

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

profit to continue to provide a drug benefit in West Virginia—then what happens? The now 83-year-old widow will have to start the process all over again.

What is worse is that each senior will face a different calculation in determining how this bill will or won't help them. Senior citizens with incomes of 135 percent of the poverty level should theoretically pay no deductible, 5 percent cost sharing up to \$4,500 in total spending, 10 percent cost sharing between \$4,500–\$5,800 and 2.5 percent cost sharing above \$5,800.

But this bill has an asset test that will prevent millions of seniors from getting the low-income subsidies in this bill. If a senior owns a burial plot worth \$1,000, a \$3,000 Treasury bill, and a vehicle worth \$6,000—indeed, if a senior owns anything that adds up to over \$10,000 in assets, not including his or her home, the cost sharing they have to pay will double.

Our Nation's neediest seniors, those with incomes 74 percent of Federal poverty, will not be permitted to enroll in the new Medicare prescription drug benefit at all. Even though these low-income seniors are Medicare beneficiaries, they will not be eligible for this particular Medicare benefit because they are now eligible for Medicaid. They will be discriminated against for the very first time under this new Medicare benefit.

Seniors who are forced to remain in Medicaid may well end up seeing their drug coverage dramatically cut back. With our Nation's economy still fairly stagnant, State budget situations remain dire. In some States, dual-eligible Medicare beneficiaries may only have coverage for three prescriptions per year, regardless of their medical needs.

Put simply, the Medicare drug benefit the Senate is about to vote on has fatal flaws. The following is a list of 10 fatal flaws that, combined, persuade me this bill should not get my vote.

1. The drug benefit has no national premium. CBO estimates that \$35 will be the national average premium. That number appears nowhere in the legislative language. It is a projection, a best guess—and it certainly could be higher.

2. Under this prescription drug plan, the premium will vary in every region of the country, perhaps State by State, and there is no limit on how high it can be. We defeated an amendment that would have limited the variation to no more than 10 percent above the national average, but it failed.

3. Private insurers will actually decide what the premium will be. And, this premium will grow each year by the rate of increase in drug costs—that is roughly 10–12 percent increases every year. That means seniors in 2008 could well be paying \$50 a month for their drug premium alone—and that is on top of the cost of their deductible and copayments.

4. There is no requirement for private plans to offer a standard benefit—private plans are only required to offer an

actuarially equivalent benefit. That means West Virginians and other rural beneficiaries may not have access to the same drug benefit that other seniors will have—again, for the very first time under Medicare seniors in some States won't get the same benefits as seniors in other States. I am not very confident that West Virginia seniors will end up with the better benefit—we never do.

5. The bill currently has a completely unstable fallback. Under this proposal, the only time a beneficiary will have the option of receiving coverage through Medicare is if there are not at least two bids from private insurers to serve a region. There is no guaranteed Medicare prescription drug benefit of the kind I believe seniors fully expect. Moreover, if private insurers do not enter an area, the fallback moves into place for 1 year. The next year, a new bidding process begins, and if two plans show up, the Medicare fallback disappears. Private insurers can then change or terminate coverage every 2 years. This means that seniors, especially seniors in rural areas where preferred provider organizations or PPOs and private plans are not likely to come to the table, may end up bouncing between a fallback, then a private plan, and then back to a fallback. Back and forth, back and forth. All the while, this senior will be forced to change doctors and pharmacists, their cost sharing will be changing, as may their premiums. The Senate prescription drug plan we are considering leaves the big HMOs and insurance companies in charge.

6. There is a significant gap in coverage. That gap is \$1,300—seniors pay their monthly premiums but get no drug benefit in that gap. Two amendments to address this problem did not achieve sufficient votes for passage. One was an amendment to eliminate this gap. Another one would have said that seniors would not have to pay premiums when they were not receiving any benefit. The failure of these two strengthening amendments means that under this legislation, if a Medicare beneficiary has \$5,900 in drug spending per year, by October 7 of that year, their benefit will run out. That beneficiary will continue to need the drugs each day for the rest of the year but her benefit will run out on October 7. Fifteen million Medicare beneficiaries will fall into the gap.

