our efforts. I hope over the next several days we do something we have not done over the last many months—work together for the benefit of the American people.

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

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

The assistant legislative clerk proceeded to call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

THE LAST CONGRESS OF THE TWENTIETH CENTURY

H.R. 2614

Mr. GRAHAM. Mr. President, I come on this early Friday evening with a sense of extreme disappointment, extreme disappointment that we are concluding the last Congress of the 20th century with so little commitment to provide a vision and a sense of assistance and help to Americans as they prepare for the 21st century. I would describe it as the ''lack of vision thing.'' We cannot seem to envisage the surplus as a once-in-a-century chance to tackle the most important issues for our day, issues that will affect our children and grandchildren, issues such as Social Security and Medicare, the two great programs in which the U.S. Government has a contract with its people, and how to deal with the national debt, which grew so explosively over the last 30 years, and that we now have an opportunity to substantially reduce.

Instead, we see the surplus as a giant windfall that allows us to dole out favors to favored constituencies, as if Halloween has already arrived. The result of this ''tunnel vision thing,'' is a bill that will absorb $320 billion of the non-Social Security surplus faster than the kids next Tuesday will be able to empty their Halloween bags.

As troubling as the specifics of this legislation is the process by which it found its way to the Senate floor. This legislation, which would propose substantial tax reductions and additional provider funding under the Medicare program, is a major assault against our ability to use the budget surplus in a rational way.

As we all remember from Abraham Lincoln's immortal Gettysburg address, ours is a Government ''of the people, by the people and for the people.''

For such a government of, by, and for the people to function, it must be conducted in full view of the people.

As several of my colleagues have already discussed earlier today, this program of tax cuts and paybacks to additional reimbursement to Medicare providers was created by a self-appointed, elite group of Members in the proverbial smoke-filled room of old-style machine politics. The irony is that the very Republicans who snuck into the closet, locked the door behind them, and emerged with this poor excuse for a fiscal plan are the same leaders who are now encouraging George W. Bush to be elected President of the United States on a promise to be a uniter, not a divider, and a builder of coalitions and bipartisan consensus.

If this is what the blueprint is for bipartisanship and consensus building, I shudder to imagine the legislation that will ooze out from this closed door should Governor Bush win the Presidency and follow the counsel of those who have brought us to this sad end on this fall evening.

Governor Bush would do well to consider that the Republican Congress lacks the vision thing. It is always more difficult to see the big picture when you are in the dark. The legislation before us is a prime example of what happens when you try to see the big picture in the dark.

I will not claim that this bill is without some positive qualities, some redeeming features. Many of those features I have strongly advocated and, in a number of instances, have been a prime sponsor. But the bill has serious deficiencies. I choose this evening to focus only on two of those deficiencies: First, the high level of additional funding being given under the Medicare program to managed care providers at the expense of the beneficiaries; and, second, the failure to provide adequate incentives for small employers to offer pensions to their employees.

Both of these deficiencies have a common theme, and that is that we are not just proposing measures as a means of adding back or increasing the payments to Medicare providers. We are not providing tax incentives just to reward certain people with additional pension or retirement benefits. We are trying to achieve objectives.

In the case of Medicare, we are trying to achieve the objectives of changing the orientation of this program from one which focuses on illness, one which focuses on treating people after they have become sick enough to go into a hospital or have suffered a major accident, to one which focuses on wellness, keeping people healthy as long as possible, and which recognizes that a fundamental part of any wellness strategy is providing access to prescription drugs which are the means by which conditions are appropriately managed or reversed so that wellness can be achieved or maintained.

We also have as a vision to provide a balanced retirement security for older Americans, a retirement security that is based on three pillars: Social Security, employer-based pensions, and private savings. It is to achieve this goal of a balanced, secure retirement program that we should be directing our attention in terms of how we fashion tax incentives and other measures that use public incentives and funds in order to achieve that objective.

I am disappointed that this tax legislation, this Medicare reimbursement legislation that we have before us, fails on both of those accounts, and I will elaborate on the nature of that failure.

