more than one category, but I can state with certainty a couple of million of my 4 million people on Medicare are going to be worse off with this bill, much worse off. That is a very bad thing to do.

I don’t know where the votes are. I think they have the votes to pass this. But if seniors across this country got a couple of days—there are about 48 hours to pick up your phone, call your Senator, maybe Seniors Day. What is the problem in taking a couple of days, call your Senator, e-mail your Senators and tell them to take some more time, to put this thing over until after the first of the year and we can come back here and have the whole year to work on this bill, which is really rewriting the Medicare Program. This Senate voted down an Energy bill which I felt, frankly, was in many ways a giveaway for the Senate and the White House. By reading the bill and trying to understand all of this, I did not even scratch the surface.

This Senate voted down an Energy bill which I felt, frankly, was in many ways a giveaway for the Senate and the White House. By reading the bill and trying to understand all of this, I did not even scratch the surface.

I remember one of my colleagues saying to me, when someone asked a question about oncology, because there has been some concern about how the oncologists are being treated—someone in the room said, just look, there is a problem. We have a healthcare company that deals with oncology, and the stock is shooting up. It must be that oncologists are being treated fairly.

I used to be a stockbroker. It is not of any interest to me to do things that make the stock of a company go up. Do you know what I want to go up? The stock of the American people, the lives of the American people, the quality of life of the American people, the quality of life of grandmas and grandpas and their families.

This is truly not a partisan issue. It is an issue of how do we give a prescription drug benefit to our senior citizens and keep Medicare strong and not make this bill a giveaway to the largest HMO and pharmaceutical companies and insurance companies in the country. They are doing very well. This debate has been a good debate so far. We have serious disagreement. I am very pleased that is very close to what baby boomers now have in the workplace.

We can choose that with an integrated drug benefit plan. So we are not trying to confuse anybody. We are trying to give seniors the right to choose. We are trying to give seniors who are totally satisfied with what they have right now an opportunity to just stay where they are right now. It is the right of seniors to choose.

I think I better be very careful because so much of the opposition to this bill today has come from the other side of the aisle, mostly Democratic Members of the Senate.

We are here today with a piece of legislation because over the years 2001 and 2002—after Senator J. EFFORDS switched from being a Republican to being an independent and casting his lot with the Democrats, so they were a majority during the remainder of 2001 and all of 2002—there was an effort early on to develop a bipartisan approach to a drug benefit during the last Congress.

When that was developing, there was a fear that there might be a bipartisan...
I want to correct what my colleague from Iowa said earlier about this bill's impact on rural America and on our State of Iowa in particular.

The rural health provisions of this bill go further and wider than any other legislation Congress has ever considered. It enjoys the strong support of the Nation's doctors and hospitals, and it is also strongly endorsed by the Iowa Medical Society and by the Iowa Hospital Association, two of the strongest advocates for rural equity in my State and my colleague's State.

I will read an excerpt from each and then ask unanimous consent that both letters be printed in the RECORD.

This is from the Iowa Medical Society president, Tom Evans, M.D.: “[P]assage of the bill, “meaning the bill before us, “is critical for rural states like Iowa.” He said: “In addition to providing seniors with prescription drug coverage”—and I want to emphasize this statement: “this legislation fixes many of the reimbursement issues that have unfairly penalized rural States. Congress must pass this legislation before the Thanksgiving (Day) recess.”

Then there was an election, and they found out that issue did not work for them; that Republicans were put in a majority. This gave, in this new majority, in this new Congress, Senator Baucus and I, the top Democrat and the top Republican on the committee, an opportunity to do our magic and put together a bipartisan bill. That bill came to the Senate floor and was passed 76 to 21. It went to conference, and came out of conference in a bipartisan way. And we are here because the majority Republicans and some sensible Democrats want to produce a product and not have an issue for the next election. I happen to think, from the comments I have heard today—all the fault that can be found with this bipartisan product—that there are still too many people on the other side of the aisle who have not learned a lesson: No. 1, how do you get anything done in the Senate? It has to be bipartisan.

And, No. 2, they did not learn from the mistakes of the last election when they thought they needed an issue. Do they think it didn't work in 2002, it is going to work in 2004?

So that is why we are where we are because there are Democrats who know that you do not get anything done in the Senate if there is not a bipartisan coalition. There are Republicans who have understood that for a long period of time.

So that is background to what I want to tell the people of America and my colleagues about why this bill should be adopted. During this process, I am going to correct some of the statements made by my colleagues so far today.

IOWA MEDICAL SOCIETY STRONGLY SUPPORTS PASSAGE OF MEDICARE REFORM LEGISLATION

The Iowa Medical Society (IMS) announced today its strong support for the Medicare Prescription Drug and Modernization Act of 2003 conference report.

IMS President Tom Evans, MD, said passage of the bill is critical for rural states like Iowa. “In addition to providing seniors with prescription drug coverage, this legislation fixes many of the reimbursement issues that have unfairly penalized rural States.” He said: “Congress must pass this legislation before the Thanksgiving (Day) recess.”

Evans said the bill protects Iowans’ access to physicians by replacing a 4.5 percent payment cut scheduled for 2004 with two years of payment increases. The bill also fixes a component of the reimbursement formula that deals with geographic practice cost adjustors that causes huge reimbursement swings from state to state.

“[If this legislation isn’t passed, the American Medical Association estimates that a 4.5 percent cut in reimbursement will take $30 million away from Iowa’s health care system in 2004],” he said. “Now add to this the fact that Iowa already receives among the lowest payment rates in the country, and you can see how Medicare is threatening our ability to care for our patients.”

Evans also thanked Senator Charles Grassley for his work on this bill as Chair of the Senate Finance Committee. He also thanked Iowa Senator Tom Harkin and Iowa’s Congressional Representatives to support the Medicare conference report.

The Iowa Medical Society is the professional association representing over 4,600 MDs and DOs. The IMS core purpose is to assure the highest quality health care in Iowa through its role as physician and patient advocate.

