

unflinching in their resolve and have already accomplished much.

I am particularly proud of the roughly 2,000 South Dakotans who have been involved in the Iraq campaign. Many of them are South Dakota National Guard members, who participated in a mobilization with few precedents in our State's history. It was, by far, the largest mobilization since World War II. At the time the fighting began, units from more than 20 communities had been called up, from Elk Point in the south to Lemmon in the north, from Watertown in the east to Custer in the west. Indeed, our State's mobilization rate ranked among the highest of all the States on a per-capita basis. Also, hundreds of personnel from Ellsworth Air Force Base were deployed overseas at the height of the campaign.

But no community in South Dakota, or perhaps the even country, is more remarkable in its contribution to this effort than the small town of Frederick.

Frederick lies roughly 30 miles from my hometown of Aberdeen. It is a small, close-knit community with a population of fewer than 300 people. But twenty-six of Frederick's sons and daughters answered the call to duty—nearly ten percent of its population! Frederick's military personnel are serving in nearly every branch of the armed forces, including the Army, Navy, Air Force, Marines, Army National Guard, Air National Guard, and Army Reserve. To put this tremendous display of patriotism in perspective, the boroughs of New York City would need to send roughly 750,000 people to match Frederick's effort.

On July Fourth, Frederick is commemorating the patriotism of its service members with a community parade and celebration that will feature a fly-over by a B-1 bomber out of Ellsworth Air Force Base. They will honor their friends, neighbors and loved ones serving in the U.S. military, and I want to join them by recognizing them here today. They are:

Air Force: A1C Justin Wallace, SSgt. Jason Strand, Senior MSgt LeRoy Fiekens, SSgt. Tara Meyers,

A1C Paul Sumption, and TSgt. Reiff Mikkonen.

Air Force National Guard: SSgt. Brian Achen.

Army: LTC Ronald Claeys, PFC Gary Kurtzhals, and PFC Mikael Schmit.

Army National Guard: SPC Stephen Achen, Sgt. Ryan Henningsen, Sgt. Robert Heider, PFC Jeff Pierce, Cpl. Mike Bunke, Col. Gordon Niva, SSgt. Eric Kinslow, Sgt. Dave Gunther, SPC Ben Deuter and Sgt. Ryan Bakeburg.

Army Reserve: Maj. Susan Lahr and PFC Glenn Gunther.

Navy: PFC Josh Larsen and Petty Officer Randy Jensen.

Marine Corps: Sgt. Eric Thompson and MSgt. Scott McCullough.

Let me also take a moment to recognize another young patriot from Frederick, 10-year-old Peyton Healy. Though she does not know any of the 26

deployed soldiers personally, Peyton took the initiative to develop a way for the people of Frederick to support troops serving abroad, creating the "Project Patriotic Penny Fund." Working with the local American Legion post, she placed donation cans in area businesses to raise money for postage on care packages to the troops. She hoped to raise roughly \$100—enough to pay for one package to every Frederick service member. The people of Frederick placed \$195 in these cans—19,500 pennies. They also donated supplies for the packages, such as crossword puzzles, pens and paper, batteries, hygiene products, and candy.

Most importantly, Peyton helped us see the defining characteristic of the people of Frederick. She helped us see that the people of this tiny town have enormous hearts. I call upon my colleagues and the people of this Nation to join with me in commending the people of Frederick, and in celebrating alongside them on Independence Day the democracy and liberty they so proudly defend and promote.

BURMA

Mr. McCONNELL. Madam President, on June 11, 1995 my colleagues joined Senator FEINSTEIN and myself in passing the Burma Freedom and Democracy Act. This legislation prohibits the importation of all products from Burma, freezes the assets of Burma's ruling thugs and their political arm, bans travel to the United States for the junta's political and military leadership, and provides assistance for democracy activists inside the country. At this time, our House colleagues are working to pass their version of this legislation and I urge them to do so quickly.

Today we have news reports from Tokyo that the Japanese Foreign Ministry will be suspending new development assistance pending the release of Daw Aung San Suu Kyi. This is a positive first step, but this is not enough.

I urge our Japanese allies to reflect upon the junta's continual efforts to smother democracy in Burma and review their overall engagement policy towards the junta. The junta put the final nail into the coffin of constructive engagement when it signaled its hostility to political dialogue and national reconciliation on May 30 by arresting Suu Kyi and murdering Burmese democrats. It is painfully clear now that the junta's support for engagement was nothing more than a farce used to bankroll its corrupt and vicious rule.