First, by making health maintenance organizations the only Medicare-based means by which a prescription drug benefit can be achieved, we are, in effect, herding seniors who need prescription drug coverage into private health maintenance organizations. This bill, by any account, gives disproportionately too much money to the health maintenance organizations, organizations that do not need it and do too little to seniors and health care providers who do. We give too much money to the HMOs, too little to the beneficiaries, and too little to other health care providers.

While I appreciate the modest improvements for beneficiaries included in this bill, the fact remains that health maintenance organizations will receive substantially more than one-third of the overall package over the first 5 years and even more over 10 years. I am alarmed by the attempt at offering substantial increases in payments to HMOs because experts tell us that these payments are already too high. The General Accounting Office says that under current law—under current law, not the increases we are considering here—and I quote from the General Accounting Office report:

> Medicare's overly generous payments rates to health maintenance organizations well exceed what Medicare would have paid had these individuals remained in the traditional fee-for-service program.

The General Accounting Office concluded that Medicare health maintenance organizations ''have never been a bargain for taxpayers.''

Increasing HMO payments will not keep them from leaving the markets where they are most needed. According to the testimony from Gail Wilensky, chair of the Medicare Payment Advisory Commission and a former Administrator of the Federal Health Care Financing Administration, HCFA:

> Plan withdrawals have been disproportionately lower in counties where payment growth has been most constrained.

The withdrawal of HMOs from counties has actually been lower where the payment growth to HMOs has been most constrained.

It comes down to priorities: Should we spend billions more on HMOs or should we try to help frail and low-income beneficiaries, people with disabilities, and children?

The managed care industry and its advocates in Congress have thwarted every effort to reform the Medicare+Choice Program so that it does what it is designed to do: provide services while saving the Government money.

There is a complex formula by which Medicare+Choice plans are reimbursed. In a simplified form, it works this way. It is an arithmetic formula:

A calculation is done in each county in the country as to how much fee-for-service medicine is costing per Medicare beneficiary. Ninety-five percent of

that number then becomes the method by which the HMO+Choice plans are reimbursed.

If you happen to have a county that has a high fee-for-service medicine, for instance, because it has tertiary medical care or particularly because it has a teaching hospital, which tend to result in driving up the overall fee-for-service costs within that county because they are providing exceptional and generally exceptionally expensive services, then you have a high reimbursement level to HMOs. That is why you tend to find lots of HMOs wanting to do business in those high-cost, fee-for-service counties.

Conversely, if you happen to be in a county that has no hospitals or only primary care hospitals and relatively low fee-for-service costs, then you have low HMO reimbursements, which frankly is a formula that makes no sense.

For many years, there has been an effort to find a new way to reimburse HMOs that is more market oriented as opposed to relying on the accident of whether you happen to be in a high fee-for-service county or a low fee-for-service county.

Several times in recent years Congress has initiated a program to do a demonstration project using some of the competitive bidding processes which are prevalent in the way in which private corporations and State and local governments determine how to reimburse their HMOs. They put their HMO contracts out for competitive bid and see what HMOs will offer in order to secure the business of a large corporation or a State or local government. I believe strongly that we should at least experiment with this approach to reimbursing HMOs through Medicare.

In 1997, as an example, two demonstration projects were included in the Balanced Budget Act. These were to provide information on the competitive bidding process for Medicare+Choice contracts. What happened? As soon as two cities—in this case Kansas City and Phoenix—were selected to be the sites for the demonstration projects, the HMOs and their allies in those communities led an assault against the demonstration project, and in an end-of-the-session, largely clandestine attack, those demonstration projects were terminated even before they had started. In so doing, the HMOs have been able to assure that they will not have to compete for Medicare's business based on merit and the marketplace. In fact, they would not have to compete at all.

This year, the HMOs have again launched a multimillion-dollar lobbying effort to pressure Congress to increase their payment rates based on this discredited 95-percent formula. The HMOs are claiming their current reimbursement rates are too low. Yet these are the same HMOs that committed congressional homicide when they killed the proposal that would have allowed a more market-oriented system, which could have resulted in higher reimbursement rates or lower reimbursement rates; at least they would have been the reimbursement rates that were set by market competition, not by an arbitrary discredited formula.