Mr. GRASSLEY. Now let me speak to what this bill does for Iowa’s seniors.

The bipartisan agreement provides all of Iowa’s 485,042 Medicare beneficiaries with access to Medicare prescription drug benefits, as I have stated previously, on a voluntary basis. It does it for the first time in the history of the Medicare Program. That begins January 2006. Beginning in 2006, the bipartisan agreement will give 142,257 Medicare beneficiaries in Iowa access to drug coverage they would not otherwise have and will improve coverage for many more.

6 months after this bill is signed—in other words, during the year 2004—Iowa residents will be immediately eligible for Medicare approved prescription drug discount cards which
will provide them with savings between 10 percent and 25 percent off the retail price of most drugs. Beneficiaries with incomes of less than $12,123, or $16,362 for couples, who lack prescription drug coverage, including drug coverage under Medicare, will get an annual assistance to help them afford their medicine along with a discount card. That is a total of $100,840,345 in additional help for 84,034 Iowa residents during these years of 2004 and 2005, as this interim program is in place, helping patients with drugs until we get the permanent program put in place. Then beginning in the year 2006, all 485,042 Medicare beneficiaries living in Iowa will be eligible to get prescription drug coverage through a Medicare approved plan.

In exchange for a monthly premium of about $35, seniors who are now paying the full retail price for prescription drugs will be able to cut their drug costs roughly in half. In many cases, they will save more than 50 percent on what they pay for their prescription medicines. One hundred thirty-three thousand beneficiaries in Iowa who have limited savings and low incomes—and this would generally be those below $12,123 for individuals and $16,362 for couples—will qualify for even more generous coverage. They will pay no premiums for their prescription drug coverage, and they will be responsible for a nominal copayment. That copayment would be no more than $2 for generic drugs and $5 for brand name drugs.

We have 41,300 additional low-income beneficiaries in Iowa with limited savings, and incomes below $13,500 for individuals and $18,000 for couples, qualifying for reduced premiums and a reduced deductible of $50 and a Medicare that will cover 85 percent of their prescription drug costs with no gap in coverage.

Additionally, Medicare, instead of Medicaid, will now assume the prescription drug cost of 50,000 Iowa beneficiaries who are eligible for both Medicare and Medicaid. These seniors generally will pay $1 and $3 per prescription and those in nursing homes will pay zero dollars for their prescriptions. This will save Iowa $175 million over 8 years on prescription drug coverage for its Medicaid populations.

I have tried to address for my colleagues, but particularly for my residents and constituents in Iowa, how this program will impact them as individual beneficiaries of the prescription drug part of our bill. And I have tried to inform my colleagues and my residents of the long-term equity package that will help provide equal care for Iowans because we are increasing the reimbursement for our hospitals and for our doctors in rural America.

Now I will address several of the most egregious misconceptions about the bill that have been spoken on the floor of the Senate today. First, I will address the issue of protecting retiree drug coverage. This would be those people who have, for the most part, coverage from places where they used to work that also continue to cover people with health benefits and prescription drugs after they leave employment.

Due to the debate on S. 1, when this bill passed the Senate the first time in June of this year, it passed by a 76-to-21 bipartisan vote. At that time, even though we had that high bipartisan majority, my colleagues raised concerns about what they referred to as the high level of employers that would drop their retiree prescription drug coverage should we enact the prescription drug benefit into the Medicare Program.

At that time, the Congressional Budget Office told us that 37 percent of the seniors who have drug coverage—that is roughly one-third of the seniors under Medicare—would lose that coverage if we passed the bill. I think I ought to say that there was another group, the Employer Benefit Association, that studied the same issue and said it would be 3 percent to 9 percent who would lose coverage. So we probably have an intellectually honest difference of opinion by the Congressional Budget Office and the Employer Benefit Association on the other hand. But we in the Congress are stuck, as we determine the cost of programs, with what the Congressional Budget Office says. We would rather—it would be easier—if we could just go by what the Employer Benefit Association says, but we go by CBO because they are God when it comes to saying what something costs. So we had to live with that 37 percent.

Well, as we all know, however, employers have been dropping or reducing prescription drug coverage for many years. So this is really nothing new. If we were not even talking about this bill today, some board of directors of a company might come to the conclusion that they couldn’t afford to cover their retirees anymore and drop them. What could Congress do about that? Nothing. But it is nice to have a program when that happens for people to fall back on. That is one of the reasons for this legislation.

Of course, we want to take care that we can do everything possible to make sure that corporation X doesn’t do that. It would be easier—if we could just go by what the Employer Benefit Association says, but we go by CBO because they are God in terms of what something costs. What could Congress do about that? Nothing. But it is nice to have a program when that happens for people to fall back on. That is one of the reasons for this legislation.

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We know these days employers are negotiating health care coverage for many of their employees in Iowa. How many times do you have to pay for something if employer-retiree coverage is there for their employees, do you think those same people are better off if Congress does zilch? Where were they when they voted in the first place, complaining about S. 1 or H. 1, the House bill, when we passed them in June?

Here we are bringing back a conference report that is being endorsed by these corporate plans. Doesn’t that mean anything to any of you? Under this conference report, employers will be given an enormous amount of flexibility—options—that already provide retiree benefits beyond Medicare coverage. This legislation will help make it more affordable for these employers to continue providing these benefits. We do that by a direct subsidy worth 28 percent of their drug spending between deductibles and the coverage gap.

I should add, too, this conference report makes this 28 percent completely excludable from taxation, so that in place of a 35 percent tax bracket that corporations are in, it does 100 percent good, bringing down the number of people who might lose coverage.

Now, some people would say, what is this corporate welfare all about—Congress giving money to corporations to do something they have been doing forever. Some people might say, well, when you buy a Chevrolet, you pay for the retirement plans. How many times do you have to pay for them? You pay for them when you buy a car and when you pay a 28 percent subsidy. We are cautious about the fact that some do that.

