That is certainly not true for people in this body, or for the 9 million Federal employees who are not responsible for 50 percent of their health care today under their insurance program.

We need to change Medicare so it gives a better value and so our seniors will be able to get the health care they need without being unfairly punished by having to pay so much out of pocket—so much more than, say, Federal employees. The list goes on.

As we debate, we will talk more at length about these issues.

I want to mention one other problem with Medicare that we need to debate on this floor; that is, the fragmentation of the system.

In 1965, through compromise at the time, there was a Part A for physicians and a Part B for hospitals. It has been fragmented into two separate categories.

Today, health care needs to be continuous. There needs to be a continuum. You want ongoing, continuous quality management, and you don't need different financing systems or different record keeping or different deductibles or different copayments set up. It is just not an efficient and effective way to deliver health care today.

In short, the Medicare system—again, as good as it is—does not live up to the standard we have set in the private sector. It is now time to address that gap, which we will be doing on the floor of the Senate.

Medicare today is still set up the way it was in the 1960s and in the 1970s to respond to acute episodic care. People get sick and go to the hospital. You treat them, and they go home.

That is not the way health care is delivered today in the private sector where you want to keep people out of the hospital, where it is not just acute care, where you are not just responding to a heart attack. The idea today is to prevent the heart attack in the first place. Now we have the expertise to do it, we have the medicines to do it, but seniors are not getting it today.

So what are we going to see play out here in the next month? We will begin to hear—probably starting tomorrow—a lot of discussion of the various plans that have been both proposed in the past and that the Finance Committee is thinking about. The Senate Finance Committee now is developing a balanced plan, a balanced proposal that draws upon a lot of the legislation that has come to this body, legislation that, in the last Congress, was the tripartisan plan, and a plan from several years ago that JOHN BREAUX and I worked on, and a House-passed plan from last Congress and the Congress before, and the framework put forth by the President of the United States.

I hope and pray but I am committed to see that we develop a bipartisan plan, bringing the best out of this body, from Democrats and Republicans, to address some of the needs—hopefully all of the needs—that I outlined a few minutes ago that make Medicare today less than what seniors deserve.

Over the next 2 weeks there will be a lot of discussion on this issue. Two weeks from now, on the floor of the Senate, we will be debating the legislation for 2 weeks. I am hopeful we can pass a plan out of the Senate before July 1 that responds to these needs.

I mention it has to be balanced and it has to be bipartisan. I say that for lots of reasons. In large part, it is because this is a huge challenge. We are going to have to take the very best of the Republican ideas, the very best of the Democrat ideas, the very best of the President's ideas, and the very best of the House's ideas and put them together. This will be the single largest expansion of Medicare in the history of the Medicare Program. As I said, it is going to be about $2 trillion that seniors are going to be spending over the next 10 years. We need to debate, as we go forward, how we can lower that barrier so seniors can get those prescription drugs.

I will close by saying that reform, modernization, strengthening has to be linked to prescription drugs, and prescription drugs have to be linked to strengthening and improving Medicare. It does not make sense in a fragmented system that doesn't have very much in preventive care that was built on a 1960s model. It does not make sense to superimpose a brand new benefit without taking advantage of putting all that in a single system that gives continuity, quality assurance, a systems approach where you can reduce medical errors that we know occur today.

There are five key principles that will guide our legislative efforts.

I think, first and foremost, we need to stress that whatever we do needs to be patient-centered. We need to think of that senior, what we can do to give him or her health care security, building whatever changes are needed around that.

Second, our seniors deserve the opportunity to voluntarily choose the health care plan, the health care coverage that best meets their individual needs. It is revolutionary in many ways but to look at a senior and say: You will have the opportunity, A, to keep exactly what you have now, what you have under current law, or, B, you can choose a type of coverage that better meets your individual needs, which may focus on your chronic disease of heart failure, which may involve disease management of your diabetes, and which will include preventive care, so whatever your status is when that progresses, we will pick it up early. Seniors will be able to voluntarily choose the type of health coverage and drug benefit that best meets their individual needs.

