with respect to export controls on high performance computers; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. BROWNBACK (for himself, Mr. KERREY, and Mr. MURKOWSKI):

S. 2540. A bill to amend the Food Security Act of 1985 to require the Secretary of Agriculture to establish a carbon sequestration program to permit owners and operators of land to enroll the land in the program to increase the sequestration of carbon, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. DASCHLE (for himself, Mr. MOYNIHAN, Mr. KENNEDY, Mr. AKAKA, Mr. BAUCUS, Mr. BIDEN, Mr. BINGAMAN, Mrs. BOXER, Mr. BRYAN, Mr. BYRD, Mr. CLELAND, Mr. DODD, Mr. DORGAN, Mr. DURBIN, Mrs. FEINSTEIN, Mr. GRAHAM, Mr. HARKIN, Mr. HOLLINGS, Mr. INOUYE, Mr. JOHNSON, Mr. KERRY, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mrs. LINCOLN, Ms. MIKULSKI, Mrs. MURRAY, Mr. REED, Mr. REID, Mr. ROBB, Mr. ROCKEFELLER, Mr. SARBANES, Mr. SCHUMER, and Mr. WELLSTONE):

S. 2541. A bill to amend title XVIII of the Social Security Act to provide a prescription drug benefit for the aged and disabled under the medicare program, to enhance the preventative benefits covered under such program, and for other purposes; to the Committee on Finance.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. COLLINS (for herself, Mr. FEINGOLD, Mrs. MURRAY, Mr. ABRAHAM, Mr. WELLSTONE, Mr. HUTCHINSON, Mr. DORGAN, Mr. GRAMS, Mr. BINGAMAN, Mr. L. CHAFEE, Mr. ENZI, and Ms. SNOWE):

S. 2528. A bill to provide funds for the purchase of automatic external defibrillators and the training of individuals in advanced cardiac life support; to the Committee on Health, Education, Labor, and Pensions.

RURAL ACCESS TO EMERGENCY DEVICES ACT

Ms. COLLINS. Mr. President, today I am pleased to join my friend from Wisconsin, Senator FEINGOLD, in introducing the Rural Access to Emergency Devices Act of 2000, which is intended to improve access to automated external defibrillators in small communities to boost the survival rates of individuals who suffer cardiac arrest.

We are very pleased to be joined in introducing this legislation by the following cosponsors: Senators MURRAY, ABRAHAM, WELLSTONE, HUTCHINSON, DORGAN, GRAMS, BINGAMAN, CHAFEE and ENZI.

Heart disease is the leading cause of death both in the State of Maine and nationwide. According to the American Heart Association, an estimated 250,000 Americans die each year from cardiac arrest. Many of these deaths could be prevented if AEDs were more accessible. AEDs are computerized devices that can shock a heart back into the normal rhythm and restore life to a cardiac arrest victim. They must, however, be used promptly. For every minute that passes before a victim's normal heart rhythm is restored, his or her chance of survival falls by as much as 10 percent.

We have a number of new and improved technologies in our arsenal of weapons to fight heart disease, including a new generation of small, easy-to-use AEDs that can strengthen the chances of survival. These new devices make it possible not only for emergency medical personnel, but also trained lay rescuers, to deliver defibrillation safely and effectively. The new AEDs are safe, effective, lightweight, low maintenance, and relatively inexpensive. Moreover, they are specifically designed so they can be used by nonmedical personnel, such as police, firefighters, security guards, and other lay rescuers, providing they have been trained properly.

According to the American Heart Association, making AEDs standard equipment in police cars, firetrucks—as I know the Presiding Officer has done in his hometown—ambulances, and other emergency vehicles, and getting these devices into more public places could save more than 50,000 lives a year.

Last December, the Bangor Mall installed an AED that is one of the first of these devices in Maine to be placed in a public setting outside the direct control of emergency medical personnel and hospital staff. Both the AED and an oxygen tank are kept inside a customer service booth, which is in an area of the mall where there is a high concentration of traffic and where heart emergencies might occur. Mall personnel have also received special training and, during mall hours, there is always at least one person who has been certified in both CPR and defibrillator use.

For at least one Bangor woman, this has been a lifesaver. On January 12th, just weeks after the AED was installed, two shoppers at the Mall collapsed in a single day. One was given oxygen and quickly revived. But the other shopper was unconscious and had stopped breathing. The trained mall staff—Maintenance Supervisor Larry Lee, Security Chief Dusty Rhodes, and General Manager Roy Daigle—were only able to detect a faint pulse. They quickly commenced CPR and attached the AED.

It is important to note that defibrillation is intended to supplement, not replace standard CPR. These devices, which are almost completely automated, run frequent self-diagnostics and will not allow the administration of shock unless the victim's recorded heart pattern requires it. When the AED is attached, it automatically analyzes the victim's vital signs. One of two commands will then be voiced and displayed by the unit: ''Shock advised—charging''; or ''Shock not advised—continue CPR.''

In the Bangor Mall case, the shock was not advised, so CPR was continued until the emergency medical personnel arrived. The EMT's told Mr. Daigle, the General Manager of the mall, that the woman—who had had a heart attack and subsequently required triple bypass surgery—simply would not have survived if they had not been so prepared. As Mr. Daigle observed, ''Twelve to fifteen minutes is just too long to wait for the emergency services to arrive.''

Cities across America have begun to recognize the value of fast access to AEDs and are making them available to emergency responders. In many small and rural communities, however, limited budgets and the fact that so many rely on volunteer organizations for emergency services can make acquisition and appropriate training in the use of these life-saving devices problematic.

The legislation that Senator FEINGOLD and I are introducing today is intended to increase access to AEDs and trained local responders for smaller towns and rural areas in Maine and elsewhere where those first on the scene may not be paramedics or others who would normally have AEDs. Our bill provides $25 million over three years, to be given as grants to community partnerships consisting of local emergency responders, police and fire departments, hospitals, and other community organizations. This money could then be used to help purchase AEDs and train potential responders in their use, as well as in basic CPR and first aid.

I commend the leadership of the Senator from Wisconsin for coming forth with this idea. I am very pleased to join him in introducing this important legislation.