So I tell my colleagues over there—each of them who are complaining about this—this 28 percent subsidy is something you ought to be glad to have. Sometimes when we give corporations something, you condemn us for giving corporations something; but when you do it and you cry when we don’t do it because they might dump their retirees. In the final analysis, we are also doing it to protect the
taxpayers and the Medicare Program because it is better to encourage these employers to keep their retirees in these plans at a 28 percent subsidy, which is about $750 per person, instead of having those corporations dump those plans. We have implemented Medicare's new drug benefits and provide them even enhanced benefits for their retirees. They can even do better than they are presently doing because of this flexibility we have in the legislation.

These new choices and options will do much more to help and, consequently, not threaten employer-sponsored health care coverage for those who currently receive it.

In the Congressional Budget Office now estimates that the so-called drop rate—in other words, the rate by which corporations will drop their retirees—is now 17 percent because of the changes that were made in conference. In other words, we listened to our colleagues to come up with an enhanced benefit. The 28 percent potential drop rate because of the way S. 1 was written. But it goes to conference and it comes back from conference with, instead of 37 percent, 17 percent, and you folks are still complaining about CBO, because of what we did in conference. In other words, we listened to our colleagues to come up with an enhanced benefit. And these 2.7 million retirees will still be better off with Medicare coverage, likely paid for by their former employees. In other words, the 2.7 million people who would have been dropped, according to CBO, because of what we did in the conference—that is better than either bill when first passed in June: 2.7 million people are still going to be in their corporate retiree plan.

So I say to my colleagues—I hope you have come a long way since June, when 75 people, in a bipartisan way, voted for this. Half of you over there voted for it. I believe company plans have a lot to be happy about under this conference agreement. All seniors deserve health care benefits. All seniors deserve access to prescription drug programs. This compromise between the House and Senate provides that, and it makes certain that good sources of existing coverage remain. You might not understand it. And these 2.7 million retirees will still be better off with Medicare coverage, likely paid for by their former employees. In other words, the 2.7 million people who would have been dropped, according to CBO, because of what we did in the conference—that is better than either bill when first passed in June: 2.7 million people are still going to be in their corporate retiree plan.

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We have also heard from a lot of them over there that somehow we are trying to privatize Medicare. How many times do I have to say it? This program is voluntary. Nobody has to go into anything in this bill if they don't want to. If they want to keep traditional Medicare, keep it. But this issue is not up. I don't know why? Because these folks over there, my colleagues over there—every one of them—like to scare seniors. You know, it is called Medicare, but you like to make Medicare into ‘‘medi-scare.’’

You know, it is easy to scare seniors. I have my town meetings around Iowa. I hold town meetings in each of the 99 counties every year so I can keep in touch with what is going on there. There are a lot of seniors—people—the older, the more so—but seniors come up to me and they actually believe what is said on that side of the aisle when people say somebody is going to take their Medicare away from them. They believe that ‘‘medi-scare’’ or ‘‘medicare.’’

They are really nervous. Some of them even have tears in their eyes. I tell them, if you just knew as seniors how you have a hook on Congress, that Congress is scared to death of you. You would be laughing at me instead of being scared of something we might do. That is how the concerns of the seniors of America are taken into consideration by people in the Congress of the United States.

Maybe we ought to have a little more of an independent view than be so concerned about the electoral power of the seniors, but they have tremendous influence on Congress. Maybe some people say too much influence. Regardless, it is very difficult to get it over here to ‘‘medi-scare’’ our seniors.

I wish to address this issue of privatization, but the easiest answer is that if you are satisfied with what you have—Medicare—don't worry. Also, if you like other provisions in this bill, they are voluntary. You don't have to do them.

This bill before us today brings Medicare into the 21st century practice of medicine. It does not privatize traditional fee-for-service Medicare. Over-all, this conference agreement relies on the best of the private sector to deliver drug coverage, supported by the best of traditional Medicare. They have that choice.

Seniors will be able to purchase prescription drug coverage on a voluntary basis as part of Medicare's traditional fee-for-service program or be part of a new Medicare-approved private plan where the drug benefit is integrated into broader medical coverage. These Medicare-approved plans have the advantage of offering the same benefits of traditional Medicare, including prescription drugs, but on an integrated, coordinated basis. This creates new opportunities for chronic disease management and access to innovative new therapies.

Let me comment on chronic disease management. That is very important if we are going to keep costs down in the future. We won't have to squeeze seniors at all. In fact, seniors will have a better quality of life under chronic disease management because 5 percent of the seniors are responsible for 50 percent of the cost of Medicare. The reason for that is that we only pay doctors to make people well after they get sick. We never pay enough to keep them well in the first place.

We can concentrate on this 5 percent in chronic disease management, and by so doing, we are going to provide a better quality of life because they will not go in and out of the hospital as much, and we save money there. But also their quality of life is going to be better, and it protects the taxpayers in the process and preserves the longevity of Medicare.

Unlike Medicare+Choice, we set up a regional system where plans will bid in a way that doesn't allow them to choose the most profitable cities and towns. Cherry-picking cannot take place. Systems like this work well for Federal employees, such as the postmaster in New Hartford, IA, my hometown. He has a choice of several plans. We want to give that same choice to those of us who live in rural America, those of us who live in rural America, those of us who live in rural America, those of us who live in rural America.

We provide an alternative plan for people who want to try something new, something that is probably close to what they have now. We have 2.7 million Medicare beneficiaries. We have set up preferred-provider organizations. Are they right for everyone? We give seniors the right to choose. Our bill sets up a playing field for preferred-provider organizations as a choice for beneficiaries. We believe preferred-provider organizations can be competitive and offer a stronger, more enhanced benefit than traditional Medicare, assuming seniors want to choose that.

Let me be clear, no senior has to go into a preferred-provider organization. My policy has always been to let seniors keep what they have if they like it with no changes. All seniors, regardless of whether they choose a PPO or not, can still choose prescription drug coverage if they want to, to go along with their traditional Medicare, but it is their right to choose.

