

from Kentucky, Mr. MCCONNELL, for bringing that bill both to our attention and shepherding it through the floor.

Last week, we also passed the Women Business Centers Preservation Act, sponsored by Senator OLYMPIA SNOWE, and we were able to complete a number of executive nominations. We have a whole range of other nominations pending, and we will work to clear these nominations on the Executive Calendar and to schedule rollcall votes as necessary.

As we enter the Medicare debate and the amendment process, I am very hopeful it will follow the same pattern we showed last week in working together. We will see robust debate. The end product is something for which I think we will have strong bipartisan support. I think the amendment process will reflect a lot of the differing approaches on both sides of the aisle within each of the caucuses as we go forward with the shared goal of strengthening Medicare, improving Medicare and, at the same time, providing America's seniors with the benefit that we have been denied in the past because traditional Medicare simply hasn't kept up to the times, and that is prescription drug coverage.

I look forward to 2 weeks from now when we will, on this floor, hopefully—I optimistically say this—pass a bill that America's seniors and future retirees will be able to look at and say, yes, that is health care security and that does include the benefits that are so important to health care delivery today, namely, prescription drugs.

We have talked a lot about modernization of the Medicare Program over the last 45 years. We had a bipartisan commission that generated a plan that was bipartisan, which Senator BREAU and I put together based on the findings of the Medicare Commission. The Senate Finance Committee, over the last several years, has had 30 hearings, with 7 devoted just to this issue of prescription drug coverage. Earlier in the month, we held an additional committee meeting to focus specifically on the framework that has been put forth by the managers of the bill, Senator GRASSLEY and Senator BAUCUS.

That hearing constituted the third committee hearing on Medicare this year. Indeed, last Thursday night, the Finance Committee voted to send this historic legislation to the floor of the Senate with a bipartisan vote of 16 to 5. I thank Chairman GRASSLEY and Senator BAUCUS for getting us to that pivotal point. This Grassley-Baucus agreement provides a strong base, a strong framework upon which we can achieve that mutually shared goal of strengthening and improving Medicare with a meaningful prescription drug benefit added. There are so many others who should be recognized who participated in the debate, but it is almost futile to do it because so many have participated in this body and in the House of Representatives, indeed, with the ad-

ministration and the bold leadership of President Bush. I think because of all of this activity and the foundation that we have of working on this for years and years, we do have an opportunity—and indeed I argue that it is an obligation—to bring this debate to a point in which we take action and actually pass a framework to give this appropriate strengthening of Medicare.

Yesterday, Members did have the opportunity to deliver opening statements. As I mentioned, they will continue through this morning and likely into the early afternoon. Later today, if appropriate, we can go to amendments and tomorrow have a very active day on amendments.

Again, I hope we will be able to turn to final passage of this bill before we adjourn for the Independence Day recess.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will begin a period for morning business until the hour of 10 a.m., with the time equally divided between the two leaders or their designees.

The minority leader.

PRESCRIPTION DRUG BENEFIT

Mr. DASCHLE. Madam President, I commend the distinguished majority leader for his statement and for the effort he has made to bring the debate on prescription drugs to the floor over the course of the next 2 weeks.

I share his hope and his goal that by the end of this period, we can have achieved what I think all Senators want—a good, vigorous debate about what is the best approach to take with regard to a prescription drug benefit under Medicare—and complete that debate prior to the July 4 recess. I have indicated to him personally that it would be my intention to work with him to accommodate that goal. I do hope we can move to the amendment phase of the debate sooner rather than later, preferably this afternoon.

I also commend Senators GRASSLEY and BAUCUS for their effort in the Finance Committee. The vote of 16 to 5 was an indication of their success in accommodating the concerns and the ideas of many of our colleagues. They have worked on this for a long period of time and I think deserve our commendation for the effort they have made on a bipartisan basis. During the committee process, I indicated it would be my hope that I could work as vigorously as they did in achieving the bipartisan tone that was accomplished during the markup last week.

I must say, I do not share the enthusiasm for the legislation that some of my colleagues do, and I wish to talk about that this morning. We may have a different perspective on how close this may be, but I also recognize that we have made the perfect enemy of the good at times, and I do not want to do that in this case.