The Rural Access to Emergency Devices Act has been endorsed by both the American Heart Association and the American Red Cross as a means of expanding access to these lifesaving devices across rural America. I urge all of our colleagues to join us as cosponsors of the bill.

I ask unanimous consent that letters of support from both the American Heart Association and their Maine affiliate be printed in the RECORD.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

AMERICAN HEART ASSOCIATION,
Augusta, ME, May 3, 2000.

Hon. SUSAN M. COLLINS,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR COLLINS: The State Advocacy Committee of the American Heart Association in Maine commends you for your leadership in sponsoring the ''Rural Access to Emergency Devices (AED) Act.'' As volunteer advocates for the American Heart Association, we are pleased that you have recognized that the placement of AEDs with trained, local, first responders, such as fire and rescue departments, paramedics, police departments and community hospitals in rural areas will make a difference in a person's chances of surviving a sudden cardiac arrest. We are also proud that this bill is being sponsored by a Maine Senator.

Heart disease is the leading cause of death in the state of Maine, as well as the nation. Early defibrillation is the only known therapy for most cardiac arrests. Each minute of

delay in returning the heart to its normal pattern of beating decreases the chance of survival by 7% to 10%. As you well know, Maine's population is dispersed over a large geographical, mostly rural, area. The Emergency Medical Services in our state are excellent, but travel times within rural communities can occasionally be too long to benefit the patient in cardiac arrest. The availability of AEDs and trained local responders should improve the chain of survival for these victims of sudden cardiac arrest. The American Heart Association estimates that the sudden cardiac arrest survival rate can improve from only 5% to 20% when AEDs and trained rescuers are readily available within communities.

Thank you, Senator Collins, on behalf of the residents of Maine and our fellow citizens in other rural states.

Sincerely yours,

GAYLE RUSSELL, RN, BSN,
Chair, Maine State Advocacy Committee.

AMERICAN HEART ASSOCIATION,
Washington, DC, April 27, 2000.

Hon. SUSAN COLLINS,
Hon. RUSSELL FEINGOLD,
U.S. Senate,
Washington, DC.

DEAR SENATORS COLLINS AND FEINGOLD: The American Heart Association applauds your commitment to saving lives and thanks you for your introduction of the ''Rural Access to Emergency Devices (AED) Act.'' The legislation will help improve cardiac arrest survival rates across rural America.

As you know, heart disease is the leading cause of death in this country. Cardiac arrest, whereby the electrical rhythms of the heart malfunction, causes the sudden death of more than 250,000 people every year. We are fighting this killer with improved technology, including automated external defibrillators (AEDs). These small, easy-to-use devices can shock a heart back into normal rhythm and restore life to a cardiac arrest victim. But, they must be used promptly. We have to act quickly because for every minute that passes before a victim's normal heart rhythm is restored, his or her chance of survival falls by as much as 10 percent.

Cities across America have begun to recognize the value of fast access to these devices and are making them available to emergency responders. The Rural AED Act recognizes that we cannot and should not leave rural communities behind in this fight to improve survival. Because the first emergency responders on the scene of a cardiac arrest may not always be the medical responders, the Rural AED Act makes resources available to rural communities to purchase AEDs for police and fire as well as emergency responder vehicles. In addition, it provides resources to train these responders in the use of the devices. The bill provides $25 million for this effort to expand access to devices that can save lives across rural America.

The American Heart Association thanks you for your leadership in the fight against heart disease and looks forward to working with you to ensure the passage of this important legislation.

Sincerely,

LYNN A. SMAHA, M.D., PH.D.,
President.

The PRESIDING OFFICER. The Senator from Wisconsin.

Mr. FEINGOLD. Thank you, Mr. President.

Let me first thank the managers for allowing us the opportunity to introduce our bill at this time. I especially thank my friend, the Senator from Maine, for taking the lead on this issue with me. She is a very effective Senator on many issues, and is specially effective, I think, when it comes to the concerns of rural people in Maine and throughout the country about an issue which is incredibly important—first aid.

I also thank the Presiding Officer, the junior Senator from Rhode Island, for joining us and cosponsoring the bill.

I rise today with Senator COLLINS to introduce the Rural Access to Emergency Devices Act. This legislation provides a first step to helping save the lives of the more than 250,000 people who die each year from sudden cardiac arrest.

Every two minutes, someone in America falls into sudden cardiac arrest—a medical emergency in which the heart's rhythm becomes so erratic it can not pump blood to the brain and other vital organs.

According to the American Heart Association, over 250,000 Americans die each year from sudden cardiac arrest. That is 700 deaths each day—a startlingly large number. Overall heart disease kills more Americans than AIDS, cancer, and diabetes combined.

In my home state of Wisconsin, as in many other states, heart disease is the number one killer. Ninety-five sudden deaths from cardiac arrest occur each day in Wisconsin.

These numbers are disturbing by any measure, but they are especially troubling because they don't need to be this high. By taking some relatively simple steps, we can give victims of cardiac arrest a better chance of survival, particularly in rural areas. Cardiac arrest victims are in a race against time, and today I'm introducing a bill to increase access to defibrillators, that are essential to reviving cardiac arrest victims.

Cardiac arrest strikes its unwilling victims with no warnings or indications. In most cases it's all but impossible to predict who will have a sudden cardiac arrest, or where and when it will happen.

Cardiac arrest can strike anyone. When cardiac arrest occurs, the victim loses consciousness, has no pulse and stops breathing normally. Death often occurs within minutes.

Cardiac arrest does not discriminate against age, gender, or race. A recent issue of Women's Day magazine detailed a number of cases in which a variety of people suffered from cardiac arrest.

The article tells about a 24-year-old woman, a writer for a Seattle comedy show, who suffered from cardiac arrest after watching her favorite television show. Another victim was a 48-year-old women who was out for a birthday dinner with her husband and friend. Yet another individual, only 31 years of age, suffered cardiac arrest at his computer programing job in Minnesota.

What these victims have in common is that all three survived. Each was saved because a properly trained person was there with an automated external defibrillator (AED). These life saving machines are compact, portable, battery-operated versions of the machines that were traditionally only in the hands of emergency medical personnel.

Wisconsin's Emergency Medical Services are some of the finest in the country. They are effectively trained to identify victims and determine when a shock is needed. There are countless stories of quick EMS responses that have saved so many lives.