7. Low-income seniors who are eligible to receive a drug benefit under Medicaid will not be eligible for the Medicare prescription drug benefit, as I illustrated in my earlier example. This means that 43,000 West Virginians will not be eligible for this Medicare prescription drug benefit. Millions more across America won't be eligible for this Medicare benefit even though they paid their whole lives into the Medicare program rightfully expecting that it would cover their health care costs.

8. Again, under this legislation, CBO estimates that 37 percent of Medicare

beneficiaries who currently receive a drug benefit from their employer will lose that coverage because of the way this legislation defines out-of-pocket costs.

9. This proposal requires private insurers to provide beneficiaries with a catastrophic limit on expenditures for medical benefits, disease management, chronic care services and preventive benefit. But, such benefits are not made available to beneficiaries remaining in traditional Medicare. Everyone keeps arguing that these private plans will provide better, more comprehensive, preventive care. But, the fact is that this bill precludes the traditional Medicare from providing better, more coordinated care. There is no reason that traditional Medicare cannot provide the same level of care as a private plan—at a significantly lower administrative cost, I might add—but not if we preclude it from doing so.

10. And if those reasons weren't enough, consider what is headed our way in conference: today, the House will include in its prescription drug bill new tax shelters for health care, that disproportionately help the rich and undermine employer-based health insurance coverage . . . the very system that the vast majority of Americans depend on for their health care and a voucher system for Medicare beneficiaries beginning in the year 2010.

Under this system, seniors would receive a defined contribution payment rather than a defined benefit. In other words, rather than defined benefits beginning in 2010, seniors would receive a set premium payment—like a voucher—from the Government.

We need to think about what we are doing here. In my judgment, every Member of Congress should think about this benefit from the perspective of their beneficiaries. This proposal is a great opportunity for seniors to shop for new coverage every few years. If you have the utmost faith in private insurers to provide good health coverage to elderly Americans and the disabled, then this is the plan for you. This plan puts private insurers in the driver's seat by giving them flexibility to vary premiums and change or terminate coverage every 2 years. But, as far as providing long-term security, this proposal fails.

Finally, several Members have come to the floor and claimed that this proposal is just a downpayment—that we will be able to revisit the benefit over the years and make it more generous. That is simply untrue. We have an administration that is intent on large tax cuts, that is focused on the minimization of Government and that is committed to the privatization of the Medicare Program. Most every amendment offered during this debate to improve this benefit has lost. I don't know why any senior would believe that we will be able to revisit this program and make it better. We should take the time to get it right.

Mr. LIEBERMAN. Madam President, I want to state my support for the

Medicare Prescription Drug Bill, S. 1, and my reasons for doing so.

I believe that by passing this legislation, we begin to answer the prayers of many seniors who are struggling to cover the rising costs of the prescription drugs they need to live longer and healthier lives. I commend the bipartisan Congressional effort to beat back the worst pieces of the President's initial proposal—which would have forced seniors out of Medicare en masse and paved the road to privatizing the system—and forged this more sensible compromise.

But my support is not an enthusiastic endorsement. We cannot ignore the substantial weaknesses in this proposal. For one, the bill does not take effect until 2006—seniors have waited long enough. More specifically, this bill has an enormous gap in coverage—the so-called “doughnut hole”—that leaves millions of seniors without the assistance they need. Premiums may vary from plan to plan. Some seniors may be forced to go round and round in a revolving door, changing plans as private plans come and go. And seniors covered under employer-based retiree plans would not get the catastrophic benefit they need. Unfortunately, Republicans defeated Democratic amendments to remedy these shortcomings.

Nevertheless, the bill represents a dramatic improvement in prescription drug coverage for our nation's seniors. It would provide comprehensive prescription drug coverage for our lowest income elderly with no or minimal premiums. It also guarantees that a drug benefit is available to all Medicare beneficiaries by giving them a “fallback” traditional government plan when there is a lack of private plans in their area. Even with the existing gap, 80 percent of Medicare beneficiaries will get back more in benefits than they pay in premiums.

Both problems and advantages to the bill are summarized in more detail below.

All in all, this is a foundation upon which to build in the months and years ahead. Senator KENNEDY is right. Seniors deserve the basic coverage this plan will provide—and an end to the political stalemate that has blocked action for the last several years. Thanks to the persistent, principled, and passionate advocacy of him and other Democrats—and the strength of Republicans who resisted President Bush's divisive prescription—that's precisely what they're getting.

