Further, if present and voting, the Senator from Alabama (Mr. SESSIONS) would have voted ''yea.''

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

The result was announced—yeas 69, nays 28, as follows:

[Rollcall Vote No. 168 Leg.]

YEAS—69

Alexander	Dole	McConnell
Allard	Domenici	Mikulski
Barrasso	Ensign	Murkowski
Baucus	Enzi	Nelson (FL)
Bayh	Feinstein	Nelson (NE)
Bennett	Graham	Obama
Bond	Grassley	Pryor
Brownback	Gregg	Roberts
Bunning	Hagel	Rockefeller
Burr	Hatch	Salazar
Carper	Hutchison	Shelby
Casey	Inhofe	Smith
Chambliss	Inouye	Snowe
Coburn	Isakson	Specter
Cochran	Johnson	Stevens
Coleman	Kohl	Sununu
Collins	Kyl	Thune
Conrad	Landrieu	Vitter
Corker	Lieberman	Voinovich
Cornyn	Lincoln	Warner
Craig	Lugar	Webb
Crapo	Martinez	Whitehouse
DeMint	McCaskill	Wicker

NAYS—28

Akaka	Dorgan	Murray
Biden	Durbin	Reed
Bingaman	Feingold	Reid
Boxer	Harkin	Sanders
Brown	Kerry	Schumer
Byrd	Klobuchar	Stabenow
Cantwell	Lautenberg	Tester
Cardin	Leahy	Wyden
Clinton	Levin	
Dodd	Menendez	

NOT VOTING—3

Kennedy	McCain	Sessions

The bill (H.R. 6304) was passed.

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

The motion to lay on the table was agreed to.

MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT—MOTION TO PROCEED

Mr. REID. What is the matter now before the Senate?

The PRESIDING OFFICER. Under the previous order, the motion to proceed to the motion previously entered to reconsider the vote whereby cloture on the motion to proceed to H.R. 6331 was not agreed to, is agreed to and the time until 4 p.m. will be evenly divided before the cloture vote.

Mr. REID. I ask unanimous consent that there be 1 hour prior to the vote, which is now set for 4 o'clock, that the time be divided, with the last 20 minutes for Senator MCCONNELL and Senator REID of Nevada; that I have the last 10 minutes; that the other 40 minutes be equally divided and controlled between the chairman of the Finance Committee, Senator BAUCUS, and the ranking member of the committee, Senator GRASSLEY.

That means there will be 20 minutes for Senator MCCONNELL and me, and there will be 40 minutes remaining, equally divided.

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

Who yields time?

Mr. BAUCUS. Madam President, may I inquire, what is the pending business before the Senate?

The PRESIDING OFFICER. On reconsideration of cloture on the motion to proceed to H.R. 6331.

Mr. BAUCUS. Madam President, the Prophet Isaiah urged:

Cease to do evil,
learn to do good;
seek justice,
correct oppression;
defend the fatherless,
plead for the widow.

Since 1965, Medicare has been about defending the disabled. Medicare has been about providing for the elderly. From its beginning, Medicare has been about doing good. Before Medicare, old age was very much about widows.

In 1960, a man could expect to live a little more than 66 years, whereas a woman could expect to live past 73. Now, with the help of Medicare providing health care for the elderly, men can expect to live beyond 75 and women can expect to live beyond 80.

Before Medicare, in 1959, more than 35 percent of the elderly lived in poverty. When President Johnson signed the Medicare Act into law, he said of the elderly:

> Most of them have low incomes. Most of them are threatened by illness and medical expenses that they cannot afford.

Thus, before Medicare, the elderly received poorer health care. They endured more pain. They met early death. But then, 43 years later, in July 1965, with my fellow Montanan Mike Mansfield looking on, President Johnson signed the Medicare Program into law. This chart to my left shows the picture of that day.

That day President Johnson said:

> No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so they might enjoy dignity in their later years. No longer will young families see their own hopes eaten away simply because they are carrying out their deep moral obligations to their parents.

Further quoting President Johnson:

> And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this country.

Thus, from its beginning, Medicare has been a moral issue. Medicare has been about doing good, about doing what is right. I come to the floor today to speak in defense of Medicare. I come to plead for the widow. I come to fight for the disabled.

Today Medicare is threatened. Health care costs have been growing rapidly. Federal Reserve Chairman Bernanke told the Finance Committee's health care summit:

> Health care has long been and continues to be one of the fastest growing sectors in the economy. Over the past 4 decades, this sector has grown, on average, at a rate of about 2.5 percentage points faster than the gross domestic product.

But the fruits of the 1997 law threaten to cut—yes, cut—payments to doctors who treat Medicare beneficiaries unless we act. If we do not act, the law will force cuts in payments to doctors by 10.6 percent. We have to stop that cut.

That cut threatens access to care for America's seniors. Already some providers are declining Medicare patients. My colleagues hear that constantly. Fewer and fewer doctors are taking Medicare; more and more are dropping. Why? Because reimbursement rates are already too low, and unless we act today, those reimbursement rates will be much lower.

Doctors know about these cuts. My colleagues in their home States hear this constantly. I am sure, over the July 4 break, they heard over and over that the doctors are very concerned about Medicare reimbursement. The share of doctors accepting new Medicare patients has been falling. It is falling for those who accept and do not accept Medicare. It is falling for those military personnel in TRICARE who seek services from doctors as well because TRICARE payments are tied to Medicare.

Unless we act, those patients in the TRICARE system, our military service men and women, will also find that their doctors are not treating them either. That trend will accelerate if we do not act. An American Medical Association survey found if the scheduled cuts stay in effect, 60 percent of doctors will have to limit the number of new Medicare patients whom they treat; 60 percent would have to limit, unless we restore these cuts.

These cuts also threaten access to health care for our military men and woman. As I mentioned, TRICARE uses the Medicare formula to pay their doctors. Those cuts could endanger health care for military retirees and even for those on Active Duty.

I do not think that is well understood, that TRICARE is tied to Medicare. If we cut Medicare, we cut TRICARE. That means about 9 million American service men and women, Active Duty and retirees, the doctors who service them will no longer provide that service; a 60-percent reduction.

The Military Officers Association of America reports that declining participation of providers due to low reimbursements is already one of the most serious health care problems facing military families.

Real and threatened cuts in the level of Medicare reimbursements have caused many providers to stop accepting new TRICARE patients.

Since 1965, there have been those few who did not think that Medicare was good. There have been those who have sought to call it evil. In the 1960s, there were those on the fringe who called it socialized medicine. In 1995, there were those who said it was going to wither on the vine, those who wanted to do away with Medicare. But the truth is, from the start Medicare has had broad,

very broad, bipartisan, very bipartisan, support. The original Medicare Act passed the House of Representatives with a vote of 307 to 16. It passed the Senate by a vote of 70 to 24. That broad support was evident again on June 24 of this year before the break. That day the House of Representatives passed the Medicare Improvements for Patients and Providers Act. That bill would stop those cuts in doctors' payments. The House passed that bill with an overwhelming vote of 355 to 59; 355 House Members voted for it. That is better than a 6-to-1 margin. Even among Republican Members of the House, more than twice as many voted for it than against it.

On June 26, the Senate fell one vote short of invoking cloture on the motion to proceed to that bill. But today the Senate will reconsider that vote, and we should. The Senate should take up and pass this Medicare bill. The Senate should pass this Medicare bill because there is no alternative. If we fail to enact this bill, millions of America's seniors will be worse off. We cannot let that happen. This bill can prevent that. The House-passed bill is very similar to the Baucus-Snowe bill the Senate considered earlier in June, but the House made three noteworthy changes. First the House-passed bill includes legislation to delay the competitive acquisition program for durable medical equipment. Congress needs to ensure that these savings do not harm beneficiary access to care. We need to take a closer look at competitive bidding before it goes forward. Passage of this Medicare bill would allow that. The House-passed bill also does not include cuts in funding for oxygen supplies and equipment, and it does not include cuts in funding for powered wheelchairs. Those who support these reforms make a good case. But ultimately, the cuts could not be included as part of this must-pass legislation.

This bill is a balanced package. It is a compromise. It makes modest changes. When the House passed its children's health bill last year, the House made major changes to the Medicare Advantage Program. Last year's House CHIP bill would have significantly restructured the program. This House Medicare bill, however, would not do that. This bill includes a reduction in the double payment for medical education costs to private plans in Medicare, and this bill would protect seniors from unscrupulous marketing practices by private health plans. This bill would require so-called private fee-for-service plans to form provider networks. It would make sure that there are doctors behind those plans. Currently, those private fee-for-service plans do not have to do that. By fiat, they deem it to be the case. But it is not accurate. This bill would make sure there will be doctors behind those plans.

This bill does not include deep cuts due to the Medicare Advantage Program. Some suggest it does. It does not at all. It does not cut private fee-for-service plan payments at all. I wish to go further on Medicare Advantage. I think we should do more. But this is not the time, and this is not the legislation on which to do so. This, however, is the time to avert the pending cut in payments to doctors. That payment cut would devastate access to care for America's seniors. We cannot let that happen.

For Medicare beneficiaries, this Medicare bill would expand access to services. We all talk about greater access to preventive services. It would eliminate the discriminatory copayment rates for seniors with mental illnesses. We all talk about that. We want mental health parity. We do it in this Medicare legislation. And it will provide additional needed help for low-income seniors. We all talk about that need too.

This Medicare bill would take important steps to shore up our health care system in rural areas. It includes provisions from the Craig Thomas Rural Hospital and Provider Equity Act. Let's do this for Craig Thomas.

This bill also includes important relief for ambulance providers, community health centers, and primary care physicians. Primary care doctors represent the backbone of our health system. We all hear from home that primary care doctors are especially vulnerable and we give additional help to them. This Medicare bill would make important improvements in pharmacy payments. It would make payments under the Part D drug benefit fairer and more timely to those who dispense drugs to our Nation's senior citizens. We have all heard that pharmacists need this help because they are in a disadvantageous position in dispensing Part D drugs.

This bill would save money by providing a single bundled payment for all the services related to treating end-stage renal disease, and that will help reduce costs. For the first time, dialysis facilities would receive a permanent, market-based update to their payments each year, giving them a little bit of predictability. This would ensure that Medicare payments keep up with costs.

The bill would expand emergency health care for veterans in rural areas. It would increase payments for doctors who work in rural areas. It would stop the payment cut to providers. It would give them a decent increase in reimbursement. All of this would help to ensure that seniors and military families would be able to keep seeing the doctors they need to see.

On July 30, 1965, President Truman watched President Johnson sign the Medicare Act. That is what is shown in this photograph to my left. President Truman at that point said:

> Mr. President, I am glad to have lived this long and to witness today the signing of the Medicare bill, which puts this Nation right where it needs to be, to be right.

Yes, from its beginning, Medicare has been a moral issue. Medicare has been about doing good. So let us defend the elderly. Let us defend the disabled. Let us provide for our military families, and let us enact this important Medicare bill.

I know others are waiting to speak on the other side of the aisle. In a moment I will yield the floor, but before doing so, I yield half of the time remaining under my control to Senator SCHUMER and half of the time to Senator DURBIN for their use when they are recognized.

The PRESIDING OFFICER. Duly noted.

Who yields time? The Senator from Utah.

Mr. HATCH. Madam President, I rise to oppose cloture on the motion to proceed to H.R. 6331, the Medicare Improvements for Patients and Providers Act.

I am beginning to feel like the character from the movie ''Groundhog Day'' who wakes up every morning to the same day. Here we are again, having the same debate about the same Medicare bill that will not be signed into law.

I believe that our time would be better spent working on a bill to restore physician payments instead of having a partisan vote just to make some political points. It would be better to work in a bipartisan way. We could do it in 10 minutes, if we just sit down and do it. I know the distinguished chairman and ranking member could do it.

