

greater fairness by increasing Medicare payments to rural hospitals and by modifying geographic adjustment factors that discriminated against physicians and other providers in rural areas. Our legislation would build on these improvements by establishing pilot programs that reward providers of high-quality, cost-effective Medicare services.

The Access to Affordable Health Care Act outlines a blueprint for reform based on principles upon which I am hopeful that a bipartisan majority of Congress could agree. The plan takes significant strides toward the goal of access to health care coverage by bringing millions more Americans into the insurance system and by strengthening the health care safety net. Most of all, it helps address the No. 1 obstacle to health insurance—and that is its cost—through a variety of incentives.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Ms. CANTWELL). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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 Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

EXTENSION OF MORNING BUSINESS

Mr. GRASSLEY. Madam President, I ask unanimous consent to add time to the order for morning business so I can speak for 25 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

MEDICARE PRESCRIPTION DRUG BENEFIT

Mr. GRASSLEY. Madam President, it is a very important issue that is going to be coming before the Senate very shortly, and it deals with the Medicare prescription drug benefit and whether the Government ought to negotiate prices as opposed to what is in the Medicare Part D bill. I wish to speak on that subject because this issue is very important to the seniors of America. It is important for the public and for Medicare beneficiaries to fully understand these proposed changes. It is equally important we explore in depth the effects these changes are going to have on this program and particularly the negative impact on the senior citizens of our country. So I am going to spend some time this week dealing with this issue.

First, everyone should recognize that political opponents of the drug benefit have, in every way, done everything they can to tear apart and denigrate this new benefit that the vast majority of seniors find to their liking, based upon a lot of different polls that have been taken over the last 7 or 8 months. In fact, the opponents of this legisla-

tion have done this ever since the ink was barely dry on the bill we called the Medicare Modernization Act of 2003.

First they said that no plan would offer—meaning no benefit plan; the people, the administrators of the program—that none of these plans would offer the new drug benefit in the first place, that eventually the Government was going to end up doing it. Of course, we know that is not the fact. The plan is up and running, and the plans are offering so many.

Then, after it was up and running, these opponents of the legislation said, well, there were too many plans. They said it was too confusing, seniors would not be able to choose a plan. But 91 percent of seniors are covered by some plan that has prescription drugs in it, and surveys show overwhelming satisfaction by seniors with their plans.

Opponents suggested plans could change their prices and the drugs they cover at the drop of a hat without even almost any notice. This did not turn out to be the case. The opponents tainted beneficiaries' views of the benefits before it even got off the ground. You wondered whether the millions of people who signed up would ever sign up, hearing so much negative stuff about it. But they did sign up.

And, as we have heard from the opponents over and over again, one of the biggest criticisms about the drug benefit is that the Government does not negotiate with drugmakers for lower prices. So they have gone to great lengths to make it sound as if nobody is negotiating with the drug companies. It is, of course, correct that the Secretary of Health and Human Services does not do negotiation with drug companies. But it is absolutely not true there are not negotiations going on with drug companies. People who say that are completely nonsensical in their understanding of the legislation or maybe they have some ulterior motive of wanting to continue to degrade and denigrate a piece of legislation that seniors have accepted.

The idea behind the drug benefit is that multiple drug plans would compete with each other to get the lowest prices from manufacturers, to be the best negotiator, and to offer beneficiaries the best possible drug plan.

The pattern for this was the 40-year-old Federal Employees Health Benefit Plan that has worked so well for Federal employees. We patterned this program, Part D, after that: plans negotiating for Federal employees, getting a good price; plans that have membership of senior citizens negotiating with drug companies to get the best possible price for senior citizens who are in a particular plan.

But the opponents of this legislation do not like plans negotiating. They think the Government directly can do a better job of negotiating because they have a belief about Government always doing good, Government always doing the best. Their faith is in big Government because they lack faith in

the American people. They find it very hard to believe anybody other than the Government could do a better job of negotiating.

Last week on the Senate floor, the senior Senator from Illinois said the law “took competition out of the program so that [the drug companies] could charge what they want.” Well, it did not take competition out of the program. Competition is what this program is all about.

In fact, the competition is working. Plans have no restrictions on the tools they can use to negotiate with drug companies. And, remember, these plans must be approved by the Secretary of Health and Human Services. Not every Tom, Dick, and Harry can go out and offer a plan and hoodwink seniors. There is control over these plans. But once the plan is approved, there are no restrictions on the tools they can use to negotiate. And, of course, this is very important because one thing we had learned is that Government is not actually a very good entity at figuring out what it should pay for drugs.

I have a chart in the Chamber with a quote from the Washington Post. They recognized this fact, that the Government cannot do a very good job of negotiating, where they said: “Governments are notoriously bad at setting prices. . . .” And then, as a matter of emphasis, it said: “and the U.S. government is notoriously bad at setting prices in the medical realm.” I will add to that: especially when it comes to medicine policy.

Now, we knew this because of the Government's experience for paying for drugs under another Medicare program, not Part D as in “Donald,” but Part B as in “Bob,” the one that pays for doctors. Those drugs are given during a physician's office visit, and they could be drugs such as oral cancer drugs.

Medicare payments for these drugs were based on what is called the average wholesale price. “AWP” is the moniker that is used for that. AWP is a little bit like the sticker price of a car. The sticker price on a car is not what you pay for the car. And the average wholesale price, AWP, is not what you pay for drugs. The joke was that AWP actually stood for “Ain't What's Paid.”

Over the past decade, reports issued by the Office of the Inspector General, the Department of Justice, and the Government Accountability Office found that by relying on AWP, Medicare was vastly overpaying for these drugs.

So the Federal Government sets the price, and we end up wasting a lot of taxpayer money under Part B with the few drugs that Medicare was paying for before we passed Part D.

Recommendations were made to change payments so that they reflected actual market cost. The Clinton administration tried to make some of these changes, but after push-back from providers, it backed off. Congress took another run at this issue in 2003 in