But I do think we can and should do more to improve this plan, and there are several specific areas we should focus on as we go forward. First, we must fill the doughnut hole I described above. This gap in coverage will hurt our seniors at their time of greatest need—financially and physically. The gap occurs because after a senior's drug spending reaches a certain amount, the benefit ends. The benefit doesn't start again until there is a significant out of pocket payment, at which time cata-

strophic coverage kicks in. Many of the beneficiaries who fall into that gap are likely to be seriously ill and financially strapped, and therefore faced with the same awful choice between medicines and necessities that too many seniors face today.

That's not the only problem with this bill. Another is that the drug benefits paid by employer-based retiree plans would not count toward the catastrophic benefit promised to seniors. Therefore, seniors covered under these plans would not gain from this new benefit. In fact, these seniors may get less Medicare coverage than other beneficiaries. Also, CBO estimates that as many as 37 percent of employers may drop their retiree drug coverage, which is the last thing we want to happen as a result of this bill.

In addition, there is no set premium for seniors under this plan. Many seniors will enroll in private drug-only plans because that will be their only option. The premiums for these plans may vary significantly and may be quite high in certain parts of the country. This is clearly unfair and will hurt those seniors in locations where premiums are high.

Moreover, the drug coverage approach in the bill relies on uncertain and historically unstable private health insurance plans. In fact, there will not be a guaranteed “fallback” option for coverage in a traditional Medicare plan. This fallback will only occur when there are less than two private plans in any region. Seniors may be pushed from plan to plan as the private plans come and go.

But on balance, this bill has more strengths than weaknesses, starting with the fact that it commits \$400 billion to help reduce the costs of prescription drugs for America's senior citizens. This is a historic breakthrough, and we should not minimize that.

One of the most encouraging parts of this bill is that it provides comprehensive coverage for low income seniors up to 160 percent of poverty with no or minimal premiums and cost sharing—40 percent of all Medicare beneficiaries. There is no “doughnut hole” for this group. Although I wish that there were better coverage for the remaining 60 percent of beneficiaries, there is at least strong, reliable coverage for the lowest income group.

Another positive aspect of the current bill is that all Medicare beneficiaries are provided a “fallback” traditional government plan when there are not two private plans in their area. This means that all Medicare beneficiaries are guaranteed that a drug benefit is available. I co-sponsored Senator STABENOW's amendment to guarantee this fallback without regard to the presence or absence of private plans to increase the stability of coverage and decrease the risk of needing to move from plan to plan. That amendment failed.

There were other important amendments that I did not have the oppor-

tunity to vote on. I would like to note my position on them for the record.

Stabenow Amendment No. 931 to Bill S. 1: I was a co-sponsor of this amendment that would have ensured the availability of the traditional Medicare plan in all areas. Bill S. 1 guarantees a “fallback” plan only when there are not two private plans in any region. This amendment would have guaranteed the availability of a Medicare-administered drug benefit for all Medicare beneficiaries in all regions and this “fallback” would not be dependent on the presence or absence of private insurers. This would have avoided the revolving door of drug insurance we may face with the enactment of the underlying bill. As discussed, seniors could be forced to change insurers and drug formularies from year to year. This amendment would have provided stability, by allowing seniors access to the federal fallback plan at all times. It is important that seniors don't just have drug coverage, but have coverage they can trust. For this reason, I was a co-sponsor of this amendment and would have voted for it.

Daschle Amendment No. 939 to Bill S. 1: This amendment would have ensured that an affordable plan would have been available to all Medicare beneficiaries by limiting the variations in the amount beneficiaries have to pay in premiums to only 10 percent above the national average, no matter where they live. Currently, premiums for Medicare HMO plans with drug coverage vary from \$99/month in Connecticut to \$16/month in Florida. Similarly, the premiums in Medicare PPO plans vary from \$166/month in New York to \$39/month in Alabama. This amendment would have limited these types of inequities. For this reason, I would have voted for this amendment.