This action, of claiming that you need to have higher reimbursement rates after you have just killed the method by which we were going to determine what would be the means of setting those appropriate rates, is the equivalent of the child who shoots his mother and father and then claims to deserve the mercy of the court because he is an orphan.

The HMO industry has shot every effort to establish a rational means of reimbursement.

Then they come here late at night, late in the session, saying that they need to have a third or more—a third or more—of all the money that is going to be used to provide reimbursement to Medicare providers because their rates are too low. They are providing services to approximately one out of six Medicare beneficiaries. Yet they want to have a third or more of all of the money that goes for additional reimbursement.

I was pleased to learn that within this bill one positive thing that was being considered was additional preventative benefits for Medicare beneficiaries. This is a cause I have long advocated as part of the fundamental conversion of Medicare from a sickness system to a wellness system.

I strongly believe that Medicare must be reformed from a system which is based on treating illness to one that is based on maintaining wellness.

I have introduced many bills to this effect, some of which are now the law of the land. The benefits that I have included have been based on recommendations made by experts in the field. We have used the medical expertise to determine which preventive modalities have been proven to be efficacious and cost-effective. Therefore, I was disappointed to find that this bill fails to provide Medicare coverage for those areas of prevention which have been identified by the U.S. Preventive Services Task Force as being the most efficacious and cost-effective.

What were these areas of prevention? Hypertension screening and smoking cessation counseling. These were the highest priorities identified by the U.S. Preventative Services Task Force. But these apparently did not meet the ''political correctness'' standards of those who were writing this final bill.

The bill also provides one of the other priorities: Access to nutrition therapy for people with renal disease and diabetes. But it leaves out the largest group of individuals for whom the Institute of Medicine recommends nutrition therapy—people with cardiovascular disease.

This is the publication of the Institute of Medicine on ''The Role of Nutrition in Maintaining Health in the Nation's Elderly,'' which urges that access to nutrition therapy be made available to people with cardiovascular disease. Again, apparently they did not meet the standard of ''political correctness'' to be included in the prevention modalities that will be funded in this bill.

I believe strongly that additions to the Medicare program must be based on scientific evidence and medical science, not on the power of a particular lobbying group or on the bias of a single Member.

It appears that instead of taking a rational, scientific approach to prevention, the Members use a ''disease of the month'' philosophy, leaving those who need help the most without relevant new Medicare preventative services.

When I asked why the authors of this bill ignored the expert recommendations, such as providing seniors with cardiovascular disease with nutritional therapy, I was told it was excluded because it was too expensive; we could not afford to provide nutrition therapy to seniors with cardiovascular disease.

It does not take a Sherlock Holmes, or even a Dr. Watson, for that matter, to understand what is happening here. This bill provides $1.5 billion over 5 years for all of the prevention programs and a whopping $11.1 billion for the HMOs. But it is just too expensive to provide adequate, rational, prioritized prevention services for our elderly.

Clearly, the money is there. But the real goal of those who wrote this plan is to herd seniors into private HMOs as a means of avoiding the addition of a meaningful Medicare prescription drug benefit for our Nation's seniors.

Whether you believe in the broad Government subsidization of the managed care industry or in providing benefits to seniors and children, we should all agree that taxpayers' money should be spent responsibly.

Congress has the responsibility to make certain that the payment increases we offer are based on actual data rather than anecdotal evidence or speculation.

How then can we justify that over the next 10 years the managed care industry is set to walk away with almost the same amount of funding increases as hospitals, home health care centers, skilled nursing facilities, community health centers, and beneficiaries combined.

Over the next 10 years, under this plan, health maintenance organizations will receive, in additional funding, the amount that hospitals, home health care centers, skilled nursing facilities, community health centers, and beneficiaries will receive combined.

The most disturbing problem with this bill is that it does nothing to address our efforts to pass a Medicare prescription drug bill in the year 2000. The Republican leadership would like for you to believe that their bill will solve the problem of providing a prescription drug benefit for seniors.

According to a story in the October 26 Washington Post:

Unlike the rest of Medicare, this plan provides some prescription drug benefits; and by pumping more money into it, the GOP can defuse Democratic charges that the Republican Congress has failed to act on prescription drug benefits for seniors.