I hope we can make a good down payment. I hope we can achieve a start. I have been concerned about how shaky a start this may be, but it is a start. If we are going to commit \$400 billion over the next 10 years to provide meaningful drug benefits, I hope we can do so maximizing the use of those resources, providing the most efficient utilization, and a mechanism, an infrastructure, for prescription drugs that will accommodate many of the goals and hopes we have for at long last modernizing Medicare in a way we know must be done.

I hope we do not overpromise. It is so easy to make proclamations about how good this accomplishment is, and I think we may create false expectations, high expectations, for this legislation that just will not be realized once the full impact of the bill is felt in the countryside.

Some have said, for example, that this is just like FEHBP, the Federal Employees Health Benefits Plan, for Senators. It is not. There is about a \$1,000-a-year difference in the value of benefits between what Senators get and what seniors are going to get.

To do what Senators get, we are told by economic analysts, it would take about \$800 billion over a 10-year period, not \$400 billion. So this is not FEHBP. This is something substantially below FEHBP.

We also must acknowledge that a senior who has \$5,000 of drug costs will get a benefit of about \$1,700; \$3,300 will still come out of pocket out of that \$5,000. So people need to be aware this is not FEHBP; that this is not going to address all of the concerns and needs that seniors have with regard to their drug costs.

Having said that, I believe we put down a marker, we set a foundation, and we should work with the administration and with especially the Department of Health and Human Services to address some of these concerns, and over time I believe we can make this an even better bill. Whether it is in the next 2 weeks, the next 2 months, 2 years, or 2 decades, we are going to make this a better bill, a better program.

There are a number of concerns I have with regard to how we can make it better that I hope we can address through amendments. The first amendment Democrats will offer is simply to give seniors more choice; to say to them: You can pick a private sector plan if you wish, but we also think you ought to be able to pick a plan that is strictly a Medicare plan; that you can simply extend your current Medicare benefits for doctors and hospitals to

prescription drugs as well, and that should be an option for you as you make your decision with regard to what choices may be right for you. That will be one of our key amendments. As I said, it will be our first amendment.

I am concerned as well about the volatility of premiums. There are those who suggest there will not be much variation, and yet in testimony we were given just last week during the markup, the experts told us they could not guarantee there would not be great volatility.

We are concerned about the past example of Medicare+Choice, the premium for such plans can cost \$16 in Florida and cost \$99 today in Connecticut. That variation is what we are afraid could be part of this plan unless we do something about it.

Seniors are going to have four cost issues about which to be concerned. The first is the premium. The second is the initial cap on benefits and the stop-loss; that is, at what point do they lose all coverage and at what point do they get catastrophic coverage—and I will get to that in a minute, the gap when they pay all of the costs. They will also have co-payments and the deductible. All four of those variables could change dramatically. The deductible is currently \$250, thereabouts, in the bill, but it could go up. The co-payments are 50-50, but it could go up. The stop loss is around \$3,700 out-of-pocket. That could change. And you have, of course, the premium itself which is estimated to be \$35, but there is no guarantee.

There is no defined benefit. One plan could have a lot more benefit than another. And seniors in their late eighties or early nineties are, I think, going to find it very confusing with all these variables with regard to their costs and also extremely different options and variables when they get to their benefits. So there is no defined benefit.

As I say, there is still a large issue with regard to the benefit falloff, the initial benefit cap for the package overall. It has been described as a donut hole, a coverage gap, but the benefit cap, the benefit stop that kicks in at about \$4,500 in drug spending, will mean that seniors between \$4,500 and at least \$5,800 are going to have to pay all of the premium costs and get no benefit whatsoever during that period of time. So we are going to have to deal with that as well, it seems to me, and that is a function of cost.

We also have another issue about which we are concerned. We are told by CBO that 37 percent of beneficiaries—this is CBO—37 percent of beneficiaries with retiree prescription drug coverage will lose it under this bill; 37 percent, one out of three retirees, one out of three at least. I guess you could not say necessarily it is one out of three employees; it could be more than that.

Thirty-seven percent of beneficiaries with retiree coverage today will lose that prescription drug coverage when this bill kicks in. There is only one

way to stop that from happening: To incent employers, to try to discourage them in as many ways not to drop that coverage, and we are going to try to do that.