Let me mention preferred-provider organizations without correcting the record regarding the preferred-provider organization stabilization fund that the other side has called a slush fund. It is no slush fund. It is something that those of us who live in rural America know we have to have. We learned a lesson from Medicare+Choice because in 1997, I worked hard to bring greater reimbursement to rural America through Medicare+Choice so that people in Iowa who today only have traditional Medicare, including pre-

We want the preferred provider organizations to serve all of America, rural as well as urban. The stabilization fund is the only way we have to stabilize the cost of Medicare, the only way we have an opportunity to get the same benefits as people in New York City or Los Angeles or Miami.
The bipartisan agreement on a final Medicare bill establishes this stabilization fund. It was not in the Senate bill. Some people say the Kyl provisions were similar to that, but Senator Kyl will tell you he had a whole different idea. This idea is not in this bill, but we did take a stabilization fund to accomplish something he wants to accomplish. He wants his entire State of Arizona to be served by PPOs, not just Phoenix. We did this in an effort to improve access to private health plans in all areas of the country and, additionally, to maintain existing health care choices in areas where health plans face particularly difficult challenges.

My colleagues on the other side who find fault with this conference report are always talking about this slush fund as benefiting some organization's profit motive. Every one of them has rural areas. My colleagues ought to want the people in the rural parts of their State to be served the same way as people in the urban parts of the State. The reality is this is not a slush fund, but it is to help beneficiaries have equal services, whether they live in rural America or urban America, and that will be helped by this stabilization fund. It is targeted and its plans are held accountable. Resources will be distributed from the stabilization fund only when specific conditions are met. Moreover, in instances where these conditions are met, then health plans will be accountable for using these funds only to promote affordable health coverage to beneficiaries, not for profit. Under no circumstances will plans then be permitted to use these funds to pad their bottom line.

It expands choices and ensures access in rural America. The fund is designed to expand and preserve beneficiary choices and benefits in areas where it is most difficult to provide private health plans and to get them to participate in this program.

The stabilization fund will ensure that millions of additional beneficiaries, including many in rural areas, will have access to health plans offering high quality, comprehensive benefits, and low out-of-pocket costs. If the stabilization fund is not successful, the worst case scenario is that the funds will be returned to the U.S. Treasury.

Now I will speak about the accurate explanation of how this bill helps low-income seniors. We did something in the conference report that the House did so the Senate receded to the House on this point, and that is where we in the Senate decided to leave dual eligibles covered by Medicaid. The House wanted to have one program. The Senate wanted to have one program. That was one of the shortcomings that Democrats said about the Senate bill in June. Now we are hearing complaints from them about aspects of this dual eligible, how it impacts seniors, particularly on asset tests. That is one reason we did not avoid putting dual eligibles under Medicare in the Senate bill, because we wanted asset tests to be the same for this group. Now they are complaining, I think inaccurately, which I will prove in a minute, of why we are impacting people with less coverage than they presently have.

We have heard from the other side how 6 million low-income eligible seniors will be worse off under this conference report. That is inaccurate. It is a lot of talk, and I want to tell the American public the truth about this issue. Beneficiaries are not hurt by this bill. They are helped. This bill provides generous predictable coverage to 6.4 million dual eligibles but it does not stop there. It provides coverage to an additional 7.7 million low-income seniors. Madam President, 141 million seniors are eligible for low-income subsidy, nearly 36 percent of Medicare beneficiaries.

So who are these dual eligibles? They are the 6.4 million who are enrolled in both Medicare and Medicaid. This conference report for the first time provides drugs to dual eligibles through Medicare rather than Medicaid. This is a great help for the States that have budget problems, and Medicaid is a growing, biggest part of State budgets.

As I said, the Senate bill left dual eligibles in Medicaid. That policy allowed the Senate to provide generous coverage for low-income seniors. S. 1 focused on providing drug coverage to seniors who did not have any coverage whatsoever, and duals did have that coverage. So out of compromise, the Senate conferences changed the policy in the Senate bill.

The conference report provides prescription drugs for dual eligibles through Medicare. It is not exactly the same, but in general policy it is the same way they were treated in the House bill. Providing drugs for dual eligibles through Medicare was a cornerstone issue for House conferees.

The conference report covers duals in the Medicare Part D Program. That coverage is designed to benefit as many low-income seniors, including dual eligibles, as possible, given the budget constraints of $400 billion in our budget.

This bill comes out at about $395 billion. Blanket statements about the reduction of benefits for the dual eligibles in the conference report are not accurate. We have heard some of those inaccurate statements this Saturday as we have debated this bill. This bill is generous and does not leave 6 million seniors empty-handed. Rather, tomorrow, those over on the other side will be putting those signs up again that say that. Well, don't do it.

In fact, most of the support for doing that—that was one of the shortcomings that Democrats said about the Senate bill in June. Now we are hearing complaints from them about aspects of this dual eligible, how it impacts seniors, particularly on asset tests. That is one reason we did not avoid putting dual eligibles under Medicare in the Senate bill, because we wanted asset tests to be the same for this group. Now they are complaining, I think inaccurately, which I will prove in a minute, of why we are impacting people with less coverage than they presently have.

For instance, unlike the Senate bill or the current Medicare Program, the conference agreement does not have cost sharing above the catastrophic limits for the dual eligibles. That is right. There is no cost sharing. I hope my colleagues on the other side get that.

I will put this in perspective, then, from the State level. According to the Kaiser Family Foundation, the Commonwealth of Massachusetts currently pays $2 for every prescribed drug filled by dual eligibles. There is no catastrophic limit for duals in that Medicaid Program in that State, just a requirement for beneficiaries to pay $2 for every single prescription.

Like many Medicaid Programs, this bill establishes copayments for a majority of the dual eligibles who are either equal to or less than those required by most State Medicaid Programs. So, there is no gap in coverage. These copayments are not more than $2 and in some cases less than, those required in most State Medicaid Programs.