Third, seniors also deserve coverage where they have continuous quality management and safety improvements, and that requires a systems approach. You hear about these medical errors being made in hospitals, confusing prescriptions and medicines that interact with each other. I think that is the sort of thing we can avoid if we incorporate it in the legislation. I know we can do it in the legislation that evolves over the next several weeks.

Fourth, as I look at these principles, seniors deserve to be able to capture innovation. If we figure out a newer, better way to do something that will improve health care, that innovation should be captured. You should not have to wait 4 years to have access to innovation. It was 4, maybe even 5 years after heart transplants were widely available that they were made available in the Medicare Program. Seniors should not have to wait that long, if it is crystal clear, if the data is there, that this type of therapy is effective.

The fifth principle I would add is that seniors deserve coverage that is less bureaucratic, that has less paperwork, that is more flexible, so it can, indeed, adapt to the times.

We have a huge task ahead of us. A lot of people say they don't know if it can be done over the course of the next month. I am confident it can be done, in large part because much of the work was done in the last Congress, and it is being done both on the floor of the Senate and in the House of Representatives. We have made tremendous progress. We are building on a lot of the work that has been done in the past.

I am confident it can be done because the American people want it to be done. I am confident it can be done because people in this body—Democrat and Republican—want to do what is best for seniors, what is best for individuals with disabilities. I think we are going to see that responsiveness of this body play out over the next 4 weeks. I am excited about it.

The House of Representatives will likely be considering strengthening Medicare, addressing prescription drugs over the course of this month as well. If we can both accomplish that—which we are going to work very hard to do—within 6 months, 8 months, or less than a year from now, seniors will have a benefit as they reach out to obtain and use those prescription drugs as part of their health care.

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

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

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

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

MEDICARE REFORM

Mr. DASCHLE. Mr. President, I welcome our colleagues back. We are looking forward to a very productive few weeks. We know we have a lot of work to do in a relatively short time. In particular, work on the Energy bill is

going to require a good and vigorous debate. I know there are a number of Senators wishing to offer amendments. I hope we can begin that process in earnest tomorrow. I know there are a number of my Democratic colleagues who have particular issues they wish to address. We will get into many of those issues in earnest as amendments are offered over the next several days.

I didn't have the opportunity to hear the distinguished majority leader, but he has indicated to me—and I understand he has announced—that it is his interest and his plan to bring up the Medicare reform/prescription drug legislation the last couple of weeks of June. We certainly welcome that. We are looking forward to another debate, picking up where we left off last year.

I am concerned, I suppose, that we are moving quickly to this legislation without the benefit of extended discussion or hearings in the committee. I was rather roundly criticized last year after giving the Finance Committee a certain deadline and having failed to meet that, going to the floor so that we could ensure that we would do all that was possible to get a bill through the Senate in order to conference with the House prior to the end of the session. That wasn't possible, but we made every concerted effort and certainly a case that we could not afford to wait beyond the August recess, which is why we took up the bill last July.

We have not had, as I say, an opportunity to see the ideas that our colleagues on the other side are considering as we look at prescription drugs. But I was very appreciative of the report that I got about the majority leader's comments with regard to the value of Medicare. I think it is important to note that some of our colleagues on the other side have argued that we ought to eliminate Medicare, or terminate Medicare, or dramatically change Medicare—but the distinguished majority leader has noted that Medicare is a very valuable program, and indeed that is the case.

Before Medicare was created—about 1965—less than half of all senior citizens had health insurance. Today, almost every senior citizen has health insurance. So I think that alone argues very well for the importance of recognizing the universality of access to health insurance by those at least over the age of 65. We only wish we could replicate that for the rest of the population.

I think it is also important to note two other things. First, Medicare administrative costs are about 2 to 3 percent. That compares very favorably to the administrative costs of private health care—some 15 percent. So you have Medicare administrative costs at such a point that would leave 97 percent of the revenue generated that could go to benefits, where in the case of private health insurance, only about 85 percent of what revenue is generated is left that could go to benefits. That is a dramatic difference.