The way we write the language on how retirees can be dropped, the way we incent employers by providing them with benefits to keep that coverage—we are going to try to do that as well. To provide 100 percent of the incentive it is going to take for companies not to drop their employees would cost more money. This bill currently has some. So we are going to see if we can get closer to that full amount to ensure that we do not find any more companies than absolutely necessary or possible that will drop their employee benefits.

So we have a number of significant concerns about the way this is written, about the benefits, about the uncertainty, about the costs, about whether or not Medicare can play more of an upfront role.

We have one other issue, the volatility of the benefit itself. South Dakota is a good example of a concern that many of us have. In South Dakota we do not have any Medicare+Choice. Companies do not want to serve the rural areas. So we are concerned about what it is going to take to bring companies into South Dakota to compete for the benefit plan to be provided in our region. If we cannot find anybody, under the bill, Medicare kicks in for 1 year. Once Medicare has kicked in, at the end of 1 year's time, these private companies can come back in and the Medicare plan that seniors had counted on for that year no longer would exist and there would be competition again for the private sector plans competing if they wish to serve that particular area.

So there is this constant change. If there is anything seniors do not like, it is change and this uncertainty that comes with change.

Not only that, we learned last week another disconcerting aspect of this. A decision would be made sometime in September on whether plans would exist for the coming year. If it can be determined by September that the plans cannot be put into effect for that coming year in a given region, then what happens is Health and Human Services establishes a Medicare plan, but they have to contract with a private company to provide that Medicare plan for the following year beginning in October.

So what happens under the bill between October and January is this: They find out first that no two plans can compete, so the Medicare plan is supposed to kick in. They contract for the Medicare plan, decide what the premium, the benefits, the stop loss, and the deductible are going to be. They somehow notify all the seniors in the region. They begin to try to implement the plan between October and December and make all of these decisions with regard to plans, benefits, notifica-

tion, implementation, and administration. Technically it is supposed to kick in on January 1.

Now, if my colleagues have seen Government work that fast in any other area than perhaps a military intervention somewhere, I would like to see where it is. I am very concerned—frankly, extremely concerned—about whether or not that is even humanly possible.

Keep in mind, this is not going to be a one-time experience. We are going to repeat this every single year perhaps. We are going to make a decision in every region whether or not these plans can compete. Whether it is Alaska or South Dakota, my guess is they will not find them. They will then say, okay, we are going to have 3 months to fully implement a Medicare fallback even though we do not know who the contractor for that Medicare fallback will be on October 1.

So I have to say, as we walk through a lot of these concerns, my colleagues will understand why many of us worry about setting these high expectations and then find out how seniors will deal with them and address them in a way that does not cause confusion, fear, anxiety, frustration that is so unnecessary if we would just do this right.

Mr. DURBIN. Will the Democrat leader yield for a question?

Mr. DASCHLE. I am happy to yield.

Mr. DURBIN. I ask the Democratic leader, as a member of the Senate Finance Committee which is deliberating on this 653-page bill, if he would acknowledge or at least respond to the following: I believe the positive aspect of this is that for those who started out this debate saying we are going to eliminate Medicare, that Medicare is going to be replaced with a private plan, private insurance, that argument is out the window. Medicare recipients will be able to continue their basic Medicare coverage for hospitals and doctors. It will not be an either/or situation. I think that is positive.

We have finally reached a point where we have an honest debate over prescription drugs, and I think for those of us on this side of the aisle who have been pushing for it for so long, those are two very positive aspects of this debate. I ask the Democratic leader if he would agree with that.

Mr. DASCHLE. I would certainly agree with that, and before the Senator came on the floor I commended those responsible for making this a better bill and bringing us to this point. I think that while perhaps it is a shaky start, it is a very important start and we can deal with all of these other issues. Those are two issues we have dealt with, and I am grateful for the fact that we have made progress.

Mr. DURBIN. I want to ask the Democratic leader three specific questions about this bill that I think go to the heart of the challenge we face.

It is my intention to vote for this bill but also vote for amendments which I think will improve it. First, the cost of

prescription drugs goes up 10 to 20 percent a year, and as these costs rise, seniors are paying more out of pocket. In 653 pages of legislation, how much is dedicated to controlling the costs of drugs, keeping them affordable, not just for seniors but for all American families?