Gregg Amendment No. 945 to Bill S. 1: This bipartisan amendment attempts to help ensure that Americans have access to generic drugs in a timely fashion. This amendment speeds the market entry of generic drugs by eliminating some patent extension practices used by brand name manufacturers. I voted for similar generic drug legislation in the last Congress, which passed the Senate. I would have voted for this amendment.

Dayton Amendment No. 957 to Bill S. 1: This amendment would require that Members of Congress receive prescription reimbursements at the same level as Medicare beneficiaries. I believe that that this it is appropriate and fair for us to be subject to the same problems to which our constituents will be subject. For these reasons, I would have voted for this amendment.

Dodd Amendment No. 969 to Bill S. 1: This amendment would have allowed an ongoing open enrollment period for two years so that beneficiaries could enroll and disenroll in Medicare Prescription Drug Plans and Medicare Advantage plans during 2006 and 2007. Medicare beneficiaries would have been able to choose which plan they wanted

as they gathered more information about each plan during the first two years of this benefit. For this reason, I was a co-sponsor of this amendment and would have voted in favor.

Dodd Amendment No. 970 to Bill S. 1: This amendment would have provided 50 percent cost sharing through the "donut hole" for seniors between 160 percent and 250 percent of poverty. Beneficiaries who have an income of only \$15,000/year (or \$20,000/year for a couple) are just over the 160 percent cut-off. This amendment would have helped these beneficiaries who have reached the initial coverage gap and before these beneficiaries have reached the annual out-of-pocket limit. I am greatly concerned that the bill voted out of the Finance Committee will hurt these beneficiaries. For these reasons, I would have voted for this amendment.

Harkin Amendment No. 991 to Bill S. 1: I was a co-sponsor of this amendment to have a demonstration project through the Medicaid program to encourage community-based services for individuals with disabilities. I believe that it is important that we treat disabled and challenged individuals in their communities to try and decrease the institutionalization of this population. We need demonstration projects to establish cost effectiveness and quality. For these reasons, I co-sponsored this amendment and would have voted for it.

Dodd Amendment No. 998 to Bill S. 1: This amendment would have increased the amount of the direct subsidy to employers who provide retiree prescription coverage. It would have encouraged retiree benefit plans to continue to exist as an alternative to Medicare. I am deeply concerned that the bill voted out of the Finance Committee will hurt seniors who currently have employer prescription drug coverage. Seniors who have worked hard all of their lives and earned drug insurance from their former employers should not lose this coverage and this bill could, according to CBO estimates, eliminate over a third of these benefits. For these reasons, I would have voted for this amendment. This provision needs to be corrected.

Clinton Amendment No. 1000 to Bill S. 1: I was proud to cosponsor Senator CLINTON's amendment to ensure that seniors get the information that they need to make informed choices about which medication they should take for a given medical condition. Often, there is more than one medication that is available for treatment. This measure would have supported research to determine which of these drugs is most effective and would have ensured that this information would be made available to patients and their physicians. I believe that it is important to support these studies as a means of improving the quality of prescribing practices and make certain that patients get the best possible care. For these reasons, I co-sponsored this amendment and would have voted for it.

Boxer Amendment No. 1001 to Bill S. 1: This amendment would have filled the coverage gap or "doughnut" for beneficiaries who are ill and who have drug expenditures that exceed \$4500. Bill S. 1 contains a provision that after Medicare beneficiaries' drug expenditures reach \$4500, there is no more coverage until the total drug expenditures reach at least \$5813 (unless beneficiaries qualify for low-income protections). No other private or public health insurance policy has this kind of coverage gap. In addition, S. 1 requires that during this coverage gap, Medicare beneficiaries would be required to pay their monthly premium. This is unfair. This amendment would have ensured that Medicare beneficiaries continue to receive the same drug coverage even after drug costs reach \$4500 and before they reach \$5800. They are paying their premiums and should continue to receive benefits. For these reasons, I would have voted in favor of this amendment.

Sessions Amendment No. 1011 to Bill S. 1: I support the Senate's vote to defeat Senator SESSIONS' amendment. The Senate Finance committee included provisions in S. 1 to extend Medicaid and S-CHIP coverage to legal immigrants. These benefits would aid tax-paying residents who have come to this country for a better future. It is only right that hard working newcomers who play by the rules receive our help when needed. Senator SESSIONS' amendment would have eliminated these provisions. For these reasons, I would have voted to oppose the Sessions amendment.