What we have here is the attempt to use this exorbitant amount of money, more money than is going into hospitals, home health care centers, skilled nursing facilities, community health centers, and beneficiaries combined, pumping all that money into HMOs in order to create the facade that we are providing a prescription medication benefit and therefore don't have to provide a prescription medication benefit to the rest of the Medicare beneficiaries, the five out of six Medicare beneficiaries who get their health care through the traditional fee-for-service program as opposed to an HMO.

The Republican leadership and George W. Bush criticize our prescription drug plan by claiming that we are forcing seniors into a Government-run HMO. By that so-called HMO, they mean Medicare, traditional Medicare, Medicare on which nearly 85 percent of the beneficiaries rely today.

In reality, the Republican plan to strengthen Medicare is to force seniors into private HMOs in order to get their prescription drugs.

Here is what seniors can count on in this plan of forcing seniors into private HMOs as the means of securing their prescription drugs.

First, the plan will cover less than one in six Medicare beneficiaries. Very few seniors have elected or in many cases even have the opportunity to participate in Medicare+Choice. Only 16 percent of the 39 million Medicare beneficiaries have joined a Medicare HMO plan.

Second, Medicare beneficiaries can look forward to plans that are here today and gone tomorrow. Nearly 1 million seniors will be abandoned by their HMOs in this year of 2000 alone. More than 87,000 of those are in my State of Florida. Seniors in 33 counties of the 67 counties in Florida either never had a Medicare+Choice plan or had one only briefly before it packed up and left town.

Third, seniors will have no guarantee of their prescription drug benefits. What is unlimited coverage today may be a capped benefit tomorrow.

Listen to these numbers. This is what the prescription drug benefit is for some of the most significant HMOs in the country operating in communities with very large Medicare beneficiary populations.

In Hernando County, FL, north of Tampa, there are two Medicare+Choice plans, Wellcare and United. Both offer a prescription drug benefit, the type of benefit we are hoping to expand by pumping more money through this Medicare additional reimbursement into HMOs. Both of those plans cap their benefits for prescription drugs, in the one case at $748 a year and in the other at $500 a year. There are many Medicare beneficiaries who spend more than that in 1 month. Yet that is the annual cap on prescription drugs for those two HMOs which claim they are providing effective prescription drug coverage for their beneficiaries.

Another example is the HIP Health Plan of Florida which offers seniors in Miami-Dade and Broward Counties a drug plan that covers up to $700 annually for brand name drugs. Seniors in the same plan in Palm Beach County, which is immediately north of Broward County, have an annual limit of $250 for brand name drugs.

What kind of prescription drug benefit is that? For many seniors, such as a constituent to whom I have referred frequently, Elaine Kett of Vero Beach, these annual capped amounts represent less than 30 days' worth of their prescription drug needs.

The HMOs' tendency toward denying choice and rationing of health care will not benefit our Nation's seniors and people with disabilities. Talk about denying people choice; talk about rationing of health care; This is it.

Fourth, seniors can expect no guaranteed choice of a doctor. HMOs have networks of doctors that are constantly changing. If Mrs. Smith's doctor is not in her HMO network, Mrs. Smith can't see the doctor. She can't see the doctor who knows her the best. She can't see the doctor she trusts to treat her and prescribe the medications she needs.

Even if Mrs. Smith's doctor writes a prescription drug, her HMO may have a restrictive formulary and substitute her doctor's wisdom for theirs by filling her prescription drug with something else. Even if Mrs. Smith's doctor writes her a prescription drug, her HMO may have a restrictive formulary which will deny her the medicine that her doctor believed was medically necessary.

To continue looking at the facts, let's look at the materials that Humana, one of the largest Medicare+Choice providers, HMOs, in the country, provides to seniors as it explains their prescription drug benefit.

Here is what Humana says:

For medications with dispensing limits and age limits, additional information may be required for approval. These requests can only be made by your physician to be considered. Please have your physician contact the Humana clinical hotline at the number below.

