Congress annually beginning in January, 2001, on the balance of trade with China for cereals (wheat, corn, and rice) and soybeans, and to direct the President to eliminate any deficit.

Hollings amendment No. 4136, to authorize and request the President to report to the Congress annually, beginning in January, 2001, on the balance of trade with China for advanced technology products, and direct the President to eliminate any deficit.

Hollings amendment No. 4137, to condition eligibility for risk insurance provided by te Export-Import Bank or the Overseas Private Investment Corporation on certain certifications.

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

AMENDMENTS NOS. 4118 AND 4121, WITHDRAWN

Mr. REID. In an effort to expedite this legislation, I ask unanimous consent that amendments Nos. 4118 and 4121 be withdrawn.

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

Mr. REID. Mr. President, I ask unanimous consent that Russ Holland, a fellow in my office, be granted floor privileges during the consideration of H.R. 4444.

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

Mr. REID. Mr. President, I further ask unanimous consent that 30 minutes of the time controlled by the Democratic leader, Senator DASCHLE, with respect to this legislation be under the control of the Senator from Iowa, Mr. HARKIN; further, that the additional 10 minutes of morning business time be designated to be controlled by the Senator from Florida, Mr. GRAHAM, that that be done this morning; and following Senator GRAHAM, Senator KENNEDY be recognized for up to 10 minutes.

The PRESIDING OFFICER. Is there objection?

The Chair hears none, and it is so ordered.

Mr. HAGEL addressed the Chair.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. May I ask unanimous consent that after Senator KENNEDY, Senator CRAIG would be allowed to speak for up to 10 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. HOLLINGS. Wait a minute, Mr. President. I was told to be here at 11 o'clock. We have these amendments. We are trying to give everybody 10 minutes here or there, so I am starting, instead of 11 o'clock, I guess we are going to 11:30, quarter to 12, and we are trying to get through these amendments. I am trying to move to the State-Justice-Commerce appropriations bill.

So what is the disposition here? What do the managers of the bill wish?

The PRESIDING OFFICER. There was an order that each leader have 10 minutes for morning business. That was ordered from last night.

Mr. HOLLINGS. Very well.

Mr. REID. Mr. President, if I could say to my friend from South Carolina, the schedule has been delayed this morning, of course, because of the speech by the Prime Minister of India, and we got started much later than we anticipated. Senator GRAHAM has been seeking an opportunity for quite some time to be able to speak on an issue that is very important to him, as has Senator KENNEDY. So the time agreements will just have to start when we finish the morning business.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. I thank the Chair.

PRESCRIPTION MEDICATION

Mr. GRAHAM. Mr. President, prescription medication is one of the most significant issues before the family of America. Unfortunately, the family is hearing most of this through 30-second television ads. These ads tend to be long on rhetoric and short on substance.

I hope the Senate can serve its national purpose as a great deliberative body by bringing some deeper focus on an issue which affects, in the most intimate way, tens of millions of our citizens. I hope I can contribute to this by a series of floor statements on different aspects of this important national issue of prescription medication, especially for older Americans.

Older Americans often must take their medicine on a daily basis. It is important that the Senate also get a daily dose of reality of life for those older Americans. I invite my colleagues with similar or differing perspectives to join me so we can have a daily discussion on this important issue. I am pleased today to be joined by my colleague, Senator KENNEDY, and invite others to join.

We have before the Senate the opportunity to achieve a broadly shared objective—reforming Medicare. Many of my colleagues have discussed Medicare reform in the context of administrative changes and organizational restructuring. While there is certainly merit to that discussion, I believe the most fundamental reform that must be made to the Medicare program is changing Medicare from a program that is based on acute care, illness, treatment after the fact, and to move it to a program that emphasizes prevention, wellness, and the maintenance of the quality of life. That is the fundamental reform we must make in Medicare.

To accomplish this shift we must first recognize that the face of health care has changed dramatically since the inception of Medicare in 1965. Thirty-five years ago, America's health care system was almost wholly reacting. Patients sought help from chronic conditions that flared up, or waited to see a doctor when acute conditions hit or if they had a serious accident. Their care was typically delivered in hospitals. Medicare responded to this acute care, hospital-based health care system.