I attempted to cast as many votes as possible during the Senate Medicare debate. I did not miss any votes for which my vote would have changed the outcome, including the vote for Senator HARKIN's amendment. Although I missed this vote and the count was 50-48 in favor of a motion to table the amendment, even if both I and another Senate absentee had cast our votes, Vice President CHENEY would have cast the deciding vote. Most of the amendments passed or failed by wide margins, as did the final bill.

In conclusion, Mr. President, I want to reiterate that on balance I view this bill as real progress, despite its flaws. But I also want to make clear that I will oppose any effort to tip that balance against senior citizens in conference. I am troubled by provisions in the House bill that would undermine traditional Medicare and force seniors into private plans. And I will not support any effort to include these provisions or ones like them into the conference report and make the bill weaker instead of stronger.

Mr. CORZINE. Madam President, I rise today to discuss the Grassley-Baucus Medicare prescription drug legislation approved by the Senate late last night.

I supported this legislation, though I did so reluctantly. On balance, I believe the proposal represents a modest

step forward toward the goal of a guaranteed prescription drug benefit under Medicare. It is a first step.

From a New Jersey perspective, I am particularly pleased that the managers agreed to my request to include a provision that will protect the ability of nearly 250,000 New Jersey seniors to continue to receive benefits through our State's 27-year-old pharmaceutical benefit program, known as the PAAD program. This program, which enjoys bipartisan support, is uniformly believed to have served our State exceedingly well. Similar long standing programs exist in other States, as well.

Unfortunately, the bill adopted by the Senate also has many shortcomings. I am hopeful that many of those problems will be addressed before the final version of the legislation is sent to the President. The Senate bill is the minimum first step I can support, however. And I will oppose the final conference report if it drops my provision protecting the ability of States to administer long standing prescription drug programs.

As I have traveled New Jersey I've heard from my constituents about their struggle to deal with rising drug prices. Many New Jerseyans fear that the cost of prescription drugs will bankrupt them in their last years. They worry about the burden those costs can impose on their families. And around our country, too many seniors are forced to choose between paying rent and buying their prescription drugs. That's a choice that no American should have to face.

I believe strongly that seniors who have worked hard all their lives, paid taxes and contributed to Medicare should have access to the medicines they need to maintain independent, productive lives. Modern medicine largely is based on pharmaceutical treatment. Providing a prescription drug benefit is the right thing to do for our seniors and their families. But it also serves broader public goals.

After all, we all pay the price if we fail to provide a guaranteed prescription drug benefit. That failure increases the number of hospital admissions and surgical procedures. It also increases costly institutionalization in nursing homes, and deprives seniors of the ability to live independently in their communities.

My own State of New Jersey recognized the value of a prescription drug benefit in 1975 when it created the PAAD program, which serves low- and middle-income seniors. New Jersey's PAAD program is considered the Nation's most generous State administered prescription drug program for the elderly. Together, PAAD and Senior Gold, a more recent program with broader eligibility added under a Republican governor, provide comprehensive prescription drug coverage to nearly 250,000 low-income seniors and disabled people in New Jersey, without deductibles or premiums.

It is absolutely essential that seniors who currently receive higher quality

benefits under state drug programs than they would under the Medicare drug benefit continue to receive the state benefits. Their position should not be diminished by Federal edict. For example, seniors in the New Jersey PAAD program pay only \$5 for their prescriptions. They do not pay premiums or deductibles. By contrast, seniors who enroll in this Medicare benefit would pay a substantial premium averaging \$35 per month, along with a \$275 deductible, and a 50 percent copay. It is unthinkable that we would force these seniors to disenroll in their more generous state program to receive less coverage under Medicare—particularly those seniors with low and moderate incomes.

I have been making this point to my colleagues on the Finance Committee for a long time, and I am very pleased that a provision to protect my State's seniors has now been included in the bill. I want to thank Senators GRASSLEY and BAUCUS for their tremendous assistance in addressing this issue. The bill before us not only allows New Jersey to continue to administer the PAAD program, but it contains language I sought to ensure that state payments on behalf of a beneficiary count toward the beneficiary's out of pocket costs, helping that beneficiary reach catastrophic coverage sooner. This will save the state of New Jersey an estimated \$105 million annually.