So those who argue that somehow the private sector is so much better, I argue that at least from a benefits structure, an efficiency point of view, you can certainly argue that the Medicare prototype or paradigm is so much more efficient. I also argue that in South Dakota it is almost impossible to get private health care benefits. You cannot find them in many parts of my State. That is true of a lot of rural areas. Health care benefits, health care insurance in rural areas is almost nonexistent, especially if it is provided through managed care. We have no managed care, virtually, in South Dakota.

So those who argue that somehow there is a panacea in the private sector overlook the fact that oftentimes, when it comes to rural areas in particular, it is almost impossible to use a private health care model. That is why we fought so hard last year. That is why when we offered the so-called Gramm-Miller-Kennedy legislation, we said, No. 1, there has to be a defined benefit; No. 2, a defined premium; No. 3, a way to ensure that rural areas are provided with the benefits; No. 4, we have to ensure as well that there isn't a coverage gap, a so-called sickness gap that was used oftentimes to make up for the fact that we needed to provide benefits right out of the box, but because we had limited dollars, they would go through a coverage gap before the benefits would kick in again.

Now, unfortunately, on all of those particular points, the bill offered by our Republican colleagues last year failed. There was a coverage gap. You paid premiums into this health insurance plan all year long, but I'm concerned that in some cases the benefits could kick out in February and might not kick back in again until roughly October. So you went through all of the spring and summer paying into the system but not getting any benefit back. That coverage gap was a serious omission and, frankly, one of the reasons we didn't believe that plan had much merit. They could not tell us what it was going to cost on a monthly premium, or what the benefits were going to be. They suggested things, but there wasn't any defined benefit. There wasn't any defined premium.

Then, of course, one of the biggest concerns many of us had is we could not count on the plan being offered in rural areas—especially in States like mine.

So I hope as we begin, we can all agree, No. 1, Medicare is a critical program, a success story of tremendous magnitude. Any time you can say you have eliminated the lack of access to health care for a certain group of people almost entirely, that is a success. That is exactly what we have done. Can it be improved? Again, like the majority leader, I think absolutely it can be. We ought to be providing more preventive care. We ought to find ways in which to promote wellness. That ought to be part of any plan. I personally believe there ought to be a lot more screening, a lot more access to all of the available techniques, all of the available methods of ensuring that we catch illness early, so preventive care is one of those things we can do. Adding a prescription drug benefit—absolutely. But if we are going to do this, let's not make this a big roll of the dice with senior citizens and say we cannot tell you what the premium is going to be, or what the benefits are going to be, or we cannot tell you for sure when your coverage kicks out and when it kicks back in with the coverage gap, or we cannot tell you for sure whether it is going to be offered in rural areas, and we will have just a Medicare backup in case all of this fails.

Well, that isn't a plan many of us would feel very good about, if, ultimately, that were the final vote. But I start with the hope and, I must say, the expectation that we can work together to find common ground; that we can address many of these shortcomings that were so evident in last year's legislation among some of our Republican colleagues; and that we can work together constructively.

I don't see any reason we cannot finish this legislation by the end of this month. But if that is going to happen, I hope, indeed, we can send each other a clear message that we are not looking for a 51-vote solution; we are looking for a 70, 80, or 90-vote solution. We are looking for a compromise in this legislation that brings about a broad consensus.

I hope we can use some discipline and avoid bringing up extraneous issues. We don't need to get into the array of controversial things that have nothing to do with prescription drugs or Medicare. If you want to derail prescription drugs, bring up any one of these extraordinarily controversial things, but I think it would be a very unfortunate set of circumstances. I am optimistic, having been given the report of the distinguished majority leader, and I am hopeful that we can work together so that by the end of this work period, not only will we have accomplished a good deal with regard to energy policy, but we will be able to say to seniors and to the country that we have at long last agreed on starting a Medicare benefit for prescription drugs that we can feel good about, that seniors understand, that would be offered in rural areas, and that builds on the model that has been such a success now for the last 40 years.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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