Unfortunately, for those in many rural areas, Emergency Medical Services have simply too far to go to reach people in need and time runs out for victims of cardiac arrest. It's simply not possible to have EMS units next to every farm and small town across the nation.

Fortunately, recent technological advances have made the newest generation of AEDs inexpensive—approximately $3,000—and simple to operate. Because of these advancements in AED technology, it is now practical to train and equip fire department personnel, police officers, and other community organizations—and that's exactly what this legislation would do.

But let me be clear, I think they are only one part of the so-called chain of survival.

This chart indicates the four crucial aspects of the chain of survival, which is a proven method to save lives.

The first link in the chain is simple: it is vitally important that cardiac arrest victims have early access to care. When someone suffers from cardiac arrest, it's crucial that bystanders dial 911 to dispatch the appropriate emergency personnel to the scene.

The next link is early CPR—if performed properly, it will at least buy a few minutes to perform defibrillation. Let me be clear though, effective CPR does not replace defibrillation in saving lives.

The critical link in the chain of survival for victims of cardiac arrest is early defibrillation. Mr. President, each minute of the delay in returning the heart to its normal pattern of beating decreases the chance of survival by 10 percent.

The final link in the chain is early access to advanced care—it is literally of vital significance. Even after successful defibrillation, many patients require more advanced treatment on the way to the hospital.

By passing this legislation, and increasing access to defibrillators, we have the chance to strengthen the more important link in the chain of survival.

Communities across America are in dire need of better access to defibrillators. Making AEDs widely available so that trained laypeople can use them to administer shocks to cardiac arrest victims will go a long way toward saving lives.

In fact, the American Heart Association estimates that over 50,000 lives could be saved each year if AEDs were more readily accessible.

This next chart illustrates a startling statistic I mentioned a moment ago—for every minute that passes a cardiac arrest victim is defibrillated, the chance of survival falls by as much as 10 percent. After only eight minutes, the victims survival rate drops 60 percent.

Our legislation, the Access to Emergency Devices Act of 2000 takes a common sense approach to strengthen this chain of survival. This legislation provides $25 million to expand access to devices that can save lives across rural America.

It also provides for training grants to give people the training they need to learn how to operate defibrillators.

And I have learned that training is very important, but also that nearly anyone can be taught to make proper use of a defibrillator.

Cities across America have begun to recognize the value of fast access to defibrillators and are making them available to emergency responders. This legislation recognizes that rural communities should have the same chance to improve cardiac arrest survival rates.

Because the first emergency responders on the scene of a cardiac arrest may not always be the medical responders, our legislation makes resources available to rural communities to purchase AEDs for police and fire as well as emergency response vehicles—and our bill also provides funds for the training that will sustain the life-saving effect of these grants.

Cardiac arrest can be a killer. But if we give people in rural communities a chance, they may be able to stop a cardiac arrest before it takes another life. Our bill is a simple and effective way to increase the availability of defibrillators, and give rural victims of cardiac arrest a better chance of survival, and I look forward to working with my colleagues to pass this legislation.

I yield the floor.

By Mr. JEFFORDS (for himself, Mr. ALLARD, Mr. BINGAMAN, Mr. KENNEDY, and Mr. LEAHY):

S. 2537. A bill to amend title 10, United States Code, to modify the time for use by members of the Selected Reserve of entitlement to certain educational assistance; to the Committee on Armed Services.

NATIONAL GUARD AND RESERVE EDUCATION ACT

● Mr. JEFFORDS. Mr. President, I strongly believe we owe it to Americans to provide them the best educational opportunities. And as a Navy veteran, I feel we owe our military greater access to education by providing maximum flexibility to use the educational benefits they've been promised. Today, on behalf of Senators ALLARD, BINGAMAN, KENNEDY, LEAHY, and myself, I am introducing legislation that will provide more time for our National Guard and Reserves to utilize their current education benefits.

Education benefits have proven to be one of the more important benefits offered by the U.S. military, both in terms of recruiting and retention, and as a means of upgrading the educational levels of our existing force. Currently, members of our uniformed services receive education assistance primarily through the successful Montgomery GI bill.

While the Montgomery GI bill goes a long way toward helping to further the education of our hardworking men and women serving in the uniformed services, there is an important gap in the number of years they have to utilize these benefits. While active duty personnel are provided education benefits for up to ten years after they separate from active duty, National Guard and Reserve personnel are only entitled to these benefits for the first ten years of their service and not after they leave the service. Since our active duty servicemembers currently have up to ten years after they separate from active duty, they are eligible to utilize their education assistance for up to thirty years (twenty years service plus ten). Our National Guard and Reserve servicemembers' benefits currently end ten years from the date they complete basic training.

The legislation I am introducing today would allow our National Guard and Reserves to use their Montgomery GI bill education benefits for the entire time they serve in the Selected Reserve. We are not asking for more benefits, just greater flexibility in the servicemembers' choice of when to use the education benefits that are already approved for them.

In addition, the Selected Reserve members who become disabled are currently allowed to use the GI bill education benefits only during the first ten years of service, regardless of what year they become disabled. For example, if a servicemember becomes disabled during the first two years of service, he has eight more years of education assistance eligibility. But if he becomes disabled after nine years of service, he would have one year of eligibility left. After ten years of service, the National Guard and Reserve have no education benefits if they become disabled.

This legislation would allow any unused portion of their 36 months of GI bill educational assistance to be utilized through the later of the original ten-year period of eligibility or a four-year period beginning on the date the person is involuntarily separated from the Selected Reserve. This adjustment also pertains to servicemembers whose unit is inactivated during a force drawdown if they have any unused months of educational assistance remaining.

As we have seen, our National Guard and Reserve continue to be tasked more and more as our nation calls on them to support missions around the world. The Selected Reserve makes up almost half of our Uniformed Services today. They, too, leave their families behind to meet the call of serving our nation. In addition, they leave their full-time employers for months on end to perform their 'part-time' jobs. This makes it even more difficult for them to take advantage of employer-provided opportunities to further their education. How can we continue to expect them to utilize their current Montgomery GI bill benefits within the current time limitations while being tasked to work two jobs, maintain a family and deploy overseas on short notice? They've earned the right to have an equitable amoun6t of time to utilize their Montgomery GI bill educational assistance. This is the right thing to do. I hope my colleague will join me in cosponsoring this legislation.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2537

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MODIFICATION OF TIME FOR USE BY CERTAIN MEMBERS OF THE SELECTED RESERVE OF ENTITLEMENT TO EDUCATIONAL ASSISTANCE.