But it is obvious that some in this body would rather have a political battle and put Medicare beneficiaries and their doctors at risk.

In the last month, I stood on the Senate floor, not once, but twice emphasizing that I want to work on a bipartisan Medicare bill that will be signed into law. In fact, we had a bipartisan agreement in the Senate.

Unfortunately, Senate Democrats are still not permitting a vote on a compromise measure or even the Republican alternative.

The bipartisan compromise bill would have passed overwhelmingly, and this issue would be behind us.

And, quite frankly, H.R. 6331, essentially, the Baucus Medicare bill, contains many provisions that both sides strongly support.

It is troubling that only the Democrat Medicare bill is being given a vote on the Senate floor, especially when there is a Republican alternative that restores physician payments as well, especially since I believe Senators BAUCUS and GRASSLEY would have worked it out long before now without all the hoopla and politicization.

In addition, when the Democrat Medicare bill failed to get cloture a few weeks ago, the minority leader asked for unanimous consent to pass a 31 day extension of the December Medicare law. The purpose of this extension was to prevent the Medicare physician cuts from going into effect until we were able to work out our differences.

But Senator REID objected to this unanimous consent request for political reasons and told the Senate that

he wanted the Republicans who voted against cloture to feel the heat when they went home for the Fourth of July recess. I was a little shocked at that.

Fortunately, the Centers for Medicare and Medicaid Services, CMS, is delaying the Medicare reduction for physicians for 10 business days to give us more time. Unfortunately, we do not agree on one key issue—the Medicare Advantage Program. This program was created in the Medicare Modernization Act of 2003. I was on the conference committee and spent months working on Medicare Advantage.

Today, Medicare Advantage provides beneficiaries with many health care choices in addition to traditional Medicare.

Medicare Advantage plans are very similar to private health plans offered to those under 65 years of age. One out of five people in Medicare are on Medicare Advantage, and they love the program.

The Democrat Medicare bill includes reforms to the Medicare Advantage Program that are unacceptable to both the White House and many of us who support the Medicare Advantage Program.

Those of us who support Medicare Advantage feel that the provision in the Democrat Medicare bill will limit plan choices currently offered to beneficiaries.

Beneficiaries participating in the Medicare Advantage Program are happy with their health care coverage.

Every month, I receive hundreds of letters from my constituents telling me how much they like their Medicare Advantage plans.

Medicare Advantage is working across the country.

On the other hand, the Medicare+Choice program, which was the precursor to the Medicare Advantage Program, did not work very well, especially in rural areas.

That was because the Federal Government did not pay plans enough money to operate in rural areas.

The Utah Medicare+Choice plans left our State because plans could not function and they were losing money.

At that point, Utah Medicare beneficiaries only had one choice—traditional Medicare. And once we start disassembling the Medicare Advantage Program, as some in this body want to do, I believe that health care choices for beneficiaries will diminish. Through the Medicare Modernization Act, we finally figured out how to provide choice to Medicare beneficiaries in both rural and urban areas and how to pay plans appropriately.

But my friends on the other side cannot leave a good thing alone and insist on making changes to a program that works well today and that 90 percent of beneficiaries in Medicare Advantage are satisfied with.

The Democrat Medicare bill, if signed into law, will no longer allow private fee-for-service plans to deem.

Deeming allows beneficiaries in private fee-for-service plans to see any Medicare provider.

Deeming has been important to those living in rural areas where it is difficult for network-based plans to persuade providers to contract with them. It is also helpful to employer groups which provide retiree health coverage to those living in rural areas across the country.

The elimination of deeming could take away health care coverage choices for Medicare beneficiaries living in rural States.

In addition, the elimination of deeming could cause some retirees to lose their health benefits because the retirement plan cannot establish networks in all 50 States.

According to America's Health Insurance Plans, known as AHIP, 21,000 Utah beneficiaries may be dropped from their current Medicare Advantage private fee-for-service plans if the provision to eliminate deeming becomes law.

In fact, AHIP believes that 1.7 million seniors across the country could lose their existing health coverage if H.R. 6331 becomes law.

A few weeks ago, I mentioned that one Utah employer has said that the elimination of deeming will force the company to stop offering health care coverage to almost 12,000 retirees, and that is probably the tip of the iceberg.

I fear that the impact of this provision could be devastating, especially to beneficiaries living in rural States.

We truly do not know the full effect of this policy and how it will affect Medicare beneficiaries across the country.

Therefore, I simply cannot support this policy and it is the main reason that I am going to vote against cloture.

Do not be fooled—the bill we are considering today will not be signed into law.

The President has said he will veto the bill and there will not be enough votes to override his veto. I suppose some on the other side think they have a great political advantage if he vetoes the bill and we can't override it. They can use that against Republicans.

This motion must be defeated for the third time. We should not have had to go to three votes.

Hopefully, my colleagues on the other side of the aisle will want to work with us on a bill that can be signed into law because it would be bipartisan.

We must move forward so Medicare beneficiaries will no longer worry about their doctors dropping out of the Medicare Program.

We must move forward so physicians participating in the Medicare Program will not be cut by 10.6 percent. I don't think anybody in this body believes that we will allow that cut to occur; certainly, I will not.

We must move forward because the American people are getting tired of a do-nothing Congress where Members are not able to work out their differences.

Why don't we put all our differences aside? We could solve this in 10 minutes without making it a political fiasco which is what it has become. I think in the end everybody would be better off. Certainly, seniors who are on Medicare Advantage would continue to be better off than they would be if this very partisan bill passes through this body and is vetoed by the President and that veto is sustained.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. How much time remains on the Democratic side?

The PRESIDING OFFICER. There is 7 minutes.

Mr. DURBIN. I yield myself 3½ minutes and reserve 3½ minutes for the Senator from New York, Mr. SCHUMER.

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

Mr. DURBIN. Madam President, this debate is about an important bill for 40 million Americans. It is about Medicare. It is about whether the doctors who provide benefits under Medicare will have a 10.3 percent cut in their reimbursement. Those of us who are for Medicare don't want to see that happen. It means fewer doctors treating senior citizens. It means fewer doctors who will be part of the program. So we are trying to stop this cut from happening. But we are running into resistance from the Republican side of the aisle.

The bill before us is a bipartisan bill that passed the House of Representatives by a margin of 6 to 1. Two-thirds of the Republicans in the House voted for this measure. It is a very bipartisan approach. But unfortunately, on the other side of the aisle, the Republicans are determined to oppose this bill.

Why? Why would they want to see fewer senior citizens with doctors they need under Medicare? Why would they want to see fewer doctors in the program? Because the way we pay for the doctors' compensation is by cutting back on the private health insurance companies currently trying to offer Medicare benefits. Now, why would we do that? Because, unfortunately, they are overcharging the Government—from 12 to 17 percent more than what the Medicare Program is charging for the same services. We believe they can cut back on their profits, they can reduce their costs, and they can still help seniors.

Remember when we started with private health insurance companies? The Republicans said: We want them to be able to play in Medicare. They can do a much better job than the Government. They will cut the costs dramatically. They will bring it down to 95 percent of what the Government charges. Exactly the opposite has occurred. The private health insurance companies have increased their costs over the years, and the Republicans who oppose this bill want to protect those companies. They do not want to see those private health insurance companies take

a hit, get a reduction in the amount of money paid by the Government. So they continue to refuse to vote for this measure to help Medicare physicians.

The last time we had this vote, we had 59 Senators who voted for it. What do we need today at 4:05 to strengthen Medicare? We need one more Republican vote, one more Republican Senator. Madam President, 9 of the 49 voted with us last time. With 10, we have the 60 votes, and Medicare will have a bright future.

For those who argue, well, President Bush just might not like the bill, I am sorry, but this bipartisan bill which passed overwhelmingly in the House should pass overwhelmingly in the Senate, and we should say to President Bush: It is much more important for us to protect 40 million seniors under Medicare and, incidentally, about 9 million military families under TRICARE from these kinds of cuts in physician reimbursement.

I have listened to the debate on the other side of the aisle, and it really comes down to a difference of philosophy. When Medicare was created, the Republicans, by and large, opposed it: Oh, it is a big Government program. It is socialized medicine. What did Medicare do for America? It gave peace of mind to seniors that the next illness would not wipe out all their savings. It gave them access to the best doctors and the best hospitals.

Do you know what? Seniors are living longer today than when they signed that Medicare bill into law in 1965. That is the proof of its success. But many on the Republican side of the aisle have never accepted it. They always want to go to the private health insurance companies, even when it costs too much for the seniors and for our Government.

This is our chance. One more Republican vote means the Medicare Program will be strong for years to come.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CORNYN. Madam President, how much time remains on this side?

The PRESIDING OFFICER. There is 12 minutes 20 seconds.

Mr. CORNYN. Madam President, will you tell me when 5 minutes is consumed?

The PRESIDING OFFICER. I would be happy to.

Mr. CORNYN. Madam President, Congress should be embarrassed to have doctors and seniors come hat in hand every 6 months, every 12 months, every 18 months, and say: Please don't cut reimbursement rates for physicians. It is just a terrible way to do business. It puts people in fear that Congress will not act. It also provides opportunities for political gamesmanship that we have seen in an abundance on this particular temporary patch.

The fact is, Congress has only on one previous occasion allowed these cuts to go into effect, in 2002. Every year since it has acted. The fact is, we will. But what we need is a permanent solution, not a temporary patch. This is a terrible way to do business. The fact is, Medicare is a deeply troubled program. In fact, it will go bankrupt—parts of it—by the year 2019. But Congress is just whistling past the graveyard—whistling past the graveyard.

We need a permanent solution to this broken Medicare system. The fact is, many Medicare beneficiaries, many seniors cannot even find a doctor who will accept new Medicare patients because reimbursement rates are below market in many parts of the country. The fact is, the majority leader, by objecting to a 30-day extension of current law to allow a bipartisan compromise between the chairman and ranking member of the Finance Committee, is doing nothing but playing partisan politics with something that should be above partisan politics. We need a permanent solution.

UNANIMOUS CONSENT REQUEST—S. 2729

That is why, Madam President, I ask unanimous consent that the Committee on Finance be discharged from further consideration of S. 2729, the Ensuring the Future Physician Workforce Act, and that the Senate proceed to its immediate consideration; that the bill be read a third time and passed, the motion to reconsider be laid on the table, and that any statements relating to the measure be printed in the RECORD.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Madam President, reserving the right to object, I have looked at the Senator's bill, and I must say that any objective observer would know that this is not a serious effort. It is a big warm kiss on doctors to show to them that they love doctors when, in fact, this is going nowhere. It is a $380 billion bill unpaid for. It is not a serious effort whatsoever. I regret the Senator from Texas has the audacity to bring this up.

I object.

The PRESIDING OFFICER. Objection is heard.

Mr. CORNYN. Madam President, I take exception to the chairman of the Finance Committee's insulting remarks. I would say to him that on this bill I have worked in consultation with the Texas Medical Association, which has endorsed it heartily, and what people should be insulted by are these temporary patches every 6 months that do nothing to solve the problem, that provide a political football for the majority party to play to try to take advantage in the next election, to put seniors in doubt as to our seriousness at keeping our commitment for Medicare.

I think it is the chairman of the Finance Committee and the majority leader who should be embarrassed by their objection to sensible and good-faith efforts to try to fix on a permanent basis this broken system. I regret Congress, once again—no wonder the U.S. Congress has a single-digit approval rating, with only 9 percent of the country believing it is doing a good or excellent job.

It is no secret that people are absolutely disgusted with the partisan politics that do not permit real solutions to serious problems, such as fixing Medicare once and for all, and particularly this part that is broken, the payment reimbursement system.

So I take very grave exception to the remarks of the chairman of the Finance Committee. It is he who is not serious about solving the problem. It is he who insists on partisan gamesmanship rather than real solutions. And I think it is a very sad day for the Senate.