Constructive engagement for Japan and Association of Southeast Asian Nations, ASEAN, has done nothing to improve the political, economic, or social situation in Burma. The ASEAN policy of noninterference will not stand. Burma's military government is a festering sore infecting the region with narcotics, HIV/AIDS, and instability. In fact, without question, Burma is

worse off now than at any point in its history. The path now is clear: isolate the vile thugs who rule this country. We must encourage Burma's neighbors to use their considerable influence to make clear to the military regime that they, too, find the political situation intolerable; it must change.

When the Prime Minister of Thailand visits the United States and his meetings with American officials are dominated by the issue of Burmese atrocities, it displaces Thai national security and economic issues from the discussion. When the Association of South East Asian Nations convened in Phnom Penh, Cambodia, this month and the discussions centered not on fighting HIV/AIDS or improving regional economic development but on the arrest of Suu Kyi and the murder of National League for Democracy political activists, it distracts ASEAN from other important issues.

The regime in Burma is pulling down the region, and it is time that its neighbors owned up to their responsibility in fixing this problem once and for all. This is not a problem that can be pushed under the rug; ASEAN and Burma's neighbors must confront this problem. Until the region confronts the junta and demonstrates backbone in the face of corrupt despotism, they will find the United States a less willing negotiating partner.

Clearly, the transfer of power 1990 elected government will provide peace, stability, and the opportunity for enhanced regional economic growth. It is this goal, not merely the release and continued harassment of Suu Kyi, that should drive the foreign policies of Burma's regional neighbors.

I welcome the statements coming from Japan demanding Aung San Suu Kyi's release from the notorious Insein Prison—a jail Burmese political prisoners call "The Hell of Asia." However, her release from prison alone will solve none of Burma's problems. There is much more that needs to be done here in Congress, and at the White House, by Japan, ASEAN, the European Union, and by Secretary General Kofi Annan and the United Nations Security Council to ensure that the thugs now ruling Burma are one day soon consigned to the ash heap of history.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT

Mr. AKAKA. Madam President, I rise today to speak on S. 1, the Prescription Drug and Medicare Improvement Act of 2003.

For far too long Medicare has lacked a prescription drug benefit. The lack of this benefit has been the gaping hole in the Medicare safety net. Prescription drugs are the largest out-of-pocket health care cost for seniors. Many who cannot afford drug coverage often break the drugs in half, skip doses, or do not fill their prescriptions.

The legislation the Senate passed last night will finally establish a benefit. I supported this bill because it is

an important step forward in meeting the prescription drug needs of seniors. However, I am particularly concerned that the bill provides insufficient prescription drug coverage for seniors and depends excessively on private plans.

Medicare beneficiaries will experience a gap in their prescription drug coverage after their drug expenditures reach \$4,500. They will not receive any benefits until their total drug expenditures reach at least \$5,813 unless they qualify for the additional low-income support. This gap in coverage will occur while they are still paying premiums. It is unfortunate that amendments designed to fill in the gap were defeated. This issue must be revisited in the future. Also, the eligibility requirements for the additional low-income support are too restrictive and will deny many seniors in need the extra help that they need.

The dependence on private insurers to administer this benefit presents additional challenges to providing seniors with access to prescription drugs. Prescription drug-only insurance policies are currently not offered and they will need to be developed. The utilization of private plans creates a system in which insurers have incentives to limit access to needed drugs. In addition, the premiums that seniors pay for coverage are likely to vary depending on what region people live in. It is not equitable for a Federal benefit to have different prices across the country. Seniors should have the option of choosing a Medicare-administered plan instead of one that is run by a private insurer.

It is unfortunate that amendments to strengthen the prescription drug coverage and to provide seniors with an option to enroll in a Medicare administered plan were defeated. I look forward to continue working with my colleagues to address these important issues to improve the Medicare prescription drug benefit.

Again, I supported this bill because it is an important step towards providing much needed prescription drug coverage for seniors. Also, I am pleased that my amendment to restore a Medicaid disproportionate share hospital, DSH, allotment for Hawaii was adopted. This amendment is vital to Hawaii's hospitals which are struggling to meet the elevated demands placed upon them by the increasing number of uninsured patients. DSH payments will help Hawaii hospitals meet the rising health care needs of our communities. I hope that this provision is retained in conference.

S. 1, THE MEDICARE PRESCRIPTION DRUG BENEFIT ACT

Mr. ROCKEFELLER. Madam President, as the Medicare prescription drug debate draws to a close, I would like to take a few moments to give my colleagues my honest assessment of this legislation.