(a) IN GENERAL.—Subsection (a) of section 16133 of title 10, United States Code, is amended by striking ''(1) at the end'' and all that follows through the end and inserting ''on the date the person is separated from the Selected Reserve.''.

(b) CERTAIN MEMBERS.—Paragraph (1) of subsection (b) of that section is amended in the flush matter following subparagraph (B) by striking ''shall be determined'' and all that follows through the end and inserting ''shall expire on the later of (i) the 10-year period beginning on the date on which such person becomes entitled to educational assistance under this chapter, or (ii) the end of the 4-year period beginning on the date such person is separated from, or ceases to be, a member of the Selected Reserve.''.

(c) CONFORMING AMENDMENTS.—Subsection (b) of that section is further amended—

(1) in paragraph (2), by striking ''subsection (a)'' and inserting ''subsections (a) and (b)(1)'';

(2) in paragraph (3), by striking ''subsection (a)'' and inserting ''subsection (b)(1)''; and

(3) in paragraph (4)—

(A) in subparagraph (A), by striking ''subsection (a)'' and inserting ''subsections (a) and (b)(1)''; and

(B) in subparagraph (B), by striking ''clause (2) of such subsection'' and inserting ''subsection (a)''.●

By Mr. ROCKEFELLER (for himself, Mr. ROBB, and Mr. DURBIN):

S. 2538. A bill to amend the Internal Revenue Code of 1986 to maintain retiree health benefits under the Coal Industry Retiree Health Benefit Act of 1992; to the Committee on Finance.

COAL MINER AND WIDOWS HEALTH PROTECTION ACT OF 2000

Mr. ROCKEFELLER. Mr. President, today I am introducing legislation that will maintain the promised health benefits of a small group of retired coalminers and their widows—the

Coalminers and Widows Health Protection Act of 2000. Retired coalminers and their widows were promised lifetime health benefits by the companies they worked for and by the federal government more than a half century ago. This commitment goes back to 1946 when President Truman guaranteed miners they would have lifetime health benefits in exchange for their return to the mines. The promise was well understood in the coalfields, and reiterated in successive coal wage agreements throughout the last half century. Congress affirmed that promise when it enacted the Coal Industry Retiree Health Benefits Act in 1992 (as part of the Energy Policy Act) to protect the health benefits of about 120,000 retirees and avoid a nationwide coal strike. The Coal Act has ensured that a small group of retirees would continue to get the health benefits that they earned and were promised for eight years now. There are now only about 65,000 miners and retirees remaining in the Fund—70% of whom are elderly widows of retired miners. Their average age is 78 years old, and more than 45% of the population is over 80 years old.

Once again, in this new century, the health care of this small group of retired miners and widows is threatened due to both significantly increased health care costs and a series of adverse court decisions. Congress must act this year to prevent a reduction in their health care benefits. Last year, we faced the first shortfall in the trust fund that pays for retired miners health benefits, and Congress responded. Senator BYRD and Congressman RAHALL's leadership forestalled a health care benefit cut. They included a stop-gap $68 million in last year's final omnibus Appropriations bill to avert a cut. If Congress fails to act this year, retired miners and their widows will be in imminent danger of losing health benefits as early as next Spring.

I am glad to report to my colleagues that the Clinton/Gore Administration recognized the need to shore up the retired miners' health fund and included in its budget a number of provisions that together secure miners' benefits well into the next decade. The Coal Act related provisions in the President's budget are based on one premise—these retired miners were promised lifetime health benefits and a promise made must be a promise kept. The Administration strongly reaffirmed the federal government's commitment to retired miners and their widows by proposing to transfer $346 million in new monies over the next ten years to the Combined Benefit Fund to ensure there will be no benefit cuts. The Administration's budget also clarified a few provisions of the Coal Act to avoid unnecessary litigation about the clear meaning of the statute. The Coalminers and Widows Health Protection Act does not include all of the Administration's proposed solutions for jurisdictional and practical reasons, but I am very grateful for their comprehensive solution to maintaining promised benefits, and believe each of their proposed remedies deserve serious consideration by Congress.

The Coalminers and Widows Health Protection Act does three things. It provides for an annual mandatory transfer of general funds to the Combined Benefit Fund to maintain its long term solvency and prevent a reduction in miners' health benefits. The annual transfers are set at a level to avoid any reduction in benefits and amount to $346 million over ten years. This bill also clarifies two aspects of the Coal Act to resolve disputed or misunderstood provisions of the law. The first clarification involves the timing of Social Security Administration's assignment of retired miners to the companies that had employed them and promised to finance their lifetime health benefits. The second clarification involves assignments to successors-in-interest of coal companies that had agreed to finance lifetime health benefits, as well as to the successors-in-interest of persons related to those companies, which is explicitly provided for in the Act. These clarifications will avoid further unneeded litigation expenses. These two clarifications do not score for the purposes of determining the cost of enacting them to the federal government.

I want to report to my colleagues that there is a bipartisan, bicameral process underway to determine how we can best shore up the miners' trust fund. Staff are meeting regularly. Chairman ROTH has informed me that he is committed to finding a way to preserve these promised benefits, and I welcome his strong support, as well as that of Senator MOYNIHAN and several other Members of the Finance Committee who are actively involved in this process.

One hundred thousand coalminers were killed while working in the mines last century. Nearly another hundred thousand suffered debilitating job related illnesses. This bill will give retired miners and their widows the health security they were promised and deserve. We owe them that security. They earned it. And you can rest assured that as Congress deals with the priority issues of funding government functions and operations through the annual budget process, and as proposed tax cuts and other legislative items are contemplated, I intend to see to it that we meet our responsibilities to retired coalminers.

There are about 20,000 thousand retired miners and their widows living in West Virginia—and tens of thousands of more living in virtually every state of the Union. The Coalminers and Widows Health Protection Act will tell them that they can count on their health care benefits being there for them when they need them, just as they were promised.

I ask unanimous consent that a copy of the bill be printed in the RECORD.