Mr. DODD. Madam President, I rise in support of this legislation and want to thank the senior Senator from Montana for his leadership and commitment to ensuring a strong Medicare Program.

Medicare is one of the twin pillars of the retirement security compact we have with our seniors. It says that after a lifetime of hard work and paying taxes, seniors deserve the dignity of a secure retirement. That includes quality, accessible health care. At a time of skyrocketing health care and prescription drug costs, this bill strengthens our commitment to our seniors by eliminating the scheduled 10.6 percent fee cut for Medicare physicians while providing a 1.1-percent update in payments. Why is that so important, Mr. President? Because it directly impacts how we care for seniors. Because doctors are already facing this payment cut because we were prevented from acting on this legislation before recess. Because my State of Connecticut could be looking at a loss of $190 million over the next 18 months—funds that would otherwise help pay for the care of elderly and disabled patients. Nearly a half million seniors in my State alone would be affected. And because military families will also benefit from this bill because they rely on TRICARE which ties its payments to Medicare. Indeed, absent this action, we could be putting at risk health care for not only military retirees but even for those on Active Duty. For all they have given to this country, we absolutely cannot let that happen. More than 50,000 TRICARE patients in Connecticut alone are depending on us.

There are other components of this bill I strongly support as well. Included among the $4 billion in improvements for Medicare beneficiaries is assistance for low-income seniors, who need this assistance the most. This legislation also protects access to therapy services, reduces out-of-pocket costs for beneficiaries who seek mental health care, and provides important improvements for our Nation's pharmacies and rural providers.

Ultimately, this legislation sends a message to our seniors and those who serve our country—it says that a promise made will be a promise kept. With this bill, we are keeping our word to

these men and women that there is no higher priority than ensuring our seniors and military families receive the quality health care they deserve.

Lastly, it is particularly appropriate that we move to deepen our commitment to Medicare on the day one of its biggest champions returns to the Senate. Throughout our history, there has been no greater advocate for our seniors and for health care than Senator KENNEDY. He is a friend to me, but more importantly he is a friend to every American who struggles to receive the affordable, quality health care they deserve, and we are thrilled to welcome him back.

Again, I want to thank Chairman BAUCUS as well as the majority leader for their leadership and dedication.

Mr. LEVIN. Madam President, the Medicare Improvements for Patients and Providers Act, H.R. 6331, makes a number of needed changes related to Medicare reimbursement, including reimbursement for physicians' services. Due to the unwise filibuster by the minority, we missed our chance to pass this legislation before July 1, when reimbursement cuts were scheduled to take place. We now have another opportunity to do the right thing. I strongly urge the Senate to pass this legislation promptly.

Medicare physician fee schedule payments are updated each year according to a complex formula based on a Sustainable Growth Rate—SGR. Unfortunately, because of the way the formula is calculated, even if Congress prevents the cuts in a given year, scheduled reimbursements cuts are likely to increase in subsequent years unless Congress takes additional action, such as developing a permanent alternative to the SGR formula.

I support efforts to ensure that physicians receive adequate reimbursement for their services. If they do not, some physicians will not continue to provide services to Medicare beneficiaries. As a result, allowing reimbursement cuts to go into effect could pose significant access problems for many Medicare beneficiaries.

While I believe past measures to alleviate this burden on physicians have been helpful, I know from my discussions with health care providers throughout Michigan that Congress must find an alternative to the SGR. The SGR is linked not to the cost of providing health services, but to the performance of the overall economy. The cost of health care has been rising much faster than inflation. Our nation should address the rising costs of health care as part of a larger discussion on health care reform. Until and unless we discover a way to contain health care costs to inflation, we should decouple Medicare reimbursement for physicians' services from the performance of the overall economy. Reimbursement should more accurately represent the cost of providing services.

In the meantime, we need to pass this legislation, which includes, among other important provisions, an 18 month delay on Medicare reimbursement cuts for physicians' services and replaces the cut with a 1.1 percent increase in 2009. I am hopeful that the minority will end their filibuster, that the Senate will pass this legislation, and that the President will heed the will of Congress and the American people and sign this bill into law before the cuts are implemented and cause many Medicare beneficiaries to lose access to health care providers.

Mr. SPECTER. Madam President, this Medicare legislation is very important. I believe that it is vital for the Senate to take up this important measure to have open debate to give Senators an opportunity to offer amendments and to have the Senate work its will on these important questions.

As noted in previous floor statements, I have been concerned about Majority Leader REID's practice of employing a procedure known as filling the tree, which precludes Senators from offering amendments. This undercuts the basic tradition of the Senate to allow Senators to offer amendments. Regrettably, this has been a practice developed in the Senate by majority leaders on both sides of the aisle, so both Republicans and Democrats are to blame.

On June 12, 2008, I voted in favor of cloture on the motion to proceed on S. 3101, legislation similar to H.R. 6331, the Medicare Improvements for Patients and Providers Act, to prevent the reduction in Medicare payments to physicians. At that time, I was assured by Majority Leader REID that he would not make a procedural motion to fill the tree. Following the failure to obtain cloture on the motion to proceed to S. 3101, Finance Chairman BAUCUS and Ranking Member GRASSLEY began to negotiate a bipartisan bill that could be brought before the Senate. I have concerns with some provisions that may have been contained in such an agreement. However, the prospect of the Senate working its will and allowing other Senators and me to offer amendments to such a bill is more favorable than filling the amendment tree.

On June 26, 2008, the majority leader brought up H.R. 6331. The posture of the Senate was such that for the majority leader to complete action on H.R. 6331 and send it to the President before the physician payment reduction was scheduled to go into effect at the end of June, the Senate must pass the same legislation the House of Representatives passed. This is the case because the House of Representatives adjourned for the Independence Day recess prior to the Senate vote on cloture on the motion to proceed to H.R. 6331. Since the House went out of session, there was no possibility for the House to consider a Senate-amended Medicare bill. To guarantee that the same Medicare legislation would be passed by the Senate, no amendments to the legislation were permitted. By bringing this legislation up at the last minute after the House of Representatives adjourned, the majority leader prevented the opportunity to offer amendments and undermined Senate procedure.

If cloture were to have been obtained on the motion to proceed to H.R. 6331 the legislation would have been vetoed by President Bush. That veto would have resulted in a further delay, since the House would not be in session to override the veto and the scheduled physician payment reductions would go into effect at the end of June. There was an expectation that the Senate would extend the current physician payment rate for 30 days and prevent the pending reduction from going into effect. However, when this legislative extension was offered by Senate Republican Leader MCCONNELL it was objected to by Majority Leader REID. The majority leader was aware of this issue for some time and scheduling should have accommodated the amendment process. I voted against cloture because there was no opportunity to amend the legislation that came before the Senate.

On June 28, 2008, I wrote to President Bush requesting that he use his constitutional authority to call the Congress back into session so that the Senate could act on H.R. 6331 with appropriate amendments and send it back to the House for its concurrence. This would have allowed for prompt action on this important matter and prevented the payment reduction from going into effect.

On Monday, Tuesday and Wednesday of this week, I spoke with Majority Leader REID regarding today's vote on cloture on the motion to proceed to H.R. 6331. During those conversations I requested that he allow Senators to offer amendments to the legislation. On those occasions he said he would not allow amendments. During the vote, when more than 60 Senators had voted for cloture, it was not possible to preserve the principle of Senators' rights to offer amendments so I voted for cloture because I agreed with the objectives of this legislation.

I have a strong history of preventing reduced payments to physicians. In April 2003, as Chairman of the Labor, Health and Human Services, and Education Appropriations Subcommittee; I worked to reverse a 4.4 percent cut in physician fees which had gone into effect in January of that year. This $54 billion effort also provided a 1.6 percent increase. In June 2003, I introduced an amendment to the Medicare Modernization Act to provide an increase in physician payments for 2 years. This provision was agreed to and was included in the bill. This prevented decreases in physician payments in 2004 and 2005, and increased payments by 1.5 percent in each of those years. I have consistently voted in favor of increasing Medicare physician payments and will continue to support the policy, but Senators must be allowed to offer amendments and let the Senate work its will.

Mrs. FEINSTEIN. Madam President, I rise to discuss the Medicare Improvements for Patients and Providers Act, H.R. 6331. This bill makes much needed changes to the Medicare program, and will pay doctors at a rate that will allow them to continue to participate in this vital program.

Medicare is a great success story, providing retirees with a health care safety net, but the formula that determines physicians' payment levels is seriously flawed. Unless Congress takes action immediately, doctors will receive a 10.6 percent cut in their reimbursements.

The consequences of such cuts would be dire. According to the California Medical Association, more than 60 percent of California physicians say they would be forced to either stop taking new Medicare patients or leave the Medicare program altogether if these reductions occur.

The same payment rate reductions will apply for health care provided to our servicemembers and their families who receive coverage through the TRICARE program. Over 870,000 Californians and at least 8.9 million Americans depend on TRICARE for their health care. We owe these families, who have sacrificed so much for our country, access to physicians and medical care when they need it.

I voted to consider and pass this bill, because we need to block these cuts and make improvements for beneficiaries.

However, much to my dismay, this bill contains a delay on a program to competitively bid for durable medical equipment. Can you believe it? A block on competitive bidding of commonly available medical goods.

Let me tell you what this means. Medicare began a competitive bidding program for durable medical equipment on July 1 in 10 metropolitan areas across the country—including the Riverside-San Bernardino area in my home State of California.

The program enabled medical supply companies to bid on 10 products, including wheelchairs, diabetic supplies, oxygen concentrators, walkers and hospital beds, in those 10 metropolitan areas. Companies that offered the best prices were awarded contracts to supply Medicare beneficiaries with medical equipment.

As a result, seniors on Medicare in these areas can expect to pay a lot less for some of their medical supplies.

In Riverside, CA, diabetic test strips, once $37 will now be $18, and portable oxygen, which cost Riverside Medicare patients $77 per month, can now be bought for $61.

The bid prices are an average of 26 percent lower than prices set by the Centers for Medicare and Medicaid before the enactment of the competitive bidding program.

Because beneficiaries pay copayments equal to 20 percent of the cost of their healthcare and medical equipment, that savings is also felt by the elderly and disabled Americans who rely on Medicare.

Competitive bidding makes sense, because there is no good reason why Medicare or seniors should pay above-market prices for medical equipment—especially as other health care costs continue to skyrocket.

The Centers for Medicare and Medicaid discovered that it was paying $1,825 for a hospital bed that can be bought for $754 online. On the Internet, you can purchase a power wheelchair for $2,174—far less than the $4,023 Medicare pays out for the same product. z

Competitive bidding forces Medicare suppliers to compete for their customers—much like retailers do. It also helps to control costs while providing the elderly and the disabled with quality healthcare and medical supplies. Participating companies must be accredited, to ensure that Medicare beneficiaries receive high quality equipment and service.

Allowed to continue, the program is expected to save $125 million in its first year. Expanded nationwide, that number would grow to $1 billion in savings for taxpayers and Medicare beneficiaries.

But just as this pilot program gets off the ground—another 70 metropolitan areas are expected to be added in 2009—this bill endangers the program's future.

Losing bidders have complained that the selection process was flawed and have convinced some of my colleagues to support a delay of the program for another 18 months and start the selection process over.

The bill before us today would terminate the existing competitively-bid contracts and delay the program launch for a year and a half.

This should not be permitted to happen. Seniors and taxpayers deserve to pay fair prices for their medical equipment. Medicare beneficiaries in Riverside, in Cleveland, in Dallas, learned about this new program, selected new providers, and are already saving money. Stopping this new effort midstream will only lead to confusion.

We all agree that entitlement programs like Medicare need to be reformed, but if we can't change a small portion of this sprawling entitlement program, how will we ever succeed in making major reforms?