So it is not the patient relying on the best medical advice of the doctor and then taking that medical advice in the form of a drug prescription to a pharmacist in whom they have confidence to be filled. It is the patient relying on the goodwill of the HMO to allow the best judgment of the doctor to be fulfilled.

Reading further in the Humana preferred drug list publication:

All of the above is not a complete list and is subject to change.

So what you think may be your relationship with your doctor and your pharmacist today may be different tomorrow, if your HMO decides it wants to make it different tomorrow.

If Mrs. Smith's doctor prescribes a medication that is not on Humana's formulary, she can only get it filled with prior authorization from Humana. That means upon learning that her medication is not on Humana's formulary, probably when she is standing at the pharmacist's counter trying to get her drug prescription filled, Mrs. Smith will have to call her doctor and ask her doctor to call a 1–800 number on her behalf.

Once the doctor gets through, Mrs. Smith's doctor will have to consult with an HMO bureaucrat and provide additional information regarding Mrs. Smith's health so the bureaucrat can determine whether Mrs. Smith is eligible to receive the medication her own doctor prescribed. After all of this, the request to have Humana cover the drug may still be denied. To add to the difficulty of having a drug prescription filled, Humana states in its materials that the list of covered drugs is subject to change. A drug that is covered for Mrs. Smith today may be excluded on her next visit to the pharmacy.

Fifth, there are few, often no, options to participate in Medicare+Choice in rural areas. Because of this perverse formula that relates the fee-for-service costs within that county to the amount of reimbursement that HMOs will receive, while seniors in urban centers may have access to Medicare+Choice plans, many of our seniors do not have that option. In over 20 counties in Florida and in the entire States of North Dakota, Utah, and West Virginia, there are no managed care programs for Medicare beneficiaries.

I wonder, do those who would advocate that this managed care approach provides meaningful prescription drug coverage for our Medicare beneficiaries think the people in North Dakota, Utah, and West Virginia do not need prescription medications?

All of these factors beg the question: If seniors don't have access to or don't like Medicare managed care now, because of their own experience, why would they like it better just because we are about to decide to throw an enormous amount of money at it, without any rational justification, without any sense of the priorities among Medicare health care providers? Why, just because we are about to act in an irrational way, would it suddenly make these plans better in the eyes of the ultimate beneficiary?

As I have said in a series of floor statements, the attack on a Medicare prescription drug benefit is, in reality, an attack on the Medicare program itself. Let me repeat that. This attack on using fee-for-service Medicare as the fundamental means by which prescription drug benefits will be delivered is but a veiled attack, an assault on the

basic principles of Medicare itself; universality, comprehensive service, affordability, those are principles that are under assault under the veil of denying prescription medication benefits through traditional Medicare.

The Washington Post article of October 27 entitled ''Ad Blitz Erodes Democrats' Edge on Prescription Drugs'' describes how Republicans have used ads to achieve ''some success in muddying the waters on prescription drugs.''

Mr. President, I ask unanimous consent that this article be printed in the RECORD immediately after my remarks.

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

(See Exhibit 1.)

Mr. GRAHAM. In the legislation we are considering today, we have found yet another smoking gun to validate our suspicions that the Republican Party—and, I am afraid, its Presidential candidate—are seeking to do as Newt Gingrich was candid enough to say publicly: Let Medicare ''wither on the vine.''

I believe the cynical way in which this bill purports to provide a prescription medication benefit by pumping enormous amounts of money away from beneficiaries in more effective prevention programs, and away from institutions such as hospitals and home care centers which have demonstrated a legitimate basis to receive additional compensation, and toward the institutions which have fought against every reform and which, by the General Accounting Office report, has not made a justifiable case for additional reimbursement. We are doing this in order to create the facade that by forcing seniors into private HMOs, that would be the means by which they would receive prescription drugs. That in itself is enough of a reason to vote against this proposal.

Let me comment on a second reason. Just as the first, prescription drugs, is an area on which the Presiding Officer and I have worked to try to develop a bipartisan, rational means by which prescription drugs can be made available to Medicare beneficiaries, the next area is another on which I, along with many colleagues on both sides of the aisle, have worked, and that is to reform our pension laws. In my judgment, the primary objective of reforming our pension laws should be to increase the number of Americans with access to employer-based pensions.