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

S. 2538

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Coal Miner and Widows Health Protection Act of 2000''.

SEC. 2. MANDATORY TRANSFER OF FUNDS TO COMBINED BENEFIT FUND.

(a) Section 9705 of the Internal Revenue Code of 1986 (relating to transfers to the Combined Benefit Fund) is amended by adding at the end the following:

''(c) MANDATORY TRANSFERS FROM GENERAL FUND.—

''(1) IN GENERAL.—There are hereby authorized and appropriated, out of any amounts in the Treasury not otherwise appropriated, to the Combined Fund the following amounts for the following fiscal years:

''(A) $38,000,000 for fiscal year 2001,

''(B) $37,000,000 for fiscal year 2002,

''(C) $36,000,000 for each of fiscal years 2003 and 2004,

''(D) $34,000,000 for each of fiscal years 2005 and 2006,

''(E) $33,000,000 for each of fiscal years 2007, 2008, and 2009, and

''(F) $32,000,000 for fiscal year 2010.

''(2) USE OF FUNDS.—Any amounts transferred to the Combined Fund under paragraph (1) shall be available, without fiscal year limitation, to pay benefits under this subchapter.

''(3) TRANSFER.—The Secretary shall transfer amounts appropriated under paragraph (1) on October 1 of each fiscal year.''

SEC. 3. CLARIFICATION OF AUTHORITY TO ASSIGN ELIGIBLE BENEFICIARIES.

(a) IN GENERAL.—Section 9706(a) of the Internal Revenue Code of 1986 (relating to assignment of eligible beneficiaries) is amended by striking '', before October 1, 1993,''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the amendments made by section 19143 of the Coal Industry Retiree Health Benefit Act of 1992 (Public Law 102–486; 106 Stat. 3037), and no assignment made under section 9706(a) of the Internal Revenue Code of 1986 shall be invalidated because it was not made before October 1, 1993.

SEC. 4. CLARIFICATION OF AUTHORITY TO ASSIGN ELIGIBLE BENEFICIARIES TO SUCCESSORS OF SIGNATORY OPERATORS.

(a) IN GENERAL.—The last sentence of section 9701(c)(2)(A) of the Internal Revenue Code of 1986 (defining related persons) is amended to read as follows: ''A related person shall also include a successor in interest of any person described in clause (i), (ii), (iii), or a successor in interest of the signatory operator itself.''

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the amendments made by section 19143 of the Coal Industry Retiree Health Benefit Act of 1992 (Public Law 102–486; 106 Stat. 3037), except that such amendment shall not apply to any proceeding initiated before the date of enactment of this Act if the proceeding (and any appeal therefrom) is not pending on such date.

By Mr. REID (for himself, Mr. BENNETT, Mr. DASCHLE, Mr. KERRY, Mrs. MURRAY, Mr. BINGAMAN, Mr. KENNEDY, Mrs. BOXER, Mr. ABRAHAM, and Mr. GRAMS):

S. 2539. A bill to amend the National Defense Authorization Act for Fiscal

Year 1998 with respect to export controls on high performance computers; to the Committee on Banking, Housing, and Urban Affairs.

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 1998 AMENDMENTS

Mr. REID. Mr. President, I rise today to introduce a bipartisan bill that is critical to maintaining our nation's lead in the high-tech sector. In specific, this bill is crucial to the computer industry. This is an issue that I have been very interested in for quite some time, and in particular, have done a lot of work on this session.

I first want to talk a little bit about the U.S. computer industry. According to an article in Computers Today, dated July 19, 1998, American computer technology has led the world since the first commercial electronic computer was deployed at the University of Pennsylvania in 1946.

This industry is constantly changing with new companies and new products emerging every day. A statistic that I find fascinating is that more than 75 percent of the revenues of computer companies come from products that did not exist two years before. That statistic is from the CSPP Freedom to Grow.

Through research and development, another issue I strongly favor, the computer industry has been able to remain competitive for all of these years.

The challenge that we not face, and frankly a challenge that we haven't lived up to in the past as a Congress, is to allow our export control policies to change with the times, and not to overly restrict our nation's computer companies.

We need to stop trying to control technology that is readily available, as we are doing today. The technology that we are regulating is readily available from many foreign companies. Companies from countries like China and other Tier 3 countries.

I remember, not too long ago, I was able to secure funding for a Super-Computer for the University of Nevada, Las Vegas. That computer, which required its own room, is now about as powerful as a laptop computer. That is exactly the kind of computer that we are still regulating.

Computers that are now considered Super-Computers operate at more than one million MTOPS, or about 500 times the current level of regulation.

The bottom line is that by placing artificially low limits on the level of technology that can be exported, we may be denying market realities and could very quickly cripple America's global competitiveness for this vital industry. If Congress doesn't act quickly, we will substantially disadvantage American companies in an extremely competitive global market.

Mr. President. On February 1, 2000, at my urging, and the urging of others in this body, President Clinton proposed changes to the United States export controls on high-performance computers. Since that accouncement, the President's proposal has been floating around Congress for a mandated 180 days, or six month, review period. When the President made his proposal, the new levels would have been sufficient, however, we are still regulating under the old levels, and therfore hindering American companies from competing in Tier 3 countries with other foreign companies.

The bill that I am offering today simply reduces the congressional review period from 180 days to 30 days to complement the administration's easing of export restrictions, by amending the National Defense Authorization Act of 1998.

I appreciate the recent bipartisan support of this bill and I look forward to debating this bill on the Senate floor in the near future.

Mr. BENNETT. Mr. President, today Senator HARRY REID of Nevada and I are introducing bipartisan legislation with respect to the review period for the sale of high-performance computers. Both Senator REID and I were hoping this legislation would not be necessary. We had planned it as an amendment to the Export Administration Act, but that act, for a variety of reasons, has been stalled here on the floor, and the issue is so important that we don't want to let it die. We are introducing this legislation in order to keep the issue alive and, if necessary, to provide a vehicle for producing the review that we think is necessary.

Let me display a chart that demonstrates what is happening in the high-tech world of business computers. These are not the computers that we carry back and forth on the planes. You and I, as we fly back to our homes, have laptops and those laptops have amazing capabilities in them and represent the changes that are occurring in the computer world.