Competitive bidding is a smart way to ensure that Medicare pays reasonable rates for medical equipment at a time when medical costs are soaring. We should not ask taxpayers to fund someone else's cash cow.

While I will vote to consider and pass this bill today, I will continue to work to see that competitive bidding moves forward, and I urge my colleagues do the same. This is a matter of common sense.

Mrs. CLINTON. Madam President, today we are voting on a piece of legislation that has the potential to make a real difference for seniors, Americans with disabilities, physicians, hospitals, and pharmacies. We are voting to ensure that doctors who care for the 44 million people in Medicare and the millions of people who rely on TRICARE, the military health care system, do not see a sudden and dramatic cut in reimbursements. And we are voting to implement a series of reforms to improve our capacity to provide preventive care, to use more health information technology in our medical system, and to measure the quality of care patients receive.

We hear a lot of talk about our broken health care system in this Chamber—and on the campaign trail—by Members on both sides of the aisle. However, all too often, there have been some all too willing to lament the crisis until it comes time to address it. But the fact is, all that matters—to seniors, to people with disabilities, to our men and women in uniform—is whether we deliver on the rhetoric. That is our test in this Chamber. And that is our test with this vote.

The choice is simple. How will we address the crisis in our health care system, as costs skyrocket, coverage declines, and quality suffers? Do we continue in this race to the bottom—or do we choose a new course?

I believe we must take immediate steps to modernize and reform our health care system to control costs, increase coverage, and improve care. The goal—as I have proposed, advocated, and championed my whole adult life—is quality, affordable health care for everyone, no exceptions, no excuses. And we all look forward to the return of our friend, Senator KENNEDY, one of America's great health care champions, to help us reach this goal.

The solution will not be to cut corners while cutting funding that will drive more and more people and providers out of the health care system. The solution has not been and will never be to stick our heads in the sand to avoid the tough work of dragging our system of care into the 21st century.

The solution is tougher—and more complex—but no less real: comprehensive reform to provide coverage for every American that emphasizes prevention, measurable improvements in quality, and a modernized system to dramatically improve efficiency and reduce errors. And we will achieve it by asking everyone to be part of this solution: patients, providers, insurance companies, employers, and, yes, the government.

That is why I hope more of my Republican colleagues will join the growing bipartisan majority in the House and Senate to support this legislation and end this Medicare blockade—an obstruction that survived by a single vote—which stands between patients and their physicians, and between this chamber and demonstrable progress in Medicare.

Here is why this legislation is so critical. First, unless we act, the 10.6 percent cut in payment to physicians will

compromise care for seniors, Americans with disabilities and—though this is largely unknown—men and women who have served in our Nation's military. TRICARE sets its physician reimbursement rates according to Medicare. So a 10.6-percent cut in Medicare is a 10.6-percent cut in TRICARE.

The consequences may be catastrophic. A recent survey by the American Medical Association found that 60 percent of physicians would limit new Medicare patients if this cut is allowed. Almost 9 million people who have served in the military would face the prospect of newly limited access to medical care, including more than 180,000 in New York.

The answer is not haphazard cuts and temporary formula fixes. The answer is a comprehensive, permanent solution which reflects the costs of doing business for providers—as well as the goals we all share for fixing the incentives in the health care system and controlling costs by improving care—not limiting it.

And preventing this cut is only the beginning. I am proud that we have included a number of important reforms I have championed that will help us chart a new course for Medicare and our health care system: We have included a provision to cover new preventive care recommended by the U.S. Preventive Services Task Force, a proposal for which I have advocated and which I believe should be part of our solution to achieve health care for everyone. Coverage for screenings for osteoporosis, breast cancer, or high blood pressure, for example, will help detect illness at the earliest stages, before becoming life-threatening and more costly.

I am proud that we have taken an important step in health information technology, requiring electronic prescribing by 2011. That will reduce errors dramatically. If all hospitals used a computerized order entry system we would reduce adverse drug reactions by an estimated 200,000 each year and save $1 billion annually. Health information technology, which I have proposed and hope to pass through the Senate soon, will allow us to make giant leaps in our health care system to cut errors, improve care, and discover new treatments—while protecting patient privacy and safety and dramatically reducing costs.

The bill also extends the Medicare Physician Quality Reporting Initiative and provides for the endorsement of quality measures, as I have long championed. In fact, the first bipartisan health IT legislation I introduced with Senator Bill Frist in 2005 included this idea and it remains in the legislation that I have cosponsored with Chairman KENNEDY, Senator ENZI, and Senator HATCH. Linking quality with coverage is essential. Today, we don't know what we don't know. With new data we can find new ways to treat illnesses and new ways to improve the care we provide.

We have previously failed by one vote. One vote between improving care or undermining it. One vote that can make the difference between solving problems in our health care system or making matters worse. This is not about politics. This is about the real people whose health and lives will be affected by our votes today. This is about the far reaching consequences of our decision in this Chamber.

I have met people across New York and our country who cannot find the medical care—or afford the health care—they need.

Mothers who whisper to me in tears, terrified that their children will get sick because they lost their insurance. Nurses who feel like each day is a deluge, as patient loads rise. Doctors forced to see more and more patients—with less and less time to do their jobs and more and more paperwork piling up. Seniors with multiple chronic illnesses who have trouble juggling the recommendations and medications from multiple health care providers.

And hospitals like A.O. Fox Memorial Hospital in Oneonta, NY, which stands to lose hundreds of thousands of dollars it cannot afford to lose. Or Bassett Healthcare in Cooperstown, NY, that stands to lose about a million dollars.

These are local hospitals struggling to provide care as that care is assaulted on all sides: rising costs, declining reimbursements, more uninsured patients walking through the emergency room doors. It would be a disgrace if these hospitals looked to us for solutions—and found that with these cuts, we were part of the problem.

These are the stakes and this is our test. I am grateful to my colleagues who have labored on this legislation and I urge my Republican colleagues to join us. And I will continue to do all I can to be champion for the people across New York and the country who feel like they do not have a voice, who look to us, who are counting on us, who depend upon us. I will always stand with them—and I urge my colleagues to stand with us.

Mr. AKAKA. Madam President, we must enact the Medicare Improvements for Patients and Providers Act of 2008. This legislation is vital to ensuring that Medicare and TRICARE beneficiaries have continued access to health care. The bill will also enhance Medicare benefits. In addition, the legislation will provide additional support for Hawaii hospitals that care for the uninsured and Medicaid beneficiaries.

I hope that my colleagues who previously opposed this legislation had an opportunity to meet with their physicians, beneficiaries, and military families during the recess. If so, I hope my colleagues now understand how tremendously important it is to seniors, individuals with disabilities, and members of our armed services and their families that this legislation be enacted to protect their access to health care.

The act will maintain Medicare physician payment rates for 2008 and provide a slight increase in 2009. If this legislation again fails to pass, doctors will be subject to a 10.6 percent cut in Medicare reimbursements for the rest of the year. This dramatic cut could severely limit access to health care for our troops and their families because TRICARE reimbursement rates are linked to Medicare reimbursement rates. Rising costs and difficulty in recruiting and retaining qualified health professionals make it essential that we improve reimbursements to ensure that Medicare and TRICARE beneficiaries have access to health care services.

The act will enhance Medicare benefits. It increases coverage for preventive health care services and makes mental health care more affordable. In addition, the act provides additional help for low-income seniors to obtain the health care services that they need.

Finally, the legislation will provide much needed relief for Hawaii hospitals. The legislation will extend Medicaid Disproportionate Share, DSH, allotments for Hawaii until December 31, 2009.

Hawaii hospitals are struggling to meet the increasing demands placed on them by a growing number of uninsured patients and rising costs. Hawaii and Tennessee are the only two States that do not have permanent DSH allotments. The Balanced Budget Act of 1997 created specific DSH allotments for each State based on their actual DSH expenditures for FY 1995. In 1994, Hawaii implemented the QUEST demonstration program that was designed to reduce the number of uninsured and improve access to health care. The prior Medicaid DSH program was incorporated into QUEST. As a result of the demonstration program, Hawaii did not have DSH expenditures in 1995 and was not provided a DSH allotment.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 made further changes to the DSH program, which included the establishment of a floor for DSH allotments. States without allotments were again left out.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made additional changes to the DSH program. This included an increase in DSH allotments for low DSH States. Again, States lacking allotments were left out.

In the Tax Relief and Health Care Act of 2006, DSH allotments were finally provided for Hawaii and Tennessee for 2007. The act included a $10 million Medicaid DSH allotment for Hawaii for 2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the DSH allotments for Hawaii and Tennessee until June 30, 2008. This provided an additional $7.5 million for a Hawaii DSH allotment.

This additional extension in the Medicare Improvements for Patients and Providers Act of 2008 authorizes

the submission by the State of Hawaii of a State plan amendment covering a DSH payment methodology to hospitals which is consistent with the requirements of existing law relating to DSH payments. The purpose of providing a DSH allotment for Hawaii is to provide additional funding to the State of Hawaii to permit a greater contribution toward the uncompensated costs of hospitals that are providing indigent care. It is not meant to alter existing arrangements between the State of Hawaii and the Centers for Medicare and Medicaid Services, CMS, or to reduce in any way the level of Federal funding for Hawaii's QUEST program. This act will provide $15 million for Hawaii DSH allotments through December 31, 2009.

These DSH resources will strengthen the ability of our providers to meet the increasing health care needs of our communities. All States need to benefit from the DSH program. This legislation will make sure that Hawaii and Tennessee continue to have Medicaid DSH assistance.

I will continue to work with Chairman BAUCUS, Ranking Member GRASSLEY, Senators ALEXANDER, CORKER and INOUYE to permanently restore allotments for Hawaii and Tennessee. However, we need to enact this legislation to continue to help our struggling hospitals.

We must enact this legislation. It will protect access to health care for seniors, individuals with disabilities, and members of our armed services and their families. The bill will improve Medicare benefits and provide much needed financial assistance for hospitals in Hawaii that care for the uninsured and Medicaid beneficiaries.

Mr. CARDIN. Madam President, our vote today on H.R. 6331 carries real and immediate consequences for people who depend on Medicare. Action on this legislation is mandatory now because, 8 days ago, the temporary fix we passed at the end of last year expired. The cuts are in effect.

Next Tuesday, when the Centers for Medicare and Medicaid Services begins paying claims for services rendered after June 30, 2008, payments will be cut unless we pass this measure.

Because I return home every evening to my State, I interact frequently with Maryland providers. They cannot sustain a nearly 11-percent cut in their Medicare payments; they and many of their colleagues will stop accepting new Medicare patients unless we pass this bill.

The pending cuts are the result of a flawed system that pegs provider reimbursement to the growth of the Nation's GDP. It was created by the 1997 Balanced Budget Act as a way to rein in dramatic growth in Medicare spending on physician services. But this system, known as SGR, has not worked as intended. In fact, every year since 2001, Congress has had to act to prevent the cuts from going into effect. We know that the SGR formula must be repealed.

I have introduced legislation in past years to eliminate SGR and replace it with a system that reimburses based on the actual reasonable costs of providing care. The bill that was passed overwhelmingly by the House, H.R. 6331, provides another temporary fix through December 31, 2009. That is sufficient time for the next Congress, working with a new administration and the provider community, to develop a new mechanism.

But although "doctor fix" is the shorthand often used, this bill is far more than that, and our failure to pass it has repercussions far beyond physician offices. Another provision that expired on June 30 is the exceptions process for outpatient rehabilitation services. The 1997 Balanced Budget Act imposed dollar limits of $1,500 on Part B therapy services—one cap for physical and speech-language therapy, and another for occupational therapy. They are adjusted annually for inflation and are now at $1,810. I was a member of the Ways and Means Health Subcommittee at the time. Congress held no hearings on this issue to examine how the caps might affect patient care. The authors of the provision had no policy justification for imposing them, and the dollar amount was arbitrary. These caps were imposed for purely budgetary reasons. They were a crude budget-cutting measure designed to deliver savings—$1.7 billion over 5 years.