More specifically, today 25 States have copayment levels for generic and brand name drugs that are higher for dual eligibles enrolled in their Medicaid Programs. In this conference agreement, dual eligibles with incomes below 100 percent of poverty will be responsible only for a copayment between $1 and $3 for their Medicare drug benefit. Taking a step back, it seems to me that this level of cost sharing is very similar to what the duals pay for in Medicare coverage.

In South Dakota, duals pay $2 per prescription. That policy is on par with the coverage offered through this bill. This conference report contains a generous drug benefit, then, for dual eligibles. There is no donut, or no loss of catastrophic coverage, for low-income Medicare beneficiaries. But my colleagues on the other side would lead us to believe otherwise.

The bill guarantees all 6 million dual eligibles access to prescription drugs. Unlike the conference report, eligibles will have better access through Medicare than they do today, specially since State Medicaid Programs are increasingly imposing restrictions on patients' access to drugs because of budget problems that 45 of our 50 States have.

Further, States have the flexibility to provide coverage for classes of drugs, including over-the-counter medicines that might not be covered by the Medicare Program.

This bill ensures appeal rights for dual eligibles. Under the agreement, duals will maintain appeal rights, such as those that they presently have in providing full drug coverage to dual eligibles. A recent study finds that dual eligibles are a fragile population and are well taken care of in this bill. The conference report recognizes and provides generous coverage to these 6 million beneficiaries and in fact goes further by providing full drug coverage to 7.7 million more low-income seniors.

So I turn now to highlighting what this bill does to protect Medicare in

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the long run. I have heard some Members trying to assert that this $400 billion expansion of one of the most successful social programs in our country’s history is going to destroy traditional Medicare; you have said it, “Medicare is dead.” The truth is that other one of your “medi-scare” tactics.

I know Members are tired. I know we are nearing the closing of our first session of the 108th Congress. Many Members are using these wornout lines because they feel rather than take a serious look at the bipartisan Medicare agreement we put together and really assess whether or not those scare tactics are true. I am here to tell all my colleagues and the people of this country that the allegations that this Medicare bill destroys traditional Medicare are falsehoods.

This Medicare bill strengthens and improves traditional Medicare in a number of ways. We are not talking about just Medicare as it has been for the last 40 years; we are talking about some improvements we made in traditional Medicare that seniors will have the choice, the right to choose to stay in if they want to. I will discuss just three.

First, we add new preventive program benefits. For the first time ever, every new Medicare enrollee will receive a “Welcome To Medicare” physical; they go to the doctor when they go into Medicare, get a benchmark physical. Hopefully, nothing is wrong. But if something is wrong, we know about it right away and it is part of our effort to see that we zero in on keeping people well, as opposed to waiting until they get sick and it costs a heck of a lot more. It is part of our program, of a quality of life for our seniors. It is part of our program of zeroing in on the 5 percent of the people who, because of not having chronic care management, are costing us 50 percent of the total.

Seniors are going to have physcians that will help them—maybe their life-style, like getting their weight checked, but more seriously, the heart; receive cancer, diabetes, and bone mass screenings. It is very important to have an initial physical because, as we say in Iowa, an ounce of prevention is worth a pound of cure.

Consider these statistics. In 2000, 6.2 percent of the U.S. population had diabetes, and stroke and heart disease are the first and third leading causes of death in the United States. In 2003, 11 million Americans will have a heart attack. Diabetes, heart disease, and other chronic conditions exact an awful toll on our seniors. By getting an initial physical, seniors can get valuable information on their health status. They can enroll in weight loss programs, start a blood pressure medicine, or know whom to call if something goes wrong.

We have also eliminated the deductibles and the copays on screening tests for heart disease and diabetes, so beneficiaries do not incur any costs.

There is an extent to which that cost today may inhibit them or divert them from having needed tests, so this is an additional incentive, particularly for those with limited resources who might not otherwise access these benefits. Adding preventive benefits is just one way we have improved traditional Medicare.

A second way we have improved the fee-for-service program is by providing access to disease management. It is a battle to compete against the programs to younger people in health insurance. If you have a chronic health condition such as heart disease, diabetes, asthma, you can get extra help managing your condition. You may be taking a lot of medications and seeing several doctors. Disease management programs help patients take responsibility for their health care and better control of their lives, but they also involve health professionals in that process, to aid you.

When this Medicare bill becomes law, seniors will have the right to access these services. It will be a voluntary program and one that will improve the quality of life for millions of Medicare beneficiaries.

Another improvement this bill provides is an additional $25 billion for rural health care providers. That is new money to strengthen our Nation’s hospitals, physicians, ambulance riders, and dialysis clinics, just to name a few. This is the biggest funding boost Congress has ever passed for our rural health care system. This is going to help fee-for-service, traditional Medicare because in some places in this country there is not an adequate number of health care providers. Providers in rural States such as mine, Iowa, practice some of the lowest cost medicine in the country. Yet health care providers in rural areas lose money on every Medicare patient they see. This Medicare bill takes historic steps to address this.

Medicare pays first for seniors and, in the future, Medicare will pay for people in their 70s. The Senate bill does not change that. The Senate bill simply allows seniors to choose whether to enroll in Medicare Part B; they go to the doctor when they enroll in Medicare, get a benchmark physical, receive a benchmark physical.

Overpayments eat away at Medicare’s reserves, eating away at its solvency slowly, like a cancer. Overpayments are bad for taxpayers, they are bad for beneficiaries, both of whom deserve to pay a fair price. In certain areas of Medicare, in many payment systems there are few fair prices.

We have also eliminated the deductibles and the copays on screening tests for heart disease and diabetes, so beneficiaries do not incur any costs.

Combating Waste, Fraud, and Abuse. Our bipartisan initiative in this bill will end overpayments, reduce fraud, and cut down on opportunities for abuse to the tune of $31.3 billion as scored by the Congressional Budget Office. That is significant.