If I can be personal for just a moment, at one point in my career, I was the head of a company that was grandly called the American Computer Corporation. We produced, among other products, a computer that was about the size of a washing machine. We were very proud of it. It had 10 megabytes of hard disc memory in it, and it sold for about $35,000. It was literally built in a garage, and we sold every single one we could make.

Today, I have in my hand a computer that costs less than $500, which has far more power and capacity than that old machine we were so proud of, with its 10 megabytes of hard disc. The laptop I carry with me back and forth between here and Utah has more computing power in it today than the computers that controlled the space shuttle.

I have been down to Cape Canaveral to the Kennedy Space Center. I have seen the space shuttle. The space shuttle computers that control the flight of that at this time are very highly technical instruments and are built throughout the entire airplane. They take up so much room that they are part of the superstructure of the airplane itself. Today, there is more computing power in the laptop that I carry than there is in that whole airplane.

This is a manifestation of what the people in the computer world call Moore's law. Mr. Moore was one of the first CEOs of Intel. He propounded over 20 years ago Moore's law which says that every 18 months, the power of computers doubles for the same price; so that every 18 months, the computer that you had 18 months ago is now obsolete and the new one is twice as fast. Then, 18 months later the new one will be twice as fast as that one was. And 18 months later, the next new one will be twice as fast, and so on. Moore's law has held for over 20 years. Every 18 months the power of the computer doubles.

Moore's law doesn't hold anymore—not because the power of the computer is not doubling but because the power of the computer is doubling in less than 18 months. It is doubling faster than Moore projected in Moore's law.

This chart demonstrates what is happening in the world with what we call ''business computers.'' These are computers that are roughly the size of that old computer we produced that was the size of a washing machine, or a college refrigerator. Only now, these computers have the power and capacity that we used to think of in terms of the giant supercomputers that would fill this room.

Thereby hangs the issue that has caused me and Senator REID to join together and introduce this piece of legislation.

When supercomputers, the huge machines that could do an enormous amount of computation work, were first invented, it was a matter of national security that they be kept out of the hands of America's enemies. So it was established by legislation that there would be a limit on the size of computers that could be exported because we wanted to make sure the supercomputers stayed in American hands.

The limit that was placed on supercomputers was at the level of 8,000 MTOPS. I don't mean to be overly technical here, but we need to understand what we are talking about. MTOPS is an acronym for millions of theoretical operations per second.

How many theoretical operations or calculations can the computer perform in a second? How many millions can it perform in a second?

At the time this legislation was put in place, it said anything over 8 trillion theoretical operations per second constituted a supercomputer, and therefore it had to be protected from export. It had to be held in the United States, for national security purposes. We were the only country in the world that had a computer that could approach 8 trillion MTOPS, or millions of theoretical operations per second.

That was then. This is now.

I hold in my hand a device that is produced here in America by Intel that

contains eight chips. And therein lies the tale that I want to talk about today.

Just think of this. This, by the way, retails for about $900. It is part of the mother board of a traditional business computer today. The mother board is about 2 feet square. This fits on the mother board with all of the other chips that are in it. But this is the controller of all of that. And it has in it eight tiny chips.

Here is the marketplace for this kind of computer worldwide. We have the figures.

In 1997, worldwide, it is a little over 2 million.

You see in the blue down below is the market in the United States, and the green is overseas. You can see that the market overseas is bigger than the market in the United States.

The chart marches on with projections made by the Gartner Group out of Connecticut to the year 2002. We see, roughly speaking, that in that 5-year period—from 1997 to 2002—this market will quadruple. We are talking hundreds of billions of dollars per year of market.

I want that understood as the matrix of what we are talking about here.

This is the size of the market for a product of which this is the heart.

Now let's talk about it in terms of export control on MTOPS.

I hope we can tie all of these together. I realize this is a little technical. But understand when the legislation was passed, anything that had more than 8,000 MTOPS in it could not be exported, and therefore could not be sold in the green part of that bar.

Let's look at what is happening as Moore's law becomes obsolete as the power of computers increases more rapidly.

Here is a blowup of this device as it existed in 1999, less than 6 months ago.

A Pentium III chip carries with it 1,283 MTOPS. So if you had one of these with one Pentium III chip in it, you could export it. If you put two Pentium chips in it, you could export it because it doubles to 2,383. If you put four Pentium chips in it, doubling it again, you went to 4,584. But when you doubled that by putting eight chips in it, it cannot be exported now because it is over 8,000 MTOPS.

In 1999, this was a product that could be purchased in the United States by anybody, carried out the door, or installed, if you are buying it for your business, by the people who are providing for you. But it cannot be sold overseas without a review of the export license. Because we were so anxious to make sure that these computers didn't get into the wrong hands, the export license time for review of this was 180 days, or 6 months. That meant that an American manufacturer who took one of these processors from Intel, put eight chips in it, and put it in his computer, could sell it anywhere he wanted to in America but could not export it for 180 days.

What happened in that 180 days while he was waiting for export approval?

Let's look at where we are now in the year 2000.

In that 180-day period where you are waiting for export approval, the Itamium chip has been developed and come on the market. It has 6,131 MTOPS in one chip. If you are going to export this product, you can only have one chip in it. If you put two in it, you are immediately close to 12,000 MTOPS. If you put in four, you are at 23,000 MTOPS. And, if you put in the standard eight that this carries, you are at 47,000 MTOPS.

The administration has proposed raising the 8,000 MTOPS level to 25,000, which clearly doesn't do you any good. The technology is moving so rapidly that you can buy 25,000 just as quickly as you can buy 8,000.

This is where we are today.

If you had applied for an export license with Pentium chips last year and waited 67 months, by the time you got your 6-month approval, you would be facing this kind of competition, and no one would want your Pentium chip. They would want one with the Itamium chip. You say, all right. I will put up with the 6 months, and I will apply for this computer with eight Itamium 2000 chips.

What is ahead of you if you do that? Looking ahead to 2001 with the Itamium 2001 chip, this is what you are facing. That chip will do 9,198 MTOPS all by itself. Even one chip in this one makes it illegal to export without waiting 180 days for approval. Go to the normal eight chips, and you are at 70,000 MTOPS.