This misguided policy ignored clinical needs and it restricted care for the most frail patients—such as those who are recovering from stroke or hip fracture, and those with multiple injuries in a given year.

And because the dollar limits are not adjusted for cost variations across the country, seniors in high cost areas reach their caps even sooner.

The University of Maryland's Shock Trauma Center was the first such unit in the Nation. It is a world-renowned leader in caring for critically injured patients. They see patients with extensive fractures, severe burns, spinal cord and brain injuries, and other debilitating conditions. These patients require lengthy therapy sessions to restore basic functioning. They cannot be rehabilitated for $1,810 a year.

The therapy caps actually went into effect once before, on January 1, 1999, and they had serious consequences for beneficiaries. By April, many patients in skilled nursing facilities had exceeded the limits and were unable to receive necessary care. The administration recognized the danger of this provision, stating:

> The limits will reduce the amount of therapy services paid for by Medicare. The patients most affected are likely to be those with diagnoses such as stroke and amputation, where the number of therapy visits needed by a patient may exceed those that can be reimbursed by Medicare under the statutory limits.

That year, I joined the now-junior Senator from Nevada, JOHN ENSIGN, to introduce a bill to repeal the caps. We had significant bipartisan support and at the end of 1999, Congress delayed implementation for 2 years. Since that time, Congress has acted several times to prevent the caps from taking effect.

In 2006, Congress created an exceptions process that would allow beneficiaries needing care above the statutory caps to receive those services. It was the right thing to do. This process has worked well. Medicare is saving money and patients are getting needed care. In February, the Centers for Medicare and Medicaid Services released a study concluding that:

> The exception process that allows beneficiaries who need therapy to get that therapy, even if the cost goes beyond the cap, has worked to control cost growth. This study reveals that from Calendar Year 2004 through 2006, although the total number of therapy users continued to increase by 3.5 percent the overall expenditures actually decreased by 4.7 percent.
>
> This suggests that the exceptions process in CY 2006 may have satisfied to some extent the Congressional intent to assure access to medically necessary services while controlling the growth in expenditures.

The CMS study shows that the exceptions process works to control costs, yet still assures access for the more than 4.4 million beneficiaries who need additional care. The exceptions process allowed them to get the therapy they need to recover, function optimally, and live more productive lives. It allowed them to learn to cook, clean, and care for themselves after a stroke, to walk correctly and strongly after a hip replacement, and to speak and communicate after cancer surgery. But as of Tuesday, July 1, the process has expired. Section 141 of the bill we are voting on today continues the exceptions process through December 31, 2009.

This provision takes up just two lines of the bill. It is a small provision, but it has a major impact on seniors.

The story of Steve Kinsey and his patients illustrates why we must pass this bill without further delay.

Steve operates Hereford Physical Therapy in Baltimore County. He is anxious to know what the Senate will do this afternoon and so are the seniors he cares for. Steve's practice has about 9,500 patient visits each year, and one-fifth of them are covered by Medicare. He told me about two patients who are waiting for the Senate to act.

The first is a 72-year-old gentleman. He is a wheelchair-bound quadriplegic who needs physical therapy to keep up his strength. He qualified through the exceptions process, and so, although he exceeded the $1,810 cap in March, he has been able to receive therapy 2 days every other week to maintain his level of function.

The second patient is an 83-year-old woman who had a total knee replacement earlier this year. She received 20 visits and was under the cap, until a few weeks later when she fell and fractured her hip.

The cost of her care exceeded the cap 6 weeks ago, but after qualifying through the exceptions process, she has been able to continue treatment.

Because of the actions of a few Senators, as of Tuesday, July 1, these two Medicare beneficiaries can no longer receive care.

On July 1, CMS told providers: (1), that the exceptions process expired on June 30, 2008; (2), not to submit any claims with the code for exceptions because they will be automatically rejected; (3), that providers can check a CMS Web site to determine the amount of services their patients have received so far this year; and; (4), that patients who have reached the caps can go to an outpatient hospital department for care or pay out-of-pocket.

Because the exceptions process was in place for the first 6 months of this year, patients who have already gone beyond the cap—the patients most in need of care—must stop therapy or pay for it themselves. The average charge is about $80 for a 45-minute session. This is wrong.

If we do not reinstate the exceptions process as the bill before us would do, these individuals who need more care will be harmed. They received appropriate therapy under appropriate rules, but that does not matter: On July 1, they were effectively cut off from services that 8 days ago they were deemed eligible for. This is unfair and it is harmful.

Let's not forget that therapy services are also paid under the Medicare fee schedule, so the 10.6 percent cut will also apply to these services as well.

Now, as CMS stated, there is a last resort—to go to the outpatient department of a hospital for additional care. But Steve has learned that the two hospitals near his practice—GBMC and St. Joseph's—are turning away new patients because they don't have the capacity to see them.

Because of the shortage of therapists in Maryland and in other States, hospitals are already overloaded. So, Steve has 10 patients who are waiting at home for him to call and say they can come back in for therapy. They have no where else to go for treatment unless they pay out-of-pocket. They can't afford that.

Outpatient therapy services are paid under Medicare Part B. The people waiting for Steve's call are seniors who worked hard to qualify for Part A coverage and who are paying premiums for Part B. Working Americans—taxpayers—who do not yet qualify for Medicare, are paying to subsidize Part B premiums. The American people as a whole, not only providers and beneficiaries, should be outraged that a minority of the Senate is preventing us from moving forward on this legislation.

The 43 million seniors and persons with disabilities who rely on Medicare deserve a program that meets their health care needs. Our goal should be to ensure that Medicare provides comprehensive, affordable, quality care.

The bill also includes important beneficiary improvements. In 1997, I worked in a bipartisan way to add to the Balanced Budget Act the first-ever package of preventive benefits to the traditional Medicare Program. That was 11 years ago. At that time, the members of the Ways and Means Committee recognized what medical professionals had long known—that prevention saves lives and reduces overall health care costs.

Preventive services such as mammograms and colonoscopies are vital tools in the fight against serious disease. The earlier that breast and colon cancer are detected, the greater the odds of survival. For example, when caught in the first stages, the 5-year survival rate for breast cancer is 98 percent. But if the cancer has spread, the survival rate drops to 26 percent. If colon cancer is detected in its first stage, the survival rate is 90 percent, but only 10 percent if found when it is most advanced.

Seniors are at particular risk for cancer. In fact, the single greatest risk factor for colorectal cancer is being over the age of 50—when more than 90 percent of cases are diagnosed.

Sixty percent of all new cancer diagnoses and 70 percent of all cancer-related deaths are in the 65 and older population. Cancer is the leading cause of death among Americans aged 60 to 79 and the second leading cause of death for those over age 80. So preventing cancer is essential to achieving improved health outcomes for seniors. Screenings are crucial in this fight.

In addition to improving survival rates, early detection can reduce Medicare's costs. Under Chairman CONRAD's leadership on the Budget Committee, we have had fruitful debates about the long-term solvency of Medicare. A more aggressive focus on prevention will help produce a healthier Medicare Program.

Medicare will pay on average $300 for a colonoscopy, but if the patient is diagnosed after the colon cancer has metastasized, the costs of I care can exceed $58,000.

There is no question that these vital screenings can produce better and more cost-effective health care.

The 1997 law established place improved coverage for breast cancer screenings, examinations for cervical, prostate, and colorectal cancer, diabetes self-management training services and supplies, and bone mass measurement for osteoporosis. Since then, Congress has added screening for glaucoma, cardiovascular screening blood tests, ultrasound screening for aortic aneurysm, flu shots, and medical nutrition therapy services. In addition, in 2003, a Welcome to Medicare Physical examination was added as a one-time benefit for new Medicare enrollees available during the first 6 months of eligibility.

But we can only save lives and money if seniors actually use these benefits. Unfortunately, the participation rate for the Welcome to Medicare physical and some of the screenings is very low. I have spoken with primary care physicians across my State of Maryland about this. One problem is the requirement to satisfy the annual deductible and co pays for these services.

Most colonoscopies are done in hospital outpatient departments, where their copay is 25 percent or approximately $85. Our seniors have the highest out-of-pocket costs of any age group and they will forgo these services if cost is a barrier.

The other barrier to participation is the limited 6-month eligibility period for the one-time physical examination. By the time most seniors become aware of the benefit, the eligibility period has expired. In many other cases, it can take more than 6 months to schedule an appointment for the physical exam and by that time, the patients are no longer eligible for coverage.

I have introduced legislation to eliminate the copays and deductibles for preventive services and to extend the eligibility for the Welcome to Medicare physical from 6 months to 1 year. My bill would also eliminate the time consuming and inefficient requirement that Congress pass legislation each time a new screening is determined to be effective in detecting and preventing disease in the Medicare population.

It would empower the Secretary of Health and Human Services to add ''additional preventive services'' to the list of covered services. They must meet a three part test: (1) they must be reasonable and necessary for the prevention or early detection of an illness; (2) they must be recommended by the U.S. preventive Services Task Force, and (3) they must be appropriate for the Medicare beneficiary population.

H.R. 6331 incorporates several elements of my bill in the very first section. It will waive the deductible for the physical examination, extend the eligibility period from 6 months to 1 year, and allow the Secretary to expand the list of covered benefits.

This bill will also help low income seniors by raising asset test thresholds in the Medicare savings programs and targeting assistance to the seniors who most need it. It extends and improves assistance programs for seniors with incomes below $14,040 a year, including the QI program, which pays Part B premiums for low-income seniors who don't qualify for Medicaid.

As this Congress continues to make progress toward passing a comprehensive mental health parity bill, this bill provides mental health parity for Medicare beneficiaries, moving their copayments from 50 percent to 20 percent gradually over 6 years. Depression, bipolar disorder, and other mental illnesses are prevalent among seniors, and yet fewer than half receive the treatment they need. This provision will help them get that treatment.

It will also ensure that a category of drugs called ''benzodiazepines'' are covered by Medicare Part D. When Part D took effect on January 1, 2006, millions

of beneficiaries found that the medicines they took were not covered by the new law. A little-known provision in the bill actually excluded from coverage an entire class of drugs called benzodiazepines. These are anti-anxiety medicines used to manage several conditions, including acute anxiety, seizures, and muscle spasms. The category includes Xanax, Valium, and Ativan. Most are available as generics.

The current-law exclusion has led to health complications for beneficiaries, unnecessary complexity for pharmacists, and additional red tape for the States. Beneficiaries who are not eligible for Medicaid have had to shoulder the entire cost of these drugs or substitute other less effective drugs. In 2005, I first introduced legislation that would add benzodiazepines to the categories of prescription drugs covered by Medicare Part D and Medicare Advantage plans.

This provision is essential for our seniors; without it, dual eligibles would have to rely on continued Medicaid coverage for benzodiazepines. Medicare beneficiaries who are not eligible for Medicaid will have to continue to pay out-of-pocket for them. For those who cannot afford the expense, their doctors would have to use alternative medicines that may be less effective, more toxic, and more addictive. This is a significant improvement for our seniors who are enrolled in Part D and for the fiscal health of our States.

This bill will also help our community pharmacies. I have heard from pharmacies throughout Maryland who cannot receive prompt reimbursement from private plans. This bill requires plans to pay them within 14 days of receiving a clean claim. It also requires plans to update their price lists weekly so that pharmacies have accurate data about what they should be reimbursed.

H.R. 6331 is paid for by small reforms to the Medicare Advantage program, in particular to private fee-for-service plans. The nonpartisan Medicare Payment Advisory Commission, MedPAC, has recommended that we equalize payments between Medicare Advantage and traditional Medicare.