The conference agreement begins to address that in significant ways.

My colleagues should read title III of the conference report, and that is entitled, “Combating Waste, Fraud, and Abuse.”

Our bipartisan initiative in this bill will end overpayments, reduce fraud, and cut down on opportunities for abuse to the tune of $31.3 billion as scored by the Congressional Budget Office. That is significant.

These measures in this bill directly reduce Medicare’s spending on overpriced, wasteful, fraudulent items, and services to the tune of $31.3 billion over 10 years.

Throughout my time in Congress, I have worked hard to combat fraud and abuse in Federal programs. I successfully passed False Claims Act improvements that give whistleblowers new rights and protections under Federal law. In just the last year alone, civil fraud recoveries have tallied a record $2.1 billion, the Justice Department announced just last week. This is a 25 percent increase over the prior years’ recoveries of $1.1 billion, and brings total recoveries to over $12 billion since I got that bill passed. Of the total, $2.4 billion is associated with suits initiated by whistleblowers.

While the False Claims Act is one of our best weapons in the war on fraud and abuse, our policies in this new language of the title III conference agreement adds still more weapons to our arsenal.

First, we make important technical clarifications to existing law that strengthen and improve what is known as the secondary payer statute. The conference agreement adds that Medicare pays first for seniors’ medical needs when other sources should be, in fact, paying instead of the taxpayer paying.
These other sources include, for instance, employer coverage. In addition, when a Medicare beneficiary is injured by wrongful conduct of another entity, that entity’s liability insurance or the entity itself, if it has no insurance, or if it might be self-insured, is always required to pay first instead of having the taxpayers pay. The provisions in title III do not change existing law in this area but, in fact, clarify the intent of Congress in protecting Medicare’s resources.

According to the Congressional Budget Office, these clarifications alone promise to restore Medicare over $9 billion out of that $31 billion.

Second, we change the way Medicare pays for durable medical equipment, first by slowing the spending growth in these areas for 3 years, and then by instituting a competitive mechanism that will deliver a fair market price for seniors.

While I have concerns about the impact of such a new system on very many small businesses across America, the supply of high-quality equipment especially in rural areas, I am confident that the protections are in this conference agreement for small business and for our seniors as well.

The Congressional Budget Office estimates that these changes will save Medicare $6.8 billion out of that $31 billion.

Next, title III institutes what we call market pricing mechanisms for drugs administered in the doctors’ offices that both the Office of Inspector General, and the GAO have concluded are priced far higher than their actual costs.

In addition to the financial toll these overpayments take on the taxpayers, they also affect Medicare’s beneficiaries who are often required to pay dramatically higher copayments for the drugs they rely on. In some instances, these copayments can even exceed the actual prices the doctors paid for the drug.

In recommendations to Congress, the GAO urged Medicare to take steps to begin paying doctors for Part B-covered drugs and related services at levels that reflect the doctor’s actual acquisition costs—not some inflated cost. And they use information about actual market transactions prices to bring that about.

I am pleased that our conference agreement accomplishes this first by reducing the average wholesale price by 10 percentage points, and then instituting a new payment system based on manufacturers’ reported average sale price—or ASP reporting—which will be closely scrutinized by the Inspector general on an ongoing basis to ensure its accuracy.

Errors or abuse of the system will be corrected swiftly so that Medicare will never again pay an unfair price. These changes result in Medicare savings of approximately $1 billion out of that $31 billion total.

Finally, title III takes similar steps to correct overpayments for prescription drugs. That is because at the Office of Inspector General has said are priced far in excess of their actual costs. These drugs will be reduced by 10 percentage points in 2004, and then priced on a similar average sale price system, as others I just mentioned, and that will begin in 2005.

The Congressional Budget Office says that this policy alone will save Medicare $4.2 billion of that $31 billion total.

I have listed three or four examples of how you save that $31 billion.

I believe all of these changes have been carried out in a compassionate fashion with twin goals of protecting both the Medicare Program’s resources and our senior citizens’ access to those services. We have done both.

Our market-based improvement Part B drug payments are accompanied by sweeping changes in payments for clinical services associated with delivering them.

We worked closely with oncologists to ensure that access to cancer care was not harmed.

Similarly, we went to great lengths to ensure that seniors who rely on medical equipment supplies will be able to rely on the supplies they need today.

Finally, to my colleagues who talk about cost containment and the need for Medicare to curtail its spending, I say this: It starts right here. Cost containment begins by ensuring that the costs to Medicare and to the taxpayers who finance it, are, in fact, fair.

The conference agreement starts us down the road. The sum total of $33.3 billion of savings, and the market prices we are imposing on future spending in this area, are in my view, the most significant cost containment policies in this conference agreement.

In the months and years ahead as Medicare spending increases with the expansion of benefits that we are going to pass, therefore, our focus on cost containment will obviously increase. The best thing that Congress can do is to be vigilant. We all need to watch.

We also need to pay attention to other private individuals who have inside information on wrong doing. We need to heed the call of the Office of Inspector General, and, most of all, insist that Medicare never pay more than market price. Taxpayers, on the one hand, and the seniors’ Medicare services, on the other hand, deserve nothing less.

I want to conclude by talking about the views of many organizations that support the conference report.

Mr. GRASSLEY. Madam President, I want to quote from some.

As you can see from the chart up here talking about the AARP. All of you colleagues on that side of the aisle have been saying to me all day how drastically it is that the AARP is backing this legislation. Some Members have even spoken of them becoming a political organization. They cannot become a political organization or they will lose their tax-exempt status. But you accuse them of being a tax-exempt organization.