To those who say: Good heavens, we are exporting or allowing people to buy supercomputers that can do all of the command and control decisions for an entire defense system, we are in terrible trouble, we are giving away our secrets; I say in the Defense Department we still have supercomputers that are currently running at the rate of 2 million MTOPS. For those supercomputers, these things are child's play. By the time we get to 70,000 MTOPS in a computer of the kind in my hand, the supercomputers will have gone up from 2 million to as high as 30 million. That is the speed with which all of this is happening.

What are we proposing in this legislation? Simply this: We are saying approval can be granted within 30 days. We are taking it from 6 months down to 1.

Why do I pick 30 days, along with Senator REID? We look at the export controls—which, again, are there to protect America's secrets—and we find that 30 days is currently the timeframe for an F–16. If a foreign government wants to buy our most sophisticated aircraft, we take 30 days to determine whether or not that particular aircraft in the hands of that particular government produces some kind of threat to national security. Yet we will take 6 months to decide whether that government can buy a computer that is available in virtually every technology center anywhere in the United States. They can buy it in the United States, throw it on the airplane, and take it abroad themselves.

Somebody could say: Gee, that is illegal to take abroad. What kind of secrecy and control is it when one can buy it on the street in the United States, any citizen can buy it as easily as they could buy one of these, but for some reason we can't allow them to export it?

There is another factor to recognize. We are not operating in a vacuum. There are Japanese companies that can do this. There are French companies that can do this. There are German companies that can can do this. If we say American companies can't do this, we just guarantee the rest of the world will get this market. Remember those lines on that bar chart showing the foreign market is bigger than the American market? We are guaranteeing the rest of the world will take this market away from the United States as we sit here with our 180-day review period, saying in effect no American company can get into this business at all, because in that 180-day period everyone overseas will have bought foreign and not bought American.

It is vitally important that we recognize the reality of what is happening in the computer world, we bring the date necessary for review down to a reasonable period of time, and we say, if you want to buy one of these from Intel with eight Itanium 2001 chips in it, it will not take any more time for you to do that than it will take you to buy an F–16. That is the reasonable, intelligent thing to do. That is what the legislation of Senator REID and myself seeks to establish.

I hope it is not necessary for our bill ever to be considered or passed. I hope the export administration bill comes back on the floor and Senator REID and I can offer our bill as an amendment to that bill and see it adopted by the Senate and sent to the President as rapidly as possible. Just in case that does not happen, by introducing this bill on behalf of Senator REID and myself today, I am making clear we have a backup somewhere in the legislative channel to which we can turn to try to make it logical and possible for American computer manufacturers and American chip manufacturers to continue America's leadership in this market.

Make no mistake, we are talking hundreds of billions of dollars where America currently has the technological leadership in the world. That leadership is now threatened by Government regulations. It is imperative we change those regulations on the floor of the Senate, if possible, working with the administration.

By Mr. BROWNBACK (for himself, Mr. KERREY, and Mr. MURKOWSKI):

S. 2540. A bill to amend the Food Security Act of 1985 to require the Secretary of Agriculture to establish a carbon sequestration program to permit owners and operators of land to enroll the land in the program to increase the sequestration of carbon, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

DOMESTIC CARBON STORAGE INCENTIVE ACT OF 2000

Mr. BROWNBACK. Mr. President, I rise today to introduce a bill that I think is going to be a significant issue for U.S. agriculture and the environment both. It's the Domestic Carbon Storage Incentive Act of 2000. I am putting forward a concept that is being talked about more and more, a concept called carbon farming, where we encourage the agriculture industry to farm in such a way that the plant life pulls CO_2 out of the air, fixes carbon in the ground, releases oxygen in an ever-increasing amount. There are farming techniques that can fix or sequester more carbon in the ground. What we are doing with this bill is encouraging more of that carbon sequestration, pulling more of the CO_2 out of the air thus reducing some of the greenhouse gases that are in the air, whether they are there by natural or man-made sources. It is a win for the environment and it is a win for agriculture, I think it is a very positive thing we can do in encouraging good agricultural stewardship and good environmentalism.

With this bill we are providing financial incentives to landowners who increase conservation practices which, as I describe, help pull carbon dioxide out of the atmosphere and store it as carbon in the soil. This bill seeks to encourage the positive contributions to the environment made by the agriculture industry. I am joined in this bill by my friend, Senator KERREY of Nebraska and Senator MURKOWSKI of Alaska along with a number of others.

For some time now I have been looking at a way for a way to approach environmental issues from an incentive-based proactive stance. I think it is important we break away from the regulatory model we have been in on the environment. We have basically said all sticks on this: If you do this we are going to do this to you on environmental rules and issues. It has all been a regulatory approach. I think it is important we engage the markets and create an incentive approach, and that is what this bill does. I believe we are on the verge of seeing agriculture come into a whole new market with this type of approach, an environmental market where producers will benefit rather than be burdened by environmental concerns.

U.S. agriculture has long been appreciated for its ability to feed the world. As any good farmer knows, in order to grow good crops you must take care of the land, be a steward of the land. Farmers take this role very seriously. My family farms. My dad and my brother are both full-time farmers. But sometimes markets and economic stress make conservation very difficult to pursue. This bill would help offset some of the costs to expand conservation practices.

It is this sort of eco-agriculture that we should encourage and enhance to deal with environmental concerns, rather than resorting to governmental regulations and mandates to solve our problems. Farmers want to do the right thing. They have more reason than anybody else to preserve and protect the land, the land and the water and the air—but Government and markets do not always make that job very easy.

I applaud my colleague, Senator ROBERTS, for all the work he has done in this area. His bill that he has to enhance carbon sequestration research has called needed attention to a very important area, the research work that we need to do about what practices fix the most carbon into the ground and what ones are the most helpful to the atmosphere. These two approaches, working together, the research on how we can do it better and more of it, along with more incentives to put that research into practice, I think are a good tandem.

Why do we do this? Carbon dioxide is a greenhouse gas believed to contribute to global warming. While there is debate over the role which human activity plays in speeding up the warming process, there is broad consensus that there are increased carbon levels in the atmosphere today. Until now, the only real approach seriously considered to address climate change was an international treaty which calls for emission limits on carbon dioxide, which would mean limiting the amount that comes from your car, your business and your farm.