The fundamental reason the program was structured as such was based on the fact that most Americans lived only a few years after they reached retirement. As we know from our colleague, Senator MOYNIHAN, the original rationale for 65 as the basis of retirement was the fact that date was set in Europe at the end of the 19th century when the average life expectancy of a European male was only 62. There was a high degree of cynicism in the selection of that date. That date has continued to be an important part of our culture. Only a few decades ago the average American could only expect 7 years of life expectancy after they reached 65. Today the average American has almost 20 years of life expectancy after they reach the age of 65, and by the end of this century an American can expect almost 30 years of life expectancy after attaining the age of 65.

We must reform Medicare to assure that today's seniors can spend that gift of years living healthy, productive lives. This can be done if we make an investment in prevention care, which includes screening, early intervention, and the management of the conditions which are detected through those early interventions.

The Medicare program should treat illness before it happens. New preventive screening and counseling benefits of the Medicare program give us that opportunity. The U.S. Preventive Services Task Force and the Institute of Medicine have recommended to the Congress that we add new preventive screening and benefits to the Medicare program. These benefits will address some of the most prominent underlying risk factors for illness that face all Medicare benificiaries. These include coverage for medical nutrition therapy for seniors with diabetes, cardiovascular disease or renal disease, screening for hypertension, counseling for tobacco cessation, screening for glaucoma, counseling for hormone replacement therapy, screening for vision and hearing, expanded screening and counseling for osteoporosis, and screening for cholesterol.

In addition to adding to our current relatively short list of preventive efforts within Medicare, we need to change the basic structure of how Medicare goes about determining when a new preventive methodology is both medically appropriate and cost effective. Today we rely upon the conventional congressional process to add new prevention methodologies. What I believe we should do is to establish a scientific nonpartisan basis to arrive at these determinations. I suggest we assign this responsibility to the Institute of Medicine and direct that institute

conduct ongoing studies of prevention methodologies to assess their scientific validity and economic cost effectiveness. When they make such a determination, they should submit it to Congress, and Congress, using a fast-track process, as we typically do in trade matters, would make a determination either to accept or reject but not to modify those recommendations made by a scientific panel. I believe that approach would assure us that we would be providing to our older citizens the most modern scientifically tested means of maintaining a high standard of living.

It is critical that we assure Medicare beneficiaries, both present and future, those most appropriate health care possibilities. By making preventive care the cornerstone of Medicare reform, we can do just that.

This discussion of a new Medicare, a Medicare focused on wellness, reminds me of an anecdote. A man walks into the doctor's office and the doctor says: I have both good news and bad news. The good news is that because we have done a screening process we have detected your disease early and we have the opportunity to prescribe the medicines and other medical treatments to stop its spread and reverse its adverse effect on your health. The bad news is you cannot afford the medicine to do this.

Sadly, this is not a joke. The list of diseases that were once fatal and are now preventable is long and growing. Years ago, people with high cholesterol could almost count on developing heart disease. Today, cholesterol levels can be kept in check with a number of drugs. One of those is Lipitor, a widely prescribed drug for high cholesterol. This drug has an average yearly cost of nearly $700. As with many other near-miracle drugs, Lipitor is too expensive for many seniors. Yet Medicare, the Nation's commitment to take care of its elderly and disabled, does not cover Lipitor or most other outpatient drugs. Medicare will, however, pay for the surgery after the heart attack which that man is likely to have because he was unable to treat his condition while it was still subject to management.

That policy may have made sense in 1965 when the man would only live a few years after retirement. Are we prepared in the year 2000 to tell an American who reaches 65 and has an average of almost 20 years of life expectancy that we are going to treat them only after they have a heart attack; that is the point when we are going to provide access to the means of managing a health condition?

I will soon address the critical link between prescription medications and preventive medicine. Prevention and prescription drugs are a key to a modern health care system for our Nation's seniors. This Senate should contribute to delivering that key, and do it now.