As we discuss the solvency of the Medicare Program, we must take note that private health plans are not saving the Federal Government money. In fact, they are costing us money. I was a member of the Ways and Means Committee when health plans approached us with an offer.

If the Federal Government would pay them 95 percent of what we were spending on the traditional Medicare Program, they would create efficiencies through managed care—efficiencies that they said were lacking in traditional Medicare—that would save the Federal Government billions of dollars each year. They promised to provide enhanced coverage, meaning extra benefits as well as all the services covered by traditional Medicare, for 95 percent of the cost of fee for service. Congress gave them a chance to do just that.

Instead, what we saw across the country was cherry-picking of younger, healthier seniors. Each time Congress indicated that it would roll back their overpayments to a more reasonable level, they responded by pulling out of markets. In Maryland, the number of plans declined over a 3-year period from eight to one, abandoning thousands of seniors. Since 2003, when payments were substantially increased, the number of plans has steadily increased as well, but at too high a cost to beneficiaries, taxpayers, and the future of the Medicare Program.

Right now, these plans are paid up to 19 percent more than the amount that we would pay if these seniors were in fee-for-service Medicare. Over 10 years, we are overpaying them by more than $150 billion.

That is enough money to fund significant valuable improvements in the overall Medicare Program, or to permanently repeal the sustainable growth rate formula. It is time, for the health of the Medicare Program, to pay these plans appropriately. This bill would make small adjustments to these overpayments as well as prohibit the abusive marketing practices, such as cold calling, door-to-door sales, and offering incentives such as free meals, which have led to many seniors being enrolled in private plans without their knowledge or consent.

Mr. President, this is a balanced and responsible bill that addresses immediate reimbursement concerns while setting the foundation for a higher quality, more cost-effective Medicare Program.

The time to act is now. With the support of just one more Senator, we can pass an urgently needed bill and restore the promise of improved access, adequate reimbursement, low-income assistance, and additional needed benefits to the seniors who depend on Medicare. I urge my colleagues to support this legislation,

MEDICAL HOME DEMONSTRATION

Mr. BINGAMAN. I rise today in support of legislation that will avert a 10.6 percent reduction in payments to providers who care for our Nation's Medicare beneficiaries. It is critical that we pass this legislation today in order to ensure that seniors, who rely on Medicare, will continue to have access to high quality health care.

I also wanted to take this opportunity to engage briefly in a colloquy with Senators HARKIN, MURKOWSKI, and COLLINS about a provision in this bill relating to an expansion of the medical home demonstration.

This bill contains a provision that gives the Secretary of Health and Human Services discretion to expand the Medicare medical home demonstration initially enacted as part of the Tax Relief and Health Care Act of 2006. I am troubled that the current demonstration does not permit nurse practitioners and other non-physician providers to lead medical home demonstrations. I believe Congress must include these providers in the demonstration.

In my home State of New Mexico, nurse practitioners have been able to practice independently and with full prescriptive authority since 1993. This recognition of their ability to function as independent primary care providers has allowed them to provide care for the most needy of our citizens. New Mexico is a very rural State. In some parts of my State, nurse practitioners are the only primary care providers available. They already serve as medical home providers for many of our citizens and without them many families would have no health care at all.

A June 2008 MedPAC report on primary care includes a discussion of the value of medical home demonstrations, stating ''Medical practices led by physicians, nurse practitioners, and physician assistants are a logical place to turn for these services, particularly practices with strong nursing and other dedicated staff support . . .'' In that report, MedPAC recommended seven requirements for a primary care provider wishing to lead a medical home demonstration. The provider must: furnish primary care, including coordinating appropriate preventive, maintenance, and acute health services; conduct care management; use health information technology for active clinical decision support; have a formal quality improvement program; maintain 24-hour patient communication and rapid access; keep up-to-date records of beneficiaries' advance directives; and maintain a written understanding with each beneficiary designating the provider as a medical home.

I firmly believe that nurse practitioners, or other non-physician providers meeting these standards should be able to lead a medical home demonstration. Furthermore, nurse practitioners epitomize the delivery of high quality, cost-effective primary care that is crucial to the medical homes model.

At a time when primary care providers are so greatly needed, the exclusion of more than 700 nurse practitioners in New Mexico—and more than 137,000 nurse practitioners across this country runs counter to the need for more qualified primary care providers.

Mr. HARKIN. I want to thank my distinguished colleague for raising this issue, which is also a great concern of mine. I am also pleased to support the legislation pending before the Senate today, which will ensure that Iowa's seniors continue to have access to their health care professionals. Iowa, like New Mexico, is a rural State where approximately 1,300 nurse practitioners provide critical access to care in Iowa's underserved areas. As you know, rural America has a higher proportion of elderly Americans than nonrural areas. In addition, Medicare providers face several unique challenges in rural America that make ensuring access to health care even more difficult. As part

of our expansion of the Secretary's authority, I would encourage the Secretary to allow nurse practitioners to fully participate and lead medical home demonstrations.

Approximately 90 percent of nurse practitioners in rural areas do primary care. Approximately one-third of nurse practitioners have practices where more than 50 percent of patients would be classified as ''vulnerable populations''.

This year, Iowa's State legislature passed legislation to use the medical home model to reduce disparities in health care access, delivery and health care outcomes and, ultimately, allow each Iowan to have access to health care. This legislation includes nurse practitioners as medical home leaders who are responsible for providing for appropriate patient care, coordinating specialty care and guaranteeing a quality of care based in evidence, and fully coordinated with patient and family.

Ms. MURKOWSKI. I want to thank my colleagues for engaging in this colloquy and raising this issue, which is also of importance to my home State of Alaska. Like New Mexico and Iowa, Alaska is a rural State where approximately 600 nurse practitioners provide critical access to care in Alaska underserved areas. As a matter of fact some areas of Alaska are so rural and isolated they are primarily served by providers who use airplanes as their mode of transportation. Among these providers are nurse practitioners, who often are the most accessible providers in certain areas in Alaska.

Alaska has one of the highest numbers of nurse practitioners per capita of any other State. Nurse practitioners function as partners in the healthcare of their patients, so that, in addition to clinical services, nurse practitioners focus on health promotion, disease prevention and health education and counseling, guiding patients to make smarter health and lifestyle choices.

NPs provide healthcare to people of all ages, all over the State of Alaska, in diverse healthcare settings such as private offices, community clinics, hospitals, long-term care facilities, schools, and health departments, and about 40 percent of nurse practitioners in Alaska practice in rural settings, outside the major cities in Alaska, and an estimated 25 percent practice in medically underserved areas of Alaska.

For these reasons and to allow Alaskans the easiest access to a provider in the medical home demonstration, I would encourage the Secretary to allow nurse practitioners to fully participate and lead medical home demonstrations.

Ms. COLLINS. Madam President, I rise in strong support of the outstanding work of our Nation's nurse practitioners—most especially the 850 or so nurse practitioners in Maine who have practiced independently since the mid-1990s. Nurse practitioners in Maine are credentialed as participating providers and serve as primary care providers in managed care organizations in my State.

Similar to my colleagues from New Mexico, Iowa and Alaska, a large percentage of Mainers live in rural areas. As such, residents are often a considerable distance from health care facilities and may be hindered from getting care because of transportation and other obstacles. Nurse practitioners fill the void for high quality primary health care in our underserved areas.

We need to encourage medical home demonstrations that allow nurse practitioners to fully participate in these models.

Mr. BINGAMAN. I thank my fellow Senators for joining me to discuss this important issue.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. Madam President, I will yield 3 minutes to the Senator from Oklahoma.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized for 3 minutes.

Mr. COBURN. Madam President, as a practicing physician in the Senate, I remember the last time a Medicare fix came through and we had the problems associated with it. I would make four points about what is going on here.

No. 1, if this bill goes through, 2.3 million senior citizens who are on Medicare Advantage will lose Medicare Advantage. Madam President, 2.3 million will lose. Not only will that happen, but also all Medicare patients will pay $200 million more per year in copays for durable medical equipment. So we have a bill that is supposedly going to do the doctor fix, but under the sleight of hand in the dark of night we are going to raise the fees on Medicare patients by $200 million for durable medical equipment, and we are going to tell 2.3 million Medicare patients who are very pleased with the program they have now that they cannot have that anymore.

We have two choices in health care in this country. We can let the Government run it all—which this is a step toward moving toward that—or we can allow the ingenuity and creativity of this country through a market-based phenomenon—which is what Medicare Advantage is going to—to create an allocation of scarce resources on the basis of quality, great outcome, and patient choice. There is very limited patient choice now because doctors do not want to take Medicare patients because the reimbursements are so low. Well, guess where they will take it. Where the reimbursements are higher because their costs are going like this, and their reimbursements are going down.

So remember this: If, in fact, you vote for this bill, 2.3 million Medicare patients on Medicare Advantage will lose that coverage, and $200 million in additional copays will fall to all Medicare patients across the board in terms of their copay for durable medical equipment.

We can fix this problem. We ought to fix it right. This is not the way to fix it.

I yield back.

The PRESIDING OFFICER. Who yields time?

The Senator from New York.

Mr. SCHUMER. Madam President, are we in a quorum call?

The PRESIDING OFFICER. No, we are not.

Mr. SCHUMER. Madam President, I rise in strong support of this legislation vitally needed from one end of the country to the other. Ask doctors who will face a significant cut, ask pharmacists who are going bankrupt because they are not being paid appropriately, and ask, most of all, our Medicare patients who will not have the ability to visit doctor after doctor after doctor.

This legislation is essential, and it is compromise legislation. The other side says ''compromise''? Sixty percent of the cuts come from medical education—something near and dear to me and my State. Only 40 percent comes from fee for service. Yet they say: Compromise. Do you know what compromise is to the other side, those opposed here? They want it all. All the money should come out of IME, none out of fee for service, or they will not budge.

Who is hurt when they play this political game? Millions of senior citizens. I would prefer to have all the money come out of fee for service. So would Chairman RANGEL. So would many others from States such as mine that have medical education. But we are willing to go part of the way for the seniors.

I say to my colleagues on the other side of the aisle: Substantively and politically, this is among the worst votes that you will take if you oppose this legislation; among the very worst both substantively because it hurts our seniors and cripples Medicare, and politically because people really care about this. I have never seen organizations such as the AMA, the pharmacists, and the AARP in unison.

So I would urge at least one of my colleagues from across the aisle to reconsider for the sake of those who work so hard in the health care field and, most of all, for the sake of our senior citizens.

This bill is essential to keep things going in Medicare. I know there may be some who want to get rid of Medicare, but most of us want to fight to preserve it. If you care about Medicare, if you care about seniors, if you care about fair pay for pharmacists and doctors, the only vote is yes.

I yield the floor.

Mr. McCONNELL. Madam President, how much time remains on this side?

The PRESIDING OFFICER. There is 4½ minutes left of the initial time that was designated for the chair and ranking member of the Finance Committee. Then there is 20 minutes of time divided between the minority leader and

the majority leader following that time.

Mr. McCONNELL. All right. Madam President, I ask unanimous consent that the Senator from Florida have 4 minutes of my time that is remaining.

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

The Senator from Florida.

Mr. MARTINEZ. Madam President, this is indeed an important debate we are having about a very important issue to many in my State of Florida. There is no doubt that my State has a large population of people who depend on Medicare for their health care. This is an important matter to them.

We also have, of course, the doctors who deliver health care who also have a concern, a great concern, about a potential cut at a time when everything else in their lives is rising—an unfair cut. The fact is, we know doctors are tremendously stressed today because of many issues in their practice. The fact is that hard-working doctors do not deserve a pay cut. I know whoever created this condition years ago was well-intentioned, but it has not worked and it does not work. Doctors should not be expected to come before the Congress hat in hand each and every year or 18 months to ask for yet another extension or a deferral of a pay cut. The next cut in pay, which would come 18 months from when we do the right thing and move beyond the politics and get something done, will be a 20-percent cut—unsustainable.