At first glance, the retirement savings section of this bill looks very similar to S. 741, the Pension Coverage and Portability Act, which I introduced with my colleague from Iowa, Senator GRASSLEY, which has the support of 17 of our colleagues in the Senate. In fact, there are some very attractive and useful provisions that will make existing pensions work better. To these, I give my wholehearted support. For example, the bill makes it easier for employees to take their pensions with them as they move from job to job. This is an important improvement to existing law and will help workers accumulate assets for retirement.

On further review, however, it becomes clear that in many ways this bill is a wolf in sheep's clothing. The principal goal of the Pension Coverage Portability Act is expanding retirement plan coverage to those Americans who currently do not have an employer-sponsored plan available to them. The measure focuses particularly on encouraging small employers to offer pension coverage.

Let me use some examples and statistics from my State of Florida, which I think are not unrelated to the national scene. Florida has benefited greatly from the strong economic growth in America in the last 8 years. Almost 2 million new jobs have been created in our State during that time. Of those almost 2 million jobs, more than 70 percent are in firms that employ fewer than 25 people. The vast growth in employment in my State of Florida—and, I suggest, in America—has been through small entrepreneurial firms. It is these small employers who have the greatest difficulty offering pension coverage to their employees. A recent report from the General Accounting Office highlights this fact.

According to the GAO report, slightly more than half—53 percent—of all employed Americans lack employer-based pension coverage. The good news is that that is 5 percentage points more than it was a decade ago. So more Americans than 10 years ago are now getting a pension through their place of employment.

The more troubling finding in the GAO report is that workers' chances of having access to a pension plan are strongly influenced by the size of the firm that employs them. While 53 percent of Americans, in general, lack an employer-based pension, if you happen to work for a firm that employs fewer than 25 people, 82 percent lack an employer-based pension. It is in precisely on those small firms that the Pension Coverage and Portability Act targeted its attention. Unfortunately, the bill before us today falls woefully short in encouraging those small firms to provide coverage to their workers.

The Pension Coverage and Portability Act contained two important provisions to assist small businesses in offering retirement plans to their employees. One of those was an income tax credit to help small businesses defray the administrative costs associated with establishing a retirement plan. Second is an income tax credit for small employers who make employer contributions into pension plans for the benefit of their employees. So there were two critical provisions in the Pension Coverage and Portability Act, both targeted at encouraging, facilitating, and making more likely that small employers would provide pensions for their employees an income tax credit to help defray the initial establishment of the plan costs; and, second, an income tax credit for the employers who made contributions on behalf of their employees into their employees' pension plan. Both of these important provisions were excluded from the tax bill before us today.

In addition, to the pension bill that was unanimously reported by the Senate Finance Committee included both of those provisions, and another important element of retirement security encouraged personal savings. This was achieved through a separate tax credit to help low- and moderate-income families save for their retirement.

The bill was unanimously reported. Every Republican and every Democrat on the Senate Finance Committee supported the provisions that would have encouraged small businesses to set up pension plans for the employer to contribute to employee pension plans, and it also creates an incentive for increased savings for low- and moderate-income families.

The bill crafted by the Republican leadership contains none of these important proposals.

Finally, the bill even has the potential to actually create incentives for small businesses to drop their existing pension coverage. Approximately 18 percent of small businesses with less than 25 employees might actually be encouraged by this bill to drop that pension coverage. How can this possibly be?

Frequently, the employers in a small business set up pension coverage not only to benefit their employees and attempt to encourage a greater sense of commitment to employment with a small firm, but they also do it out of self-interest. As long as an employer is willing to cover his employees, he generally can set aside more funds for his own retirement through an employer-based plan than is possible to be done through an IRA, individual retirement account.

This bill includes a substantial increase in the maximum contribution allowable to an individual retirement account. That amount today is $2,000 a year and will be increased to $5,000 a year by the year 2003. By securing a separate IRA for the employer's spouse, effectively $10,000 can be tax sheltered for retirement.