Mr. DASCHLE. In response to the Senator from Illinois, some of the bill's proponents would say that is what they hope to achieve through competition, but we have not seen that work. Medicare+Choice was supposed to be competition, and it has not worked.

What we need to do is to have real competition with a Medicare benefit plan that will kick in, that will allow us to compare what could be done in the private sector with what could be done in the public sector. We have seen real cost containment in the Veterans' Administration. We have seen it in the Defense Department. To a certain extent, we have seen it in other governmental agencies, such as the Indian Health Service. We have not seen it yet with Medicare+Choice. That is No. 1. No. 2, we will be offering an amendment offered at least by Senators GREGG, SCHUMER, and others on access to generic drugs which will give people an option to buy the generic version of a given drug, and that will help. Senator DORGAN will offer an amendment for reimportation of drugs sold cheaper in other countries to allow greater cost containment. Those three things could go a long way to addressing the issue of costs more effectively, and that is what this amendment process is going to be all about.

Mr. DURBIN. The second question is: When seniors have to figure out whether or not they want to get involved in this program, they have to make a calculation: Is it worth it to pay a premium each month and face a deductible at the end of the year? Will I be ahead or behind? As I understand it, we have heard a lot about a \$35 monthly premium, but that is not mandated in this bill. There is no requirement that it be \$35 a month. It could be considerably more. The \$250 deductible that is in here I guess could be changed as well. So for the seniors who are trying to decide whether this makes sense based on their personal budgets—and that is what it comes down to—have we not created kind of a moving target as to what this is going to cost each senior across America?

Mr. DASCHLE. Well, there is not only one, there are four moving targets. The first moving target, as the Senator suggests, is the premium. It is suggested it be \$35 a month, but there is no guarantee. It could be \$100. It could be \$20. No one knows. They will not know until they are able to determine just what it is going to take to bring a benefit to a given region. That is only the first.

The suggested deductible is \$275. There is no guarantee. Nobody knows whether it is going to be \$500 or \$100. There is no guarantee on the copay. It

is supposed to be 50/50. It could be 70/30. There is no guarantee on the so-called initial cap on benefits, or the benefit loss at some point, whenever that kicks in. It could be \$4,500. It could be different. That is the benefit cap beyond which one has to pay all of the costs of a prescription drug.

So there are those four variables. As the Senator suggests, more clarity and certainty in this legislation would go a long way to eliminating a lot of the anxiety seniors have about this.

Mr. DURBIN. The last question I will ask the Democratic leader—and I see others are in the Chamber—it is my understanding that when Medicare was created under President Johnson, from the date of the passage of the legislation until Medicare went into effect was less than a year. It is also my understanding that this prescription drug protection, whatever it offers, is not going into effect until 2006—is my understanding correct—after the next election? Is that correct?

Mr. DASCHLE. Unfortunately, the Senator is correct. Some suggest it takes that long to set up the infrastructure, but as he also noted, Medicare took 11 months. When we established Medicare, 11 months later it was up and running. If an entire health care system can be developed with a payment regime for doctors as well as hospitals—and I might add there were two different payment regimes, Part A and Part B—in 11 months, I do not understand why it would have to take 3 years for us to do this. But that is what is incorporated in the bill.

Mr. DURBIN. I say to the Democratic leader, those are the three areas that jump forward as you look at this bill, the uncertainty in terms of cost, the complete lack of cost controls and reduction in prices for prescription drugs for American families, and the fact this is being delayed until after the next election strikes me that those who are proposing this are afraid once seniors actually see these uncertainties they may decide this is not as good a bargain as they had hoped.

Although this is a step forward, the alternatives we will offer on the floor are going to create more certainty, more price competition, and a better approach for seniors.

I thank the Democratic leader.

Mr. NELSON of Florida. Would the Democratic leader yield for a question?

Mr. DASCHLE. I am happy to yield.

Mr. NELSON of Florida. Recognizing that several States, including the State of the distinguished Democratic whip, Nevada, have implemented prescription drug plans of which they were not able to get any insurance company to step forward to offer prescription drugs under that plan because the insurance companies could not make any money, are we likely to see this revolving door the distinguished Senator from South Dakota has talked about, that two companies are supposed to compete and offer prescription drugs to the senior citizens but they do not step

forward, and they go back to the backstop, which is the Medicare plan, and then there is the thought they will step forward again but they don't, and then they backstop back to the Medicare prescription drug plan? Does that suggest not only uncertainty but chaos?