SENATE AGENDA

Mr. KENNEDY. Mr. President, I yield myself 8 minutes.

First of all, I commend my friend and colleague from Florida on an excellent presentation and one that commends itself to the common sense of all of us in the Senate.

The fact is the Medicare program was built upon the existing programs in 1965. Since that time, we have discovered the importance of preventive health care—how important it is in keeping people healthy and how important it is for actually saving Medicare funds over a long period of time. The Senator from Florida has indicated a pathway we might follow to deal seriously with these issues. We should not have to explain to this body that for every $1 we spend for immunizations, we save $8 to $9 by preventing disease.

I admire and am a strong supporter of the administration's series of recommendations for preventive care. The Senator from Florida has outlined a process and system where we can finally take action on these recommendations.

The bottom line is the Budget Committee doesn't take into consideration the savings from preventive care so this body has been extremely slow in enacting these programs. But these preventive measures make a great deal of sense. They make sense for ensuring good quality health care for the families of this country, and they make sound economic sense. I certainly agree with the Senator that along with preventive care, we ought to understand the importance of prescription drugs. I think what he has outlined today is enormously important for us to consider.

I will take a few moments to move beyond this very excellent presentation into what the challenge is for all of us in the Congress over these next 5 weeks. There is time, I believe, to take action on a good prescription drug program. We have, now, two different systems which have been offered to the American people. The first is the proposal that was advanced initially by President Clinton and is now enhanced by Vice President GORE. The proposal has been changed—not really dramatically—but I think it has been more carefully attuned to the needs of Medicare enrollees than the alternative which has been presented by Governor Bush.

I hope even in the short time that remains—when we conclude the action on trade issues we still have more than 3 weeks of Senate time—I hope we can still take action on a minimum wage. Every Member of this body knows that issue well. We know what is before us. We ought to take action on the Patients' Bill of Rights. We have a bipartisan effort to try to do that. There have been some suggestions and recommendations in order to accommodate some of those who voted against this previously. We now, hopefully, will gain support for those proposals.

Finally, and very importantly, the other remaining issue which is of vital importance to seniors is a prescription drug program. Let me mention quickly some of the concerns I have about this program and some of the advantages that I believe are in the Vice President's program.

The Vice President's program is built upon Medicare. We have heard on the floor of the Senate the Medicare system is a one-size-fits-all program. The fact is that seniors understand Medicare. They support Medicare. They understand there have to be some changes in the Medicare program but, nonetheless, it is a tried, tested process and it is one which offers the necessary flexibility.

What has been proposed by the Vice President is a prescription drug program that goes into effect a year from now, and is gradually phased in over a period of time. The seniors of this country would have a benefit for prescription drugs a year from now. I think that is very important and one of the most compelling parts of the Vice President's program.

The alternative is the proposal offered by Governor Bush. I read here from the Governor's own proposal. It says in his proposal that effectively it will be a block grant program that will in effect ensure low-income seniors do not have to wait for overall reform.

Our seniors ought to have some pause, because he is talking about overall reform of the Medicare system. That ought to bring some pause. We do not really know what overall reform is. I think most seniors would say: We have confidence in the Medicare system. We want a program that will get the benefits to us quickly.

He says that low-income people will not have to wait for the overall reform. We are not sure what that really means. To have your prescription drugs covered, Governor Bush will establish the immediate helping hand which will provide $48 billion to States for 4 years to deal with low income seniors. So it will be 4 years before 27 million seniors will be able to participate because there are 27 million seniors who do not fall within Governor Bush's definition of those who need an immediate helping hand. Those 27 million seniors will wait 4 years—and then wait for the overall Medicare reform. The Vice President's plan goes into effect 1 year from now.

Second—and I think enormously important—is what we call the guaranteed benefit. This is very simple. A guaranteed benefit means the doctor will make the decision on your prescription drug needs. When seniors go in—whatever their condition, whatever their disease, whatever their problem—the doctor makes the recommendation