By making IRAs more attractive to small employers, those small employers might decide that it is in their self-interest to discontinue the employer-based plans which they now sponsor and rely on their own and their spouse's IRA as the means of providing for their retirement security.

Thus, the unintended consequence of increasing IRA limits without providing incentives to encourage small businesses to provide pension coverage and then for the employers to contribute to their employees' plan may be to erode the retirement plan coverage for employees in small businesses. The percentage of those workers in small firms without coverage—82 percent already—could grow even higher.

As disappointed as I am in this legislation as a whole, I am not in the least bit surprised. This legislation is the work of lobbyists—not statesmen.

Instead of a strategic vision of what will be required in order to convert Medicare into a wellness program and what will be required to assure that the large and growing number of Americans who work for small businesses will have the benefit of a pension and retirement fund—instead of those strategic visions—this is the work of special interest tunnel vision. Instead of balancing the interests of all Americans, this bill goes full tilt towards the luckiest few.

I suggest when legislation is drafted in the dark this is what we can expect. Behind those closed doors, the drafters seem to forget basic math. That basic math is that every dollar we spend—such as pumping excessive funds into HMOs—is $1 that we take directly out of the surplus.

Every dollar spent on tax cuts is one that will not be spent on saving Social Security by paying down the national debt, and will not be spent on modernizing Medicare to make it a wellness program.

I have used words such as ''squandering,'' ''flittering,'' and ''wasting'' before this body more often in the last 2 weeks than I would have liked.

I have watched any chance that this body had to create a comprehensive strategic spending plan for our future die a small and painful death.

I am left with the hope that President Clinton will indeed veto this bill as promised, and that a few billion dollars can be spent paying down the national debt before the next Congress gets its hands on the purse strings again.

I am not surprised that we are at this point. But I must admit I am a bit puzzled.

Is it really possible that some of my colleagues don't realize that a slice here and a snack there will eventually leave nothing but crumbs? Can it be that they truly believe we can have our surplus and eat it too? Or are they feasting on the surplus behind closed doors fully aware that they are telling the system, starve for reform, that we will be fine, and go ahead, eat cake?

Thank you Mr. President.

EXHIBIT 1

[From the Washington Post]

AD BLITZ ERODES DEMOCRATS' EDGE ON PRESCRIPTION DRUGS

(By Juliet Eilperin and Thomas B. Edsall)

Buoyed by a massive advertising blitz from business groups, Republicans have managed to erode some of the Democrats' political advantage on the issue of prescription drugs for seniors, according to polling data and independent analysts.

Republicans have had some success neutralizing an issue the Democrats had hoped to ride to victory in both the presidential race and many congressional contests across the country, the analysts said. In fact, in a few key races, Republicans have successfully used the issue to skewer the Democrats as big government spenders.

Fueling the Republicans have been tens of millions of dollars in ads from the pharmaceutical industry, the U.S. Chamber of Commerce and other business groups lauding the GOP's private-sector-oriented approach to providing drug coverage for seniors. Republican ads for Texas Gov. George W. Bush and other candidates have also portrayed Democratic proposals to add a drug benefit to the Medicare program as a potential bureaucratic nightmare.

Democrats ''just assumed we would roll over and say, 'You know, we are against seniors and for the big drug companies, so come on over and take the House and Senate back with it,'" said GOP pollster Glen Bolger. ''But Republicans decided not to do what the Democrats wanted.''

Just three months ago, Bush had no plan to provide prescription drug coverage for seniors and was badly trailing Vice President Gore on the issue. A Washington Post/Henry J. Kaiser Family Foundation/Harvard University poll in July showed Gore with a strong advantage over Bush, 49 percent to 38 percent, when voters were asked which candidate would do a better job ''helping people 65 and over to pay for prescription medicines.''

Three months later, after an onslaught of Republican National Committee advertising on the drug issue, the Gore advantage had disappeared: When voters were asked whom they trusted to handle ''Medicare and prescription drug coverage,'' they were evenly split, 45 percent saying Gore and 43 percent Bush.

Democratic operatives acknowledge that Republicans have had some success muddying the waters on prescription drugs. In mid-September, the party's own internal surveys showed that Gore's advantage on the issue has slipped to single digits, one top pollster said.