I recall last year when they did not come out for the bipartisan bill that several Members brought out, that the Democrat majority did not want to let pass because they wanted an issue in the last election instead of a product, the AARP was not backing what I, Senator SNOWE, Senator JEFFORDS, Senator BREAUx, and Senator HATCH wanted to do. Ours was a bipartisan effort, or a tripartisan effort, with Senator JEFFORDS being an independent, to get a bill through because you cannot get through anything in this body if it is not bipartisan. The AARP did not like what we were doing. They did not discourage us but they did not help us. They actually sent letters out to support what Senator KENNEDY was trying to do a year ago.

I did not accuse the AARP of being a tool of the Democrat Party like Members on the other side are accusing the AARP of being in bed with the Republican Party. I am not in bed with the Republicans. They are in bed with a bipartisan group of this body who want to do something for seniors of America.

It is funny how the AARP is OK when they are helping Senator KENNEDY but they are not OK if they are helping a bipartisan group led by Senator GRASSLEY and Senator BAUCUS.

I would say they are discretionary in what they do. They may not be consistent, but thank God they are not consistent because they would not be representing the diverse group they represent.

Here is what the AARP says in their endorsement:

AARP believes that millions of older Americans and their families will be helped by this legislation.

They continue:

This bill provides prescription drug coverage at little cost to those who need it most: People with low-incomes, including those who depend on Social Security for all or most of their income. It will provide substantial relief for those with very high drug costs and will provide modest relief for millions more.

The last sentences I will read:

An unprecedented $88 billion will encourage employers to maintain existing health retiree benefits. The legislation will help spread generic drugs to millions and add important new preventive and chronic care management services. This legislation protects poor seniors from future soaring prescription drug costs.

All the Members complaining about the AARP, put that in your pipe and smoke it.

Then we have the National Council on the Aging:

...we find it too difficult to again say to millions of vulnerable seniors in need. Sorry, come back in a few years and maybe there will be some help for you then.

Another sentence:
We urge Congress to pass the Medicare bill so that millions of seniors with greater needs will receive long-awaited and badly-needed prescription drug coverage.

Are Members trying to tell me the National Organization on the Aging does not know what is good for seniors when they see it? Put that in your pipe and smoke it.

The Alzheimer's Association says:
This is a historic accomplishment that may potentially provide meaningful relief to the 4.5 million Americans dealing with Alzheimer's disease—many of whom also suffer other health issues.

That is from Sheldon Goldberg, president and CEO of the Chicago-based national organization for the Alzheimer's Association.

Are Members telling me the Alzheimer's Association cannot make a judgment if this bill is good for their members? Go put that in your pipe and smoke it.

From the American Diabetes Association:
This legislation will improve Medicare coverage for seniors and protect access to the physicians and services upon which they rely for quality of care.

The proposal creates a comprehensive benefit that provides coverage for drug products and pharmacist services, and provides seniors their choice of pharmacists and ensures any willing pharmacist can participate in a plan and incorporates important administrative efficiencies.

Those Members who oppose this bill, are you trying to tell the people of America that the American Pharmacists Association does not know a good piece of legislation when they see it and that they cannot speak for not only their membership but also their patients and clients they serve?

From the College of American Pathologists:
We commend the Senate and House conferences on their historic step to benefit every senior in America. Partisan politics and rhetoric-without-results on prescription drugs are simply unacceptable. Years of work by many in both parties and leaders of heartache for America's seniors have led us to this point. The whole senior world is watching and Congress must not collapse so near the finish line.

Are you trying to tell me that the United Seniors Association looks at this legislation and sees it is good for their members, and yet you cannot see that?

We have The 60 Plus Association:
This bill makes available much needed assistance to millions of seniors who lack any prescription drug coverage. Significantly, those who can least afford to pay will get the help they need from this legislation.

From the Rural Hospital Coalition:
We support your efforts to modernize Medicare and give senior citizens a prescription drug benefit that they deserve. . . . [T]his bill strengthens health care in rural America.

From the National Rural Health Association:
This bill is a big boost for the rural healthcare system. A stronger healthcare system will help revitalize rural economies which will positively impact rural Americans throughout the country.

We have the National Hospice and Palliative Care Organization:
NHPCO strongly supports these provisions and believes these changes will improve the quality and timeliness of hospice and palliative care for seniors and their families.

From the Mayo Clinic, 150 miles from my home in Iowa:
Mayo Clinic supports the compromise Medicare reform legislation that has emerged from a congressional conference committee.

We have NAMI, The Nation's Voice on Mental Illness:
This conference agreement does represent an improvement for Medicare beneficiaries living with mental illness. . . . NAMI feels strongly that it is time for Congress to end partisan stalemate over this issue and take advantage of the $400 billion available this year to spend on a new drug benefit.

This is kind of a partisan statement I am going to read to you, but it does represent a group of people who are impacted by what we do here with dual
Ms. MURKOWSKI. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

The bill clerk proceeded to call the roll.

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

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

Ms. MURKOWSKI. Mr. President, I realize the hour is late. This body has been discussing the issue of Medicare legislation for close to 12 hours now on this Saturday.

I want to speak briefly this evening about the legislation that is under consideration in the Senate and its impact on senior citizens in my home State of Alaska as well as around the Nation.

We have heard a great deal today on the floor about the need for reform, about what we need to provide for our senior citizens.

We must keep in perspective what we owe our seniors. This is the generation of Americans who paid most dearly to protect the freedoms we enjoy. Many of our older Americans today went through the Depression and have very personal, truly gut-wrenching memories of the hunger that they perhaps went through at the time. They were the generation who settled the frontier and redefined the meaning of the State of Alaska. They remember the horror and the stories from Pearl Harbor. We owe this generation of Americans many things, not the least of which is honesty.

Since Medicare was enacted in 1965, it has provided health security to millions of America's seniors and people with disabilities. Medicare is that promise of health security we must always keep.

Many of my colleagues on the other side of the aisle would take these statements into consideration, particularly tomorrow, when I am told 15 of the other side of the aisle would take these provisions into consideration in order to meet certain levels for low-income subsidies for Medicare beneficiaries.