I join many of my colleagues in recognizing how difficult it has been for

the managers of this bill to hold to a proposal that fits within a \$400 billion budget constraint. In that respect, they are to be commended for their discipline. But for my part, I believe that constraint, combined with the fervent intent by some to move Medicare to a private insurance model, has produced a bill that is fatally flawed. Seniors will not get the affordable, meaningful prescription drug coverage they expect because the majority of Members seem to have concluded that we cannot break the \$400 billion barrier. I think it is a false choice.

The actual prescription drug benefit in this bill is inadequate to meet the needs of more than 40 million Medicare beneficiaries and eventually America's seniors are going to figure that out. The fact of the matter is that \$400 billion is simply not enough to buy an adequate benefit. But we already knew that—our debates last year made that abundantly clear.

I believe that insisting on the capped amount of \$400 billion for a Medicare drug benefit as a precondition of moving a new benefit through the legislative process serves as a convenient excuse. It means this drug benefit is sure to fail to meet seniors' real drug coverage needs. It also means that we will only cover 20-25 percent of seniors' drug costs.

What is worse, the complicated structure of this bill will cause seniors to be angry and confused by the benefit—and they will be entitled to be. This is not the straightforward guaranteed Medicare prescription drug benefit seniors have been repeatedly promised. There is no standard premium and there is no uniform benefit. For the first time under Medicare there is no universal coverage for all Medicare beneficiaries. This bill falls fall short of what seniors expect and need.

Let's take a few minutes to look at how the shortcomings of this bill will become apparent to a Medicare beneficiary—a senior or disabled person who enrolls in this benefit. For illustrative purposes, let's take an 80-year-old West Virginia widow living at 250 percent of the poverty level.

Assume this widow spent her entire career working for the same employer. Since her retirement, her employer has provided her with a fairly generous drug benefit—\$150 deductible, \$10 copays, and catastrophic coverage. However, once the Senate's proposed drug benefit is enacted, she becomes one of the 37 percent of Medicare beneficiaries who currently receive good employer-sponsored coverage who lose that coverage. That is because the way this bill works her former employers' contribution to her drug costs are meaningless because they do not count toward her catastrophic limit.

I want to note here that, during the health care reform debates of more than a decade ago, one of the few things that we seemed to agree on was that we should not disrupt the health care coverage that Americans already

rely on. My friends on the other side of the aisle, in particular, were quite adamant about that point. Well, this bill would not just disrupt the drug coverage for millions of seniors, it would completely strip the drug coverage from 4.5 million seniors who have employer-sponsored coverage today.

It will strip their employer-sponsored coverage and leave them with an inferior drug benefit which is either less generous or more expensive. I offered an amendment to correct this problem, but it failed just 2 days ago.

To return to my example, as a result of having lost her employer-sponsored coverage, this 80-year-old senior decides she has to enroll in the new drug benefit next year—in 2004—only to find out that it will not be implemented until 2006. There is a discount drug card, but it is not substantially better than the discounts she gets today—and it is far worse than the drug benefit she used to receive from her former employer.

This widow spends the next 2 years trying to figure out whether it is to her benefit to enroll in this new Medicare prescription drug benefit. But she can't really make an informed decision because she has no idea what the premium will be or what the benefit will actually look like. She decides to enroll in the voluntary benefit having been told that if she waits to enroll she will have to pay a very harsh late enrollment penalty.

This particular 80-year-old senior lives in West Virginia, so let's assume that no private insurers enter the area to provide a drug benefit. That has been my State's experience with the Medicare+Choice Program and I have no reason to believe that this proposal will produce a different outcome.

My illustrative senior citizen enrolls in the fallback. Her sister, however, lives in northwestern Ohio and has enrolled in a Medicare Advantage Plan. For the first time under Medicare, the West Virginia widow and her sister in Ohio have a different Medicare benefit and are paying a different premium for that benefit. In addition, her sister is being offered additional benefits like a catastrophic limit on her medical expenditures and disease management. These additional benefits are not even being offered to the West Virginia senior because she remains in traditional Medicare.

Now, fast forward 1 year and assume that private insurers decide to enter West Virginia. The fallback plan she received through traditional Medicare disappears and she is required to enroll in a private insurance plan. She cannot see the doctor she was seeing because he is not in the private insurer's network. She cannot go to the pharmacy she usually visits—the one that is right down the street—because it is also outside the network. She can't have the drug she was taking because it is not on the insurers' formulary.

Again, fast forward, this time it is 2 years later. Let's assume that the private insurers did not make enough