I particularly want to thank Liz Fowler and Andrea Cohen of Senator BAUCUS' staff for all of their efforts on these issues. They have devoted many hours to these issues and done great work, and I want them to know that I appreciate their assistance.

I would note that giving states the money we would otherwise give private plans to administer benefits would allow states to expand their programs. Rough estimates indicate that the Medicare subsidy for those seniors currently enrolled in New Jersey's PAAD program is at least \$300 million. With this new Federal money, the State of New Jersey could expand this successful program to higher income seniors, eliminating gaps and strengthening the program in many ways. This is a win-win for everybody. And, I want to note that the provision is budget neutral: it won't cost the taxpayers one penny. I will work hard with my colleagues in the New Jersey delegation to ensure that this provision will be retained in conference.

In addition to preserving state pharmaceutical assistance programs, we must also work to make this drug benefit better for all Americans. While I plan to support the underlying bill in order to push the legislative process forward, let me be clear: this is not the Medicare prescription drug proposal I would have preferred and it is not the proposal I have advocated with my constituents for the last few years.

The bill before us would require seniors to pay hefty premiums—premiums that will vary by region, and are likely

to be especially burdensome in my State of New Jersey. The bill also won't pay a penny in benefits until seniors pay \$275, on top of those premiums. And, even after paying that \$275 deductible, the program still will pay only 50 percent of the cost of drugs.

I'm also concerned that the proposal contains what is called a "doughnut hole"—a gap in coverage that will leave seniors with high drug costs paying premiums but not getting coverage for some time. While the Federal Government would pay 50 percent of a beneficiary's drug costs up to \$4,500, a beneficiary with drug costs that exceed that level would have to pay all of their drug costs between \$4,500 and \$5,800. Those Medicare beneficiaries who require drugs that exceed \$4,500 are usually the sickest and most vulnerable seniors. And it is wrong to force them to bear these costs on their own, especially considering that they will be paying premiums at the same time. Some have called this the sickness tax.

In addition, the bill fails to provide equal benefits for low-income Medicare beneficiaries who also qualify for Medicaid, the so-called "dual eligibles." These seniors will not be guaranteed the same benefit, and the burden on states will be increased.

When you add up all the limitations and all the costs that will be imposed on seniors, you end up with a benefit that's a far cry from the comprehensive coverage provided under the traditional Medicare program. In fact, most seniors actually will pay into this program more than they receive. That's not what most seniors were expecting. It's not what many of us have been promising. And, as more older Americans appreciate what this bill is really about, more are getting angry about it, and understandably so.

Compounding matters, even the limited benefit provided in this bill will not go into effect until 2006. There is no good excuse for that. I was pleased to cosponsor an amendment offered by my distinguished colleague from New Jersey, Senator LAUTENBERG, to make the benefit effective in July of next year. That would have given the Administration as long as it took to get the entire Medicare program underway back in the 1960's. Unfortunately, the amendment was defeated.

Another concern of mine is that the bill before us could serve to weaken private insurance coverage, and actually might encourage employers to eliminate prescription drug coverage to their retirees. The Congressional Budget Office has estimated that the Grassley-Baucus bill could lead to a 37 percent reduction in employer-sponsored retiree drug benefits. This is largely because under the Grassley-Baucus plan, retirees with employer sponsored prescription drug coverage would not qualify for catastrophic coverage if their employer plan paid for their drug costs.

This is a major disincentive for employers to offer their retirees prescription drug benefits. Today, approximately 12 million seniors have some form of prescription drug coverage through their former employers. By and large, these employer-based drug benefits are more generous than those provided for in this bill. And it is imperative that the final version of this legislation ensure that all prescription drug costs paid by an employer help the beneficiary achieve catastrophic coverage. Without this critical provision, seniors enrolled in retiree health plans may never trigger their Medicare catastrophic drug coverage.

Today I have noted several problems with the substance of this bill, and many of them are quite serious. There are many others. At the same time, it is important to remember that, for all its problems, the bill provides \$400 billion to create a critical new public program for our Nation's seniors. It's a start. And for many seniors, especially those with very low incomes, it will be of tremendous help.