Mr. DASCHLE. The Senator from Florida has put his finger on one of the big concerns many Members have, the volatility, as he called it, the revolving door.

What private insurance companies have stated in the past, insuring drug coverage for seniors is almost like insuring for a hair cut. A hair cut is inevitable. So is the utilization of prescription drugs for seniors. Because we cannot make the actuarial analysis work, there is no choice; either not to go in or to be significantly subsidized to make a profit, to make this work. That is why for so long we have not seen Medicare+Choice work very well. It has not been adequately subsidized and ultimately people have just not found it in their interest to sign up.

What we have seen is that the Medicare system has worked, has served this segment of our population very effectively, and we are simply trying to ensure that there is some stability. If seniors want to stay with Medicare, let them do so, rather than this revolving door, rather than being the guinea pigs in the private sector to find a way to devise a formula, where some private insurance companies could offer benefits that may or may not work over a period of years.

This process of selection and deselection and analysis and ultimately implementation in a matter of 3 months every year could pose some serious problems for seniors in Florida or South Dakota.

Mr. NELSON of Florida. Therefore, we could clear up that uncertainty, stop that revolving door, if, in fact, we gave seniors the automatic choice they could get their prescription drugs through Medicare, but if they had a better option, a more favorable menu of prescription drugs in the private sector, they could opt for that?

Mr. DASCHLE. That is exactly what we would be suggesting with the first amendment the caucus will propose. The distinguished Senator has characterized it exactly right. Why not give seniors a little more choice? But with that choice, perhaps a little more certainty that regardless of what may happen in the private sector they will always have the Medicare plan available as a choice. That is all we are asking. If Medicare cannot compete effectively, no one will use it and everyone will go to the private sector. If it can compete, if it can provide a comparable benefit, why not have it, instead of going through this backup business every year.

That will be a key priority amendment for us when we have the debate.

Mr. NELSON of Florida. I would like to ask one more question of the distinguished Democratic leader. At the end

of the day, if we are not able to improve the bill with some of these amendments that have been discussed, it is either yea or nay. If we know that this kind of chaos and uncertainty is coming down the road when the legislation kicks in in 2006, is the theory of the Senator from South Dakota that half a loaf is better than no loaf at all?

Mr. DASCHLE. I have come to the conclusion, that this may not even be half a loaf but it is a start. As a start, it affords an opportunity to come back in 2 months, 2 years, within the next two decades, and gives us a chance to build. It has the elements of a foundation upon which we can improve a system of prescription drug health care delivery to seniors for the first time in our lifetime, for the first time in the lifetime of Medicare. That to me is a valuable asset to put in the bank so that I am prepared to accept the many deficiencies in this bill in an effort to get something started.

I don't expect I will enjoy unanimous support for that point of view within our caucus, perhaps within the Senate. But it seems to me we have to start somewhere. If we fall victim to making the perfect the enemy of the good, then I believe we will have lost yet another year and there will be no help for seniors under any circumstances. I don't find that acceptable.

Mr. NELSON of Florida. I thank the Senator from South Dakota.

Mr. DASCHLE. I yield the floor.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER (Mr. ENSIGN). Morning business is closed.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Resumed

The PRESIDING OFFICER. Under the previous order, the hour of 10 a.m. having arrived, the Senate will proceed with consideration of S. 1, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the Medicare Program, to provide prescription drug coverage under the Medicare Program, and for other purposes.

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. Mr. President, I rise today to praise the exceptional commitment of Chairman GRASSLEY as chairman of the Senate Finance Committee, ranking member, Senator BAUCUS, to meld both political and policy differences and produce a bill that can garner support of 16 members of the Finance Committee, 16 Members of the Senate Finance Committee who represented every facet of the political spectrum.

That they were able to execute this extraordinary achievement and produce this bill, especially less than a

year after the committee process was bypassed altogether, is a testament not only to their skill but also to their passion for this issue.