But a fall advertising campaign has helped put the issue back into the Democratic column, this pollster said, and Gore and his party now hold a 15-point advantage on the question of who would better address the prescription drug problem.

Robert Blendon, a health policy specialist involved in the Post/Kaiser/Harvard poll, said surveys suggest the public, in fact, prefers Gore's proposal to add a prescription drug benefit to Medicare over Bush's plan to encourage insurance companies to provide the coverage.

But he added that most voters ''don't exactly understand the nuances between the two policies,'' making it difficult for Gore to gain an advantage.

On the congressional level, Republicans have tried to defuse the issue by approving a measure allowing the reimportation of cheaper prescription drugs and, in the case of the House, passing their own drug coverage bill along the lines of what Bush is proposing.

And when Republican candidates have had the money to spend, they have been able to tarnish their opponents: Sen. Spencer Abraham (Mich.) saw his numbers surge this summer after he ran a series of unanswered attacks against the drug proposal of Rep. Deborah Ann Stabenow (D-Mich); and both Sen. Conrad Burns (Mont.) and Senate hopeful John Ensign of Nevada improved their standing in the polls after launching similar ads.

But according to Michigan-based pollster Ed Sarpolus, older voters who became confused on the drug issue are now beginning to gravitate back to Gore and Stabenow.

''It's human nature. If you're confused, you vote for what you know,'' said Sarpolus, who added that voters tend to trust Democrats more on health care.

Individual House Republicans, bolstered by their party committees and business groups, have also aggressively defended their records on drug coverage in recent months. Rep. Heather A. Wilson (R-N.M.) saw her poll numbers rise significantly among seniors once she began running ads on the GOP plan. Ohio Republican Pat Tiberi—who is hoping to succeed his former boss, Rep. John R. Kasich—also expanded his lead in the polls after the National Republican Congressional Committee funded ads attacking his opponent's position on prescription drugs.

Former representative Scotty Baesler (D-Ky.), who is hoping to defeat freshman Rep. Ernie Fletcher (R-Ky.), said the Republicans ''muddied the waters very well'' on the question of prescription drugs, prompting him to air ads on gun control instead because ''it's a definite separation between myself and Fletcher.''

Rep. E. Clay Shaw Jr. (R-Fla.) has even turned the issue into a liability for his opponent Elaine Bloom, blanketing his district with ads highlighting how she served on the board of directors of a company that makes generic drugs and that received payments from a competitor in exchange for keeping a heart medicine off the market.

The party committees are not the only groups touting the GOP's drug plan in recent weeks. The U.S. Chamber of Commerce has run several commercials decrying the Democrats' proposal as a potential bureaucratic nightmare while Citizens for Better Medicare—a group funded by the pharmaceutical industry—has spent $50 million on an ad campaign supporting the position taken by House and Senate Republicans.

Democratic Congressional Campaign Committee Chairman Patrick J. Kennedy (R.I.) said, ''The $50 million in independent expenditures from the major pharmaceutical companies has validated the Republicans' belief that money can buy anything including their inaction on a real prescription drug benefit for Medicare.''

Republican pollster Bill McInturff said that in the battleground states where GOP advertising on prescription drugs has been concentrated, ''these are roughly parallel numbers'' concerning which party and which candidate has the advantage. ''This is clearly a case where advertising has affected people's opinions,'' he said.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. MURKOWSKI. Mr. President, I ask unanimous consent that I be allowed to speak in morning business. I apologize for the lateness of the hour.

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

Mr. MURKOWSKI. I thank the Chair.

NO DEFINED ENERGY POLICY

Mr. MURKOWSKI. Mr. President, it is late. We have had pretty candid discussions on various issues before us. It is a political season. There is a lot of finger pointing, whether we talk about Social Security, Medicare, or the benefits of care associated with drug plans. I think we all share a common commitment to try to have meaningful legislation come out of the process. We simply have different points of view.

You heard the Senator from Florida comment extensively on the Republican plan to strengthen Medicare. I am not here to comment on the Republican plan on Medicare, although I think it is quite defensible. But I am here to talk about the Democratic plan for an energy policy.