I would say the real answer for the long term is to fix Medicare and to fix the doctors' pay problem. Unfortunately, we have not been able to come to an agreement. I daresay I don't believe we will today either. So I believe the real answer to the issue is to extend the program temporarily. We have not done so in the past, even though it has been requested. I wonder why.

The fact is that to date, the Congress has passed 28 temporary extensions for programs where agreement has yet to be reached so these programs can continue without interruption during the time those differences are ironed out. These extensions are commonplace, as demonstrated by the 28 temporary extensions during this Congress alone. In fact, at the time the majority objected to the first request for a short-term extension, Medicare payment rates were already operating under a 10-month temporary extension from last December.

So I would say it is time for us to stop the political ''gotcha'' games and allow the doctors to be assured that they will not be suffering a pay cut while we get to a bipartisan agreement because it is important that this be a bipartisan effort and that we come at it in a bipartisan way with ideas from both sides of the aisle. We can do that. While that takes place, I believe the only way to proceed would be for there to be a 30-day extension that can allow uninterrupted payments to continue. The differences can be worked out, as they always are in this environment, although not always on a timely basis, and then we can move forward.

UNANIMOUS CONSENT REQUEST

At this time, I ask unanimous consent that if cloture is not invoked on the motion to proceed to the House-passed bill, the Senate proceed to the immediate consideration of a Senate bill which I will send to the desk, and it is clean, a 1-month extension of the Medicare payments bill. I further ask unanimous consent that there be 15 minutes of debate equally divided and that following the use or yielding back of time, the bill be read a third time and the Senate proceed to a vote on passage without any intervening action or debate.

Mr. REID. Madam President, reserving the right to object, in the 10 minutes I have before the vote, I will address in some detail why this is such a fallacious idea, and I object.

The PRESIDING OFFICER. Objection is heard.

Mr. McCONNELL. Madam President, the issue before us is the physician payment update, and on that point we don't disagree at all. Everyone agrees we should prevent the cut and preserve seniors' access to care under the Medicare Program.

Republicans have been flexible on finding a solution. When it was clear that the Senate wouldn't move to the last partisan bill that was proposed, I asked my friends on the other side to work with us on a bipartisan compromise with Senator GRASSLEY and Senator BAUCUS. Both have a long history on finding workable compromises on very tough issues. If that wasn't possible, we proposed an 18-month extension of current law. Then we proposed a 1-month extension. There is no good reason patients and physicians should suffer while Congress works out its disagreements. The majority objected to all of these proposals out of hand. They weren't interested. They even rejected the opportunity to have a single amendment on the bill—no amendments.

So now, rather than resolving the problem in a way that is acceptable to everyone and in a form the President will sign, we are no closer to a solution for seniors and their doctors than we were 2 weeks ago. Rather than passing a short-term safety net bill while we get a good, bipartisan bill to protect 2 million seniors from losing their private Medicare Advantage plans, the majority chose an all-or-nothing approach.

It seems to me that if we can't resolve policy issues today, we should at least agree to a short-term extension of existing law, which my good friend from Florida just offered, including a bipartisan proposal to delay competitive bidding that is identical to a provision in the House bill that the other side has already voted for.

So let's sum it up. The Democrats don't want a bipartisan compromise. They don't want a long-term extension of current law. They don't want a short-term extension of current law. Yet they are not to blame for this Medicare cut going into effect? We know how to prevent this cut from going into effect, but we can't stop it. We can't protect the doctors, and we can't protect access of choice for seniors if the Democrats won't let us.

How much time remains on this side?

The PRESIDING OFFICER. There is 8 minutes 14 seconds remaining.

The Senator from Iowa.

Mr. GRASSLEY. Madam President, I wish to review some facts.

At the end of last year, we agreed to a short-term Medicare extension so that we could complete work on a bipartisan Medicare package this year that would fill out the 2 years that we previously had planned to do it. We were very close to a deal then and needed time to finish that work, so that is why we did the short-term extension. Both sides agreed that we would work quickly to get a bill that could be signed into law. Unfortunately, that effort has been intentionally derailed by the majority's desire to play politics with Medicare.

The fact is that the majority has twice walked away from good-faith, bipartisan negotiations. The fact is that we had been working for months before the rug was pulled. The fact is that we had actually completed that bipartisan deal 2 weeks ago yesterday, about 11 o'clock in the morning. It was a deal that would be signed into law—in other words, not be vetoed by the President of the United States. But the other side thought they saw a political advantage, and they have taken that into consideration. So they scuttled the deal in favor of a bill that would, in fact, be vetoed by the President of the United States, and that is where we are again right now. Now they have spent the last 2 weeks engaged in an effort to scare seniors and providers, and the worst thing yet is that it has been aided and abetted by the American Medical Association.

The bill is riddled with problems and missed opportunities. First and foremost, the bill we are going to be voting on would do serious harm to Medicare drug benefits on which millions of seniors have come to depend. It would tie the hands of Medicare Part D plans, resulting in higher drug prices and higher premiums for seniors.

Let me quote from a communication I received today from the Medicare Office of the Actuary. Their conclusion is that it would ''very likely result in additional Federal spending for the Part D program.'' Also, outside analysts have likewise concluded that this provision has the potential to undermine the long-term financial sustainability of the Medicare drug benefit.

This provision, which is tucked away in a seemingly harmless provision intended to clarify what classes of drugs might be protected under Part D, is a perfect example of why we work best in this body when we work together and

when we do it in a bipartisan way. When we work together, we catch these little landmines tucked away in House-passed bills that could do real harm to a program seniors rely on for their drug coverage.

Instead of writing a bipartisan bill, the majority twice walked away from the table, and now we are in a position of ''take it or leave it.'' The process here today does a disservice to the purpose of the Senate, but more than that, it does a disservice to seniors, to doctors, and everyone who depends on Medicare.

There is a deal to be reached here. We could vote on a deal today that includes many of the policies in the underlying bill but fixes glaring problems. We could vote today on a bill that would provide a 1.1-percent update for physicians. We could vote on a bill today that would not be vetoed.

To my colleagues today, I say we should vote no on this motion so we can get back to something the President will sign and get it done and get it done quickly.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. MCCONNELL. Madam President, I yield back the remainder of our time.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. REID. Madam President, thank you very much.

My distinguished counterpart, the Republican leader, has often said there is a right way and a wrong way to get things done here in the Senate. The right way, he says, is through bipartisanship. I agree with my colleague.

Before the Fourth of July break, we saw such a stunning moment of bipartisanship in the House of Representatives. Democrats and Republicans saw the harm our country could face if Congress did not take action to pass the doctors fix. Members of Congress knew that without bipartisan leadership, doctors would face cuts in the payments they receive, which would cause them to drop patients and even drop out of Medicare completely. Members of the Senate knew that if they sat on their hands, nothing would be done, obviously, but the House of Representatives knew that if they sat on their hands, millions of senior citizens, people with disabilities, Active Duty, retired military, and their families could all face a reduction in the quality of their care. So the Democrats and Republicans in the House of Representatives passed an identical bill that is now before us, the so-called doctors fix—listen to this—by a bipartisan majority of 355 to 59. Every single Democrat voted for the measure. Two-thirds—two-thirds—of the Republicans joined them.

This is bipartisanship at its very best. When the House, by a vote of 359 to 55, votes as they did, this is bipartisanship at its best. In fact, one of the small number of Republicans who voted no felt so badly after the vote took place that he wrote a letter to all the physicians in his district and all the senior citizens in his district and said: I am sorry. I am sorry. I made a mistake. I didn't know it was so important. He said: If I ever have a chance to vote on it again, I will vote with the vast majority of the Members of the House of Representatives.

If Senate Republicans are looking for bipartisanship, they need to look no further than the bipartisan breakthrough we saw on Medicare in the House of Representatives. Republicans in the Senate should have seen the overwhelming support for this critical legislation from both sides of the aisle in the House and joined the effort here in the Senate.

As I look across this body, I see a number of us who have served in the House of Representatives: the ranking member of the Finance Committee, the Senator from Michigan, the Senator from Illinois, the chairman of the Finance Committee, and others. The House of Representatives is known as a partisan body. We are not. They showed that, for the good of the American people, they could set their partisanship aside and vote, and they did that.

If, in fact, the Republicans here in the Senate had looked and studied what took place in the House of Representatives, this bill would have passed before the break we took before Fourth of July and it would have been sent to the President and we would be spending our time today focusing on other critical priorities for the American people such as gas prices, such as housing, and issues on which Republicans have done a lot of talking but no legislating. Instead, though, Senate Republicans have once again chosen the side of delay and obstruction.

The Republicans may talk about bipartisanship—and when they do, we agree with every word they say—but words alone won't solve the Medicare problem today. Words won't support doctors. Words won't keep senior citizens healthy or veterans or Active military and their families getting proper health care. This critical problem calls not for words but action, and the only action the Republicans have taken on this Medicare issue is delay, delay, delay.

What can the American people conclude, except that the Republicans have chosen the side of the insurance companies—the insurance companies—and the HMOs that are already making untold fortunes. Last year, the so-called Medicare Advantage, they made $15 billion. How did they make it? They made it at the expense of millions of senior citizens who rely on Medicare to stay healthy.

This morning in the Senate, the Republican leader made a very interesting point, and all should listen to the point he made. He said that with more than 300 Members of the House of Representatives having voted in favor of the legislation, the Senate should follow suit and pass it immediately.

He argued that delaying or trying to amend a bill with such strong, bipartisan support from the House would serve no purpose but to delay its implementation. Senator MCCONNELL was talking about the Foreign Intelligence Surveillance Act, FISA. But it appears that the Republican leader and his colleagues on the other side of the aisle want to have a different set of rules for each piece of legislation. On FISA, having an overwhelming 300 votes meant don't delay it and vote for it here. It means something different on Medicare, when even more voted for it.

If the 300-plus vote in the House was good enough on the FISA bill, shouldn't the 355 votes for Medicare be good enough as well? I would hope so.

In their effort to block this critical legislation, the Republicans have now concocted an argument that their opposition lies in their inability to offer amendments.

Think about that. Their opposition lies in the fact that they cannot offer amendments.

If only the majority would allow amendments, they say, this bill would sail through passage. But the facts are clear. The Senate Republican leadership was at the table when the process of the bill was discussed. The Republican leader agreed to the process about which we are now engaged. This process was agreed to unanimously by every single Senator, Democratic and Republican alike. We are here today because of that unanimous consent agreement.

The process—to which, I repeat, all Republicans agreed and all Democrats agreed—was that after a 60-vote margin on a motion to proceed, the bill would go directly to the President. There was ample opportunity to make the case for amendments prior to the unanimous consent agreement.

I have gotten to know MAX BAUCUS, of Montana, very well in my 26 years in the Congress. I don't know of a Senator who has more of a reputation for bipartisanship than the Senator from Montana. He is known as a person who works with Republicans. That is why we, on the Democratic side, so admire him and support his chairmanship of the Finance Committee. But even MAX BAUCUS has had enough. He has had enough. He knows he has tried. He knows this is stalling and that this is obstruction. Even MAX BAUCUS—I believe the most bipartisan Member of the 100 Senators here—said that is enough.

Well, I made it clear a long time ago to Senator BAUCUS and others that we would have considered any reasonable proposal. But that time has long since passed. If Republicans were serious about passing this legislation and amendments were the only thing standing in the way, that would be one thing. They would have negotiated for amendments long before the 59-vote debacle of 2 weeks ago and certainly long before now.

It could not be clearer that the amendment argument is the latest

thinly veiled excuse for opposing this legislation to provide for doctors, senior citizens, and veterans.