Given that, I hope my colleagues will join me in approving the legislation before us and sending it to conference. And then I hope the conferees will listen more closely to the concerns of America's seniors and improve it. If those concerns are heard, and the conferees respond, we could soon witness an historic achievement that makes a huge difference in the lives of millions of America's seniors.

Mrs. CLINTON. Madam President, I have long championed a prescription drug benefit that would provide real prescription drug coverage for seniors and individuals with disabilities. Last year and again during this debate, I voted for proposals that provided a comprehensive, reliable benefit without gaps in coverage that force seniors to pay premiums even while they get no benefits in return.

S. 1, the Grassley-Baucus bill that passed, however, contains serious shortcomings, including these large benefit gaps. So I must reluctantly oppose this legislation unless it is improved.

I am particularly concerned that it poses a strong danger to significant numbers of New Yorkers. It leaves 37 percent of seniors who rely on their retiree drug coverage at risk of losing their employer coverage because of incentives in the bill for employers to drop coverage. It also leaves out 300,000 of New York's nursing home residents who rely on Medicaid and another 230,000 low-income New Yorkers who also rely on Medicaid because Medicare beneficiaries who are also eligible for Medicaid are excluded from receiving the prescription drug benefit that passed last night. These New Yorkers could actually find themselves worse off than they are today if their employers or Medicaid programs drop or reduce coverage.

The provisions excluding those beneficiaries who are dually eligible for

Medicare and Medicaid also harms New York State's finances. New York State has effectively been subsidizing the Federal Government for years in the absence of a Federal provision for prescription drug benefits, by paying for the drug costs of these Medicare beneficiaries. But by failing to include dually eligible Medicare beneficiaries in the Medicare prescription drug benefit, this bill continues to leave New York, which is in a precarious State budget situation, to subsidize the Federal Government's lack of adequate investment.

Finally, the bill includes a Grassley-Baucus amendment that starting in 2009 will allow for government subsidization of private plans at levels much higher than the government funding for beneficiaries in traditional Medicare, and would then allow the private plans to offer benefits not available to the 90 percent of seniors in traditional Medicare, which I believe begins to subordinate the goal of health care for seniors to the goal of privatizing Medicare.

While I am pleased that New York's State drug program, EPIC, will still be available under a provision that Senators CORZINE, LAUTENBERG, SCHUMER and I worked hard to include, the other measures I supported to make sure seniors with other sources of coverage were not harmed by this proposal were unfortunately left out of the bill.

For their sake, for the sake of New York's fiscal situation, as well as for the sake of other New York seniors who will be confronted with an unnecessarily complex maze of bureaucracy to navigate in order to access benefits, I felt obliged to oppose the bill. There were some important provisions in the bill, including Senator SCHUMER's amendment that provides greater market competition for generic drugs so that seniors will have a cheaper alternative and don't have to rely on higher priced name-brand drugs.

These positive provisions were not enough, however, for me to vote for the bill unless it is substantially improved. While I believe New York deserves a better bipartisan alternative than the one that passed the Senate yesterday, I hope that those in conference will fight against changes that make the bill even worse for New York, and I will continue fighting this year, as well as in years to come, to correct these deficiencies and actually to deliver on the long-awaited promise of a simple, affordable, comprehensive prescription drug benefit for all seniors.

I request that this statement and a separate document, Governor Pataki's letter dated June 12, 2003, be submitted for the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

STATE OF NEW YORK,

June 12, 2003.

DEAR NEW YORK CONGRESSIONAL DELEGATION MEMBERS: Prescription drug costs continue to strain the budgets of the nation's senior citizens. I applaud your efforts this year to address this important issue. As you

begin consideration of legislation to provide prescription drug coverage to all senior citizens, please consider two issues vitally important to New York State.

First, New York taxpayers continue to support a significant cost for prescription drug coverage for its dual eligible population. The dual eligibles are elderly and disabled individuals who qualify for both the Medicare and Medicaid programs. Medicaid is required to provide medical services not covered by Medicare—including prescription drugs.