They have built upon the leadership that has been provided by the President, who challenged the Congress to enact a Medicare prescription drug benefit, offered principles, and more recently issued the charge to the Congress to have a bill on his desk in July. The Senate majority leader has been steadfast in his commitment not only that a markup should be held in the Finance Committee but also to ensuring we had a timetable to make the process work and to have this legislation on the President's desk in July. Thanks to his determination and also to the determination, commitment, and long-standing contributions made by my colleagues, Senator HATCH, Senator BREAU, and Senator JEFFORDS, along with Chairman GRASSLEY and Senator BAUCUS, with whom I have worked over the past few years, seniors will be able to celebrate a second independence day this summer: Independence from the crushing cost of prescription drugs.

As one who teamed with Senator WYDEN almost 6 years ago to forge this first bipartisan prescription drug coverage bill in the Senate, I know it has been a rather lengthy road that has led to this day, but it has been a much longer and more arduous journey for America's seniors who cannot afford to wait any longer for Washington to act. So I am pleased we now stand on the brink of passing legislation that will provide every senior with the security of a comprehensive prescription drug benefit under the Medicare Program. That means we have the opportunity to pass this benefit this month and to have it on the President's desk in July.

We have certainly come a long way since I started in this process with my colleague, Senator WYDEN, almost 6 years ago, when we fired some of the opening shots in this legislative battle. We progressed from the \$28 billion former President Clinton proposed for a prescription drug proposal to the \$40 billion program that we established—Senator WYDEN and I, in the Budget Committee as members of that committee, for a \$40 billion reserve fund over 5 years—to finally enacting a reserve fund several years later, again, a reserve fund for more than \$300 billion. Ultimately, we had the proposal last fall for \$370 billion, and then the bipartisan bill that included that amount of money, and then, of course, the \$400 billion that was proposed by the President this year.

I remind my colleagues that is almost \$200 billion more than the President originally initiated for a proposal just last year. So we have come a long way in this process over a 6-year period, from \$28 billion to \$40 billion to \$300 billion to \$370 billion to \$400 billion right now.

There are those who argue they have not been included in the process that has brought us to the floor of the Sen-

ate this week, but I can say we have had extensive hearings in the Senate Finance Committee. I remind my colleagues, since 1999 the Finance Committee has held 30 Medicare hearings with 8 focused specifically on the creation of a prescription drug benefit. Last year, we spent 2 weeks on the Senate floor considering 5 different initiatives. During the Finance Committee's consideration of this bill last week, the chairman allowed an extensive discussion of the issues and more than 136 amendments were filed.

The bottom line is the policies in this consensus bill certainly were not achieved in a vacuum. They are the combination of 5 years of vetting and bipartisan bridge building. They are the direct descendants of last year's tripartisan bill that we spent 2 years developing, meeting every week. That was, again, Chairman GRASSLEY, Senator BAUCUS, Senator BREAU, Senator HATCH, Senator JEFFORDS, and myself, and this ultimately resulted in an evolutionary process of numerous iterations of various legislative initiatives and provisions. It has been a healthy competition of ideas that has been forged into this piece of legislation today, recognizing it is virtually impossible in a 51-49 Senate to design the largest domestic program, in nominal terms, ever created and to pass the most significant enhancement of the Medicare Program in its 38-year history with a "my way or the highway" approach.

Concessions must be made. Thankfully, they have been made in arriving at this policy equilibrium that acknowledges, not only what is politically possible but, most critically, what is workable and meaningful and effective for America's seniors. The President made concessions, Republicans made concessions, Democrats made concessions, and then there were concessions made across the ideological spectrum in each of our respective parties. But, in the final analysis we also have acknowledged that if we want to pass a prescription drug benefit, then we have to achieve a consensus to ensure that seniors get this benefit this year and now.

As a result, we maintained that there were certain principles that had to be adhered to in the development of this legislation. Certainly it maintained the four principles we established when we designed the original tripartisan plan.

First of all, the benefit must be universal—that is the No. 1 priority for seniors, ensuring that any new benefit is available in every region of the country regardless of whether you live in an urban area or a rural area—and that you could receive this benefit at the lowest monthly cost possible; that the benefit be targeted, with lower income seniors receiving the most assistance, with limited cost sharing and reduced or eliminated premiums; that the benefit be comprehensive, providing coverage for every therapeutic