These excuses for voting the wrong way aren't convincing anyone. Doctors, senior citizens, military families who rely on TRICARE, and all Americans see these Republican tactics for what they are. The Republican call for a 31-day extension is another duck and dodge. Let's think a minute. Where are we going to be in 31 days? Do you think there might be conventions going on, where OBAMA is being nominated and MCCAIN is being nominated? We are out of session. That shows how fallacious and foolish a 31- or 30-day extension is. What would happen when that time runs out? We would be out of session. Well, of course, that would lead to nothing but redtape and confusion for Medicare providers during the next 30 days.

This legislation that is before this body is the very same that passed the House of Representatives, with all the Democrats and two-thirds of the Republicans voting for it, and it is supported not by a bunch of fringe groups. For example, AARP supports this. The physician community, including the American Medical Association, and all the specialist groups, such as the internists, orthopedic surgeons, and brain surgeons, all support this legislation.

The pharmaceutical industry supports it. My friends say this is very bad for seniors as it relates to pharmaceuticals. Why in the world would the pharmaceutical industry support what we are trying to do? Hospitals, the American Hospital Association, patient groups such as the American Heart Association, American Cancer Society, and hundreds and hundreds of other organizations support this.

Who opposes this bill? I will tell you who. Not hundreds of organizations, not AARP, not the American Cancer Society. Only two organizations: the insurance industry, that always has the best interests of the American people in mind. They always look out for us, as you know. Who is the other special interest group that supports doing nothing? The HMOs. How many of you remember that Jack Nicholson movie, when they brought up HMOs and whole theaters booed all over America when that provision came up?

The American people are booing the Republicans today because they have sided with the insurance industry and the HMOs. We have sided with senior citizens and with the veterans and their families. We know President Bush opposes this legislation and he threatened to veto it. Some Republicans said: Why pass a bill now when the President is going to veto it? Think about this. First of all, talk to my colleagues on the other side of the aisle. We have a government that is founded by our Constitution as three separate and equal branches. We have to do the right thing. That is how checks and balances work.

We should pass this bill because we owe it to senior citizens, veterans, the doctors who are working hard. I remind our Republican friends that the House of Representatives has more than enough votes to override the veto. There is no reason we cannot do the same in the Senate. I also remind our colleagues of what happened to the GI bill of rights, one of the landmark pieces of legislation to pass this country in the last 50 years. When Senator WEBB and others introduced that legislation to give something back to our troops in the form of educational opportunities to help them succeed when they return home, President Bush and many Republicans, including JOHN MCCAIN, declared the bill was too generous. The President vowed he was going to veto the bill.

Surely then, some Republicans said that if the President opposes the bill, the Senate has no business debating and passing it. But we did our job. We did what was right for our troops and veterans, and we passed the GI bill overwhelmingly. To his credit, President Bush acquiesced.

I believe that if the Senate Republicans follow the lead of their House counterparts by voting for cloture today and sending the Medicare doctors fix bill to the President's desk with an overwhelming bipartisan majority, President Bush will heed the calls of the House and the Senate, of doctors, of patients, of advocacy groups, and of our troops.

I, personally, support this legislation on behalf of the 320,000 Medicare patients in Nevada and Dr. Edward Kingsley, a cofounder of the Comprehensive Cancer Centers in Las Vegas, who said:

> Some physicians are not going to be able to afford [to continue taking Medicare patients]. . . . That's ultimately what we all fear—these patients are not going to have access to the care they need.

I support this legislation also on behalf of the approximately 320,000 Nevadans who are Medicare patients.

I support this on behalf of the almost 9 million service men and women and families enrolled in TRICARE.

I support this legislation on behalf of the 44 million senior citizens and the people with disabilities who rely on Medicare to stay healthy and live their golden years to the fullest. That is what Medicare is about.

Since President Lyndon Baines Johnson signed the Medicare law more than 40 years ago, the Congress and Senate has always worked to improve and maintain it. Congress has never seriously threatened Medicare or the benefits our senior citizens have earned.

Before the July 4 recess, 59 Senators voted to move toward passage of the doctors fix. All Democrats voted yes—every one of us. We were joined by a small group of exemplary Republicans who were willing to stand up to the insurance companies and HMOs and the veto threats of the President.

We needed 60 votes to pass this. We came up one short. Today, we remain one Republican vote away from passing this bill. As I look across the aisle to my Republican friends, the 60th vote is there.

I urge my colleagues to vote for cloture so we can send this legislation to the President with an overwhelming bipartisan vote to reflect overwhelming support for it among the American people.

The PRESIDING OFFICER. Under the previous order, the clerk will report the motion to invoke cloture.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to proceed to H.R. 6331, the Medicare Improvements for Patients and Providers Act.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call is waived.

The question is, Is it the sense of the Senate that debate on the motion to proceed to H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008, shall be brought to a close?

The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Arizona (Mr. MCCAIN).

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

The result was announced—yeas 69, nays 30, as follows:

[Rollcall Vote No. 169 Leg.]

YEAS—69

Akaka	Durbin	Murray
Alexander	Feingold	Nelson (FL)
Baucus	Feinstein	Nelson (NE)
Bayh	Harkin	Obama
Biden	Hutchison	Pryor
Bingaman	Inouye	Reed
Boxer	Isakson	Reid
Brown	Johnson	Roberts
Byrd	Kennedy	Rockefeller
Cantwell	Kerry	Salazar
Cardin	Klobuchar	Sanders
Carper	Kohl	Schumer
Casey	Landrieu	Smith
Chambliss	Lautenberg	Snowe
Clinton	Leahy	Specter
Coleman	Levin	Stabenow
Collins	Lieberman	Stevens
Conrad	Lincoln	Tester
Corker	Martinez	Voinovich
Cornyn	McCaskill	Warner
Dodd	Menendez	Webb
Dole	Mikulski	Whitehouse
Dorgan	Murkowski	Wyden

NAYS—30

Allard	Crapo	Inhofe
Barrasso	DeMint	Kyl
Bennett	Domenici	Lugar
Bond	Ensign	McConnell
Brownback	Enzi	Sessions
Bunning	Graham	Shelby
Burr	Grassley	Sununu
Coburn	Gregg	Thune
Cochran	Hagel	Vitter
Craig	Hatch	Wicker

NOT VOTING—1

McCain

The motion was agreed to.

The PRESIDING OFFICER. Upon reconsideration, on this vote the yeas are 69, the nays are 30. Three-fifths of the

Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

Under the previous order, all postcloture time is yielded back and the Senate will proceed to consideration of the bill.

Under the previous order, the clerk will read the bill for the third time.

The bill was ordered to a third reading and was read the third time.

The PRESIDING OFFICER. Under the previous order, the bill is passed and the motion to reconsider is considered made and laid upon the table.

The bill (H.R. 6331) was passed.

AMERICAN HOUSING RESCUE AND FORECLOSURE PREVENTION ACT OF 2008

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

The legislative clerk read as follows:

A message from the House of Representatives to accompany H.R. 3221, an act to provide needed housing reform, and for other purposes.

Pending:

Reid amendment No. 5067 (to the motion to concur in the amendment of the House adding a new title to the amendment of the Senate), to change the enactment date.

Reid amendment No. 5068 (to amendment No. 5067), of a perfecting nature.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

EXPLANATIONS OF VOTES

Mr. SESSIONS. Madam President, I missed the final vote on the FISA final passage that occurred earlier this afternoon. Had I been present for the vote, I would have voted in favor of the bill. This position is consistent with all my previous votes on the matter, and with my considered judgment that this legislation is critical to protecting our country from future terrorist attacks.

Madam President, I yield the floor, and I note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mrs. HUTCHISON. Madam President, I wish to say that we have had a very dramatic moment here on the floor of the Senate, and I think there wasn't a person in the room or the gallery who wasn't thrilled to see Senator KENNEDY back and looking so good, to do what he always does, and that is have the commitment and go the extra mile to keep that commitment.

I wanted to say, though, that I don't think this was the Senate's finest hour. I want us to all remember that in the Senate we have had a long tradition of bringing up legislation, having amendments, and then voting on legislation. That was not the case in the bill that was before us today. There was an attempt to pass a bill that had no ability for amendments—not one.

I voted for the bill. It is not the way I would have written it, but I thought the risk was so great that the doctor fix in Medicare might actually lapse and the upheaval for our senior citizens and voters would be a risk too great to take. But it didn't have to be that way. It did not have to be a shutout of Republicans in order to ram something through, when 100 percent of us wanted to fix the doctors; when 100 percent of us had an agreement on 90 percent of the bill that was before us. But there were legitimate differences.

Although I chose to make sure there would not be a cut in service to our seniors and our veterans, I don't think we had to do it that way. Any of my colleagues who didn't vote that way were voting conscience, and it was a tough vote for them as well. They had no input. Several of us who voted ''yes'' believed we could have changed the bill for the better, or at least if we had the opportunity for an amendment we would have known that we had our say and the majority would have ruled, and the result would have been the same.

I do not think this is the way we want to continue proceeding in the Senate, and though it was a great victory for the Democrats, and it was certainly something that is going to save a cataclysmic event, I hope that going forward we will not allow this kind of tension to be in this body because it is not necessary. This is not the House. The House does operate that way. I do not want that to happen in the Senate.

It is my plea to the majority leader that he is the leader of the Senate, not just the leader of the Democrats. I hope going forward he will give us the opportunity for bipartisan solutions. That is something I think all of us would feel better about.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mrs. DOLE. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

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

Mrs. DOLE. I ask consent to speak as in morning business.

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

REMEMBERING JESSE HELMS

Mrs. DOLE. Madam President, yesterday, hundreds of people from all walks of life and across the political spectrum traveled from near and far to Hayes Barton Baptist Church in Raleigh, NC, to pay their final respects to United States Senator Jesse Helms and to express condolences to his beloved wife, Dot, and their family.

In the days since Jesse's July 4 passing, we have heard it said by many: You knew where Jesse Helms stood. As my husband, Bob Dole said, ''You didn't have to look under the table. You always knew where Jesse was.''

Even those who disagreed with Jesse on an issue could respect the fact that he always stood tall and firm—for his convictions, his faith, his family, his home State of North Carolina, and the United States of America.

When I announced that I was running to succeed Senator Helms—and I have always said ''succeed'' him because no one could replace him—I pledged to continue his commitment to constituent service that was second-to-none. He helped thousands upon thousands of North Carolinians, Democrats, Republicans, and Independents alike. No problem was too small or too great for Jesse and his staff to take on during his 30 years of service for the people of our State and the Nation.

I can still hear my father saying, ''Jesse Helms is our watchdog. He's a relentless watchdog for North Carolina and for America!'' And Jesse often recalled that my mother was on the front row at his very first rally in Rowan County. Through the years, Jesse unfailingly phoned my mother on her May 22 birthday, and she lived to be just 4 months short of 103 years old. In fact, Jesse would often stay late at his Senate office, making thoughtful phone calls and writing personal letters to constituents, colleagues, and friends.

For all his small gestures of kindness and his great acts of service, Jesse Helms was not driven by self-serving motives. He did not seek recognition for good deeds, or public acclaim for success. Jesse shunned the spotlight of the Sunday morning talk shows. The people he served from North Carolina, he said, weren't watching, they, like he and Dot, were in church.

In 1997, Fred Barnes wrote a piece in the Weekly Standard that proclaimed: ''Next to Ronald Reagan, Jesse Helms is the most important conservative of the last 25 years . . . and the most inner-directed person in Washington.'' And Fred adds, ''No conservative save Reagan comes close to matching Helms' influence on American politics and policy in the quarter century since he won a Senate seat in North Carolina.'' Of course many have said that President Reagan might never have been elected at all without the help of Jesse Helms in the 1976 North Carolina primary—a win most pundits credit with rejuvenating the Reagan campaign—and setting Ronald Reagan up to win the nomination 4 years later.

On the national political stage, Jesse Helms was known by both fans and critics as a tough-as-nails Senator who