More than 600,000 New Yorkers are considered dual eligibles and each year New York's Medicaid program spends nearly \$1.5 billion on prescription drugs for the dual eligible population alone. We have always believed that these costs should be borne by the federal government and strongly support efforts to federalize prescription drug costs for the dual eligible population.

In addition, New York administers the nation's largest prescription program for seniors, EPIC. Today, more than 300,000 seniors are enjoying the significant benefits EPIC offers and savings thousands of dollars each on vitally important medicines. Costs for this program exceed \$600 million annually in State only dollars. Currently eighteen states have programs similar to New York's to provide prescription drug benefits to senior citizens.

Any federal program created this year to provide prescription drug coverage should recognize state efforts and allow seniors to choose their benefit plan (in New York, that choice would be between EPIC and the federal plan) while providing a direct Medicare subsidy to the state program for individuals that choose that option.

The Federal government has accepted responsibility of providing health care to senior citizens and I strongly urge an expansion to include prescription drug coverage. I applaud President Bush for his leadership on this issue and our Congressional delegation for its commitment to our seniors.

Your efforts on this important legislation could dramatically improve the health of a segment of our population that has given so much to New York's and America's safety and prosperity. We urge you to work with us to ensure that our seniors get the prescription drug coverage they deserve, and that the federal government assumes its rightful role in supporting services for our dual-eligible population.

Very truly yours,

GEORGE E. PATAKI,
Governor.

MEDICARE REIMBURSEMENT OF MAMMOGRAPHY

Ms. MIKULSKI. Madam President, I rise to state for the record my strong support of Senator HARKIN'S amendment to the Medicare prescription drug bill (S. 1) to increase Medicare reimbursement for mammograms. I am a proud cosponsor of this amendment. I am pleased that Senator GRASSLEY and Senator BAUCUS agreed to include it in the Medicare prescription drug legislation that passed the Senate earlier today. Americans must have access to mammography because it is an important tool to screen and detect breast cancer.

It is vital for Medicare beneficiaries to have access to mammography. A woman's risk of having breast cancer increases with age. A woman's chance of getting breast cancer is 1 out of 2,212

by age 30. This increases to 1 out of 23 by age 60 and 1 out of 10 by age 80. More than 85 percent of breast cancers occur in women over the age of 50. There will be 70 million Americans aged 65 and over in 2030. At the same time about 700 mammography facilities have closed nationwide over the last 2 years. Adequate reimbursement is essential to help ensure that women have access to this important screening tool. This amendment will increase Medicare reimbursement for mammograms. This amendment is also an important step to help radiologists enter and remain in the field of mammography by providing more adequate reimbursement. Mammography is not perfect, but it is the best tool we have now.

I have long fought to ensure that Medicare beneficiaries have access to mammography. I cosponsored the Assurance Access to Mammography Act, S. 869, that would increase Medicare reimbursement for mammograms. It would also increase the number of radiologists by increasing Medicare graduate medical education, GME, to provide three additional radiologists in each teaching hospital. In 1990, I introduced the Medicare Screening Mammography Amendments of 1990 to provide Medicare coverage of annual screening mammography. My legislation was included in the Omnibus Budget Reconciliation Act of 1990. Before that, Medicare did not cover routine annual screening mammograms. Additional legislation since then has expanded access to mammography for Medicare beneficiaries. I will continue to fight to ensure that women have access to quality mammography, and I urge that the final version of the Medicare prescription drug bill include provisions to increase Medicare reimbursement for mammograms.

EDUCATION FUNDING

Mr. KENNEDY. Madam President, there is troubling news on the education front. Yesterday, the Republican majorities on the House and Senate Appropriations Committees approved education budgets filled with harsh cuts that will hurt families, students, schools, and teachers throughout the country.

Unfortunately, the pattern is all too clear. Our Republican colleagues promise strong support for education and quietly break the promise. The bills unveiled yesterday contain a litany of broken promises on education.

Obviously, money is not the answer to all the problems of our schools. But the way we allocate resources in the Federal budget is a clear expression of our Nation's priorities. And the priorities on education reflected in this Republican Appropriations bill are profoundly wrong.

In January 2002, President Bush promised that "America's schools will be on a new path of reform . . . our schools will have greater resources to meet those goals." But yesterday, on a