I thought, wait a minute, that can't be true. That is not a part of this legislation. Seniors will not have to do that. So I said: Show me. Let me know for sure that, in fact, this is not the case.

We pulled it out and looked at the application of the asset test. It very clearly states those resources that are not counted for an asset test, excluded resources, include, and No. 3 on the list is memorabilia such as a wedding ring. For us to stand here on the Senate floor and suggest to a senior citizen that in order to meet certain requirements to keep your Medicare benefits you might have to give up your wedding ring, I sure hope my 84-year-old next-door neighbor was not hearing that because she slept that night. She would not sleep well knowing that that could be true.

We have to be real. We have to be honest with our statements, and we have to talk the truth about what is and is not contained in the legislation before us.

Americans deserve to know that this bill, while not perfect—I don't think any of us would suggest it is perfect—will provide good drug coverage for any senior citizen who wants to enroll. Americans deserve to know that this bill doesn't force seniors to join HMOs to get prescription drugs.

This legislation is designed to provide choice, not coercion. If seniors want choice on drug coverage to the Medicare plan that they have right now, they would have that option. Their benefits would not be reduced, would not be taken away. If they don't have drug coverage or if they are happy with the coverage they have now through their retirement plan, they don't have to accept the voluntary Medicare benefit.

The incentives for employers to keep offering their own prescription drug benefits: The Employer Benefit Research Institute indicates that they expect between 97 percent and 99 percent of beneficiaries won't have any change under this provision. We need to clearly repeat these provisions.

The bottom line is this: If you like Medicare the way it is today, you can keep it that way because it is designed to be a voluntary benefit.

The problem is for many Americans, including those in Alaska, Medicare has not been living up to its promises. It will only pay for your drugs if you have been hospitalized. And for many, it is not paying for the health care professionals. Essentially, this program is still stuck in the 1960s mindset of reactive care rather than the kinds of proactive care we expect today.

Several months back I had an individual come to me talking with me and going out to senior centers. We were talking about the Medicare legislation in front of us at that time. She made the analogy that Medicare is like the telephone. In 1965, the black rotary dial was the only way to make a phone call. It was the black rotary dial. They came in one color and one style, and that was it. And that is how we talked.

Now in the year 2003, we talk on cell phones by fax, e-mail, on colored phones. The technology has changed incredibly, but we are still doing the talking.

Medicare is essentially the rotary dial system of health care that just hasn't been ramped up.

Americans need to know that Medicare still doesn't provide full coverage for preventive care, including cancer, diabetes screenings. It doesn't offer protection against catastrophic medical expenses, including those in Alaska, Medicare has not been living up to its promises. It will only pay for your drugs if you have been hospitalized. And for many, it is not paying for the health care professionals. Essentially, this program is still stuck in the 1960s mindset of reactive care rather than the kinds of proactive care we expect today.

The problem is for many Americans, including those in Alaska, Medicare has not been living up to its promises. It will only pay for your drugs if you have been hospitalized. And for many, it is not paying for the health care professionals. Essentially, this program is still stuck in the 1960s mindset of reactive care rather than the kinds of proactive care we expect today.

Several months back I had an individual come to me talking with me and going out to senior centers. We were talking about the Medicare legislation in front of us at that time. She made the analogy that Medicare is like the telephone. In 1965, the black rotary dial was the only way to make a phone call. It was the black rotary dial. They came in one color and one style, and that was it. And that is how we talked.

Now in the year 2003, we talk on cell phones by fax, e-mail, on colored phones. The technology has changed incredibly, but we are still doing the talking.
the access to vital specialty care and educational resources.

While we all seem to agree that it is important to add preventive benefits to Medicare, there has been a lot of discussion about whether to allow government participation in the design of health plans, but yet we would deny our senior citizens that same choice.

The bill before us rejects this philosophy of “big Government knows best,” and tells our seniors: You have the right to select a benefit that meets your needs. If you don’t need drug coverage, you don’t have to enroll. You can keep Medicare the way it is today. If you don’t want to join a private plan, you don’t have to. If you don’t want to change anything about Medicare, you don’t have to.

I also want to address a comment that a number of Members—primarily on the other side of the aisle—have made characterizing Medicare as good the way it is. I can have seen a pretty large number claiming that the Medicare Program today gives seniors such things as a choice of doctors. While I agree with them that Medicare is a good program, and I believe we need to make it even better, I would like to address the issue of how many seniors—so-called doctors who can write the prescriptions, if we don’t have doctors who can write the prescriptions, if we have no gap in coverage; and Medicare will pay about 90 percent of their drug costs. They deserve to know the group purchasing power we are giving to seniors is going to make the drug companies work for the business.

Mr. President, those who stood defending our freedom deserve more than the partisan rancor that has been sailing around this Chamber. They deserve to know more than some of the half-truths that have been told. Medicare, as we know it, should provide seniors with access to vital health care services and the physician of their choice. I believe this bill does those things, and I believe it will meet the needs of my constituents.

We have come a long way toward making good on our promise to our senior citizens, and that is to the credit of the administration and to the leadership of this Congress, certainly to the leadership of the Senator who is providing this example. We do not need to strengthen Medicare, and seniors do need access to vital prescription drugs.

Many who are now on Medicare fought for the freedom that we enjoy today, and Monday we will, hopefully, have the opportunity to keep our promise to seniors and to defend their behalf by providing them with a voluntary prescription drug benefit.

I urge my colleagues to support this legislation.

ORDERS FOR SUNDAY, NOVEMBER 23, 2003

Ms. MURKOWSKI. Mr. President, on behalf of the majority leader, I ask unanimous consent that when the Senate completes its business today, it adjourn until 1 p.m., Sunday, November 23. I further ask unanimous consent that following the prayer and pledges, this measure be re-debated and the time thereon be extended for the use of the next day.

The Journal of proceedings be approved as written today, and Monday we will, hopefully, have the opportunity to keep our promise to seniors and to defend their behalf by providing them with a voluntary prescription drug benefit.