The Kyoto treaty also favored exempting developing nations from emissions limits, putting the U.S. economy at a distinct disadvantage. Approaching the issue of climate change in this fashion would be very costly and would not respond to the global nature of this problem because they are exempting several countries already.

Instead, the approach I am putting forward encourages offsetting greenhouse gases through improved land management and conservation. As a result, these practices will also lead to better water quality, less runoff pollution, better wildlife habitat, and an additional revenue source for farmers. It truly is one of those win-win propositions for the environment and for agriculture.

Specifically, my bill will allow landowners to submit plans detailing practices they would be willing to undertake to store additional carbon in the soil. These plans would then compete for entrance into the program, with the best plans achieving funding. Verification of this program would be similar to current conservation programs, such as the Environmental Quality Incentives Program where farmers need only comply with the practices they set forth in the contract. The program is limited to 5 million acres and is not a setaside. Rather, this bill encourages conservation practices such as no-till farming, buffer strips, and biomass production, to name a few, which are known to enhance the soil's ability to store carbon.

Under this program, contracts will be for a minimum of 10 years and USDA will be required, in conjunction with other agencies and land grant universities, to finalize criteria for measuring the carbon-storing ability of various conservation practices. This objective will be greatly enhanced by the organizations such as Kansas State University in my home State, which have conducted significant research already on ways that various carbon-storing practices occur in agriculture.

Agriculture can play a substantial role in protecting the environment if we put these incentives forward. One might ask, is there benefit to carbon storage? Are we talking about significant numbers? Listen to some of these numbers. The total carbon sequestration and fossil fuel offset potential of U.S. croplands is currently estimated at 154 million metric tons of carbon per year, or 133 percent of the total greenhouse gas emissions by all these activities. In other words, even current agricultural croplands have the ability to store carbon in the soil. Imagine how much more this process can be enhanced if a focused effort is made.

Early estimates indicate that the potential for a carbon market for U.S. agriculture could reach $5 billion per year for the next 30 to 40 years. Carbon markets are already emerging in the private sector with farmers selling their carbon-storing practices to utilities. There is a Consortium for Agriculture Soils Mitigation of Greenhouse Gases that is marketing this already.

Farmers are already beginning to look toward carbon sequestration or carbon farming practices as a potential new market. Between 1998 and 1999, Iowa farmers grew and harvested 4,000 tons of switchgrass for use by a utility. These farmers not only benefit from the sale of the biomass commodity itself but are able to sell the additional benefit they are providing in growing the switchgrass, which is carbon sequestration. This bill will allow all farmers to progress toward verification

and potential sale of carbon benefits to third parties.

The estimated amount of carbon stored in world soils is more than twice the carbon living in vegetation or in the atmosphere. Approximately 50 percent of the soil organic carbon has been lost from the soil over a period of 50 to 100 years of cultivation. This loss represents the potential for storage of carbon in the soil.

In the tall grass prairie located in Kansas, Kansas State University researchers have demonstrated an increase of approximately 2 tons of carbon per acre through increased conservation practices—2 tons additional carbon pulled out of the air and put into the ground per acre. That demonstrates the potential in rangeland soils, and there are already a number of agricultural practices which enhance carbon sequestration.

Obviously, carbon sequestration has a lot to offer as an environmental and agricultural policy. It is something that can provide a win-win situation for the environment and agriculture as we look forward to an era of another income source and a good way the environment and agriculture can work together.

Mr. President, I introduce the bill on behalf of myself, Mr. KERREY, Mr. MURKOWSKI, and a number of other cosponsors.

● Mr. KERREY. Mr. President, today I am introducing the Domestic Carbon Storage Incentive Act of 2000 with Senators BROWNBACK and MURKOWSKI. Agriculture must play a major role in any climate change plan, since it is an important part of both the cause and the solution. While the facts about global warming are not all clear, what is clear is that global warming is occurring. What is also clear is that human activities are emitting increasingly large volumes of greenhouse gases, and that these gases are influencing global warming.

Carbon sequestration, that is pulling carbon from the air into the soil, is an important part of fighting global warming, and agriculture is one of the largest and most economical carbon ''sinks.'' Farmers and ranchers can store additional carbon in the soil fairly easily, using best management practices such as no-till farming, increased production of high carbon-storing crops, and increased use of winter cover crops. Storing carbon in the soil is not only good for the environment, it is also advantageous for soil quality and agriculture production. I am pleased that farmers and ranchers are beginning to realize that carbon sequestration is a win-win situation. Agriculture is sometimes hesitant to adopt change, however, and it is important to provide producers with the opportunity to fully utilize carbon-storing techniques.

This bill will give agriculture producers added financial incentive to adopt these best management practices. Unlike CRP, the land will not be a set-aside, but rather these practices will be used on land in production. This program will be completely voluntary, with farmers competing for entrance into the program by proposing specific plans to store more carbon in their land. The best plans will be awarded ten-year contracts with payments no greater than twenty dollars per acre each year.

Some farmers have expressed concern about using these carbon-storing techniques on their land, however, because current studies only involve small experimental plots. This legislation will implement carbon sequestration practices on whole farms, both to gather more data on beneficial techniques and to set examples for other farmers to follow.

While measuring carbon storage is a difficult task, the most direct means of determining soil carbon sequestration is to measure, over time, sequential changes in the soil. At a recent Senate Agriculture Subcommittee hearing, several scientists and policy-makers advocated a greater need for more research and more data. This program will provide actual data from different soil types across the nation, furthering our collective knowledge of causes and solutions to global warming.

The Domestic Carbon Storage Incentive Act is an important step in moving agriculture's role in fighting climate change forward. Carbon sequestration will benefit everyone: farmers, ranchers, the environment, and society. This bill will serve a public good, valued far above the cost of the program. Congress has the opportunity to take action to combat global warming, and I hope that the Senate can begin to achieve this goal by acting on this sound legislation.●

By Mr. DASCHLE (for himself, Mr. MOYNIHAN, Mr. KENNEDY, Mr. AKAKA, Mr. BAUCUS, Mr. BIDEN, Mr. BINGAMAN, Mrs. BOXER, Mr. BRYAN, Mr. BYRD, Mr. CLELAND, Mr. DODD, Mr. DORGAN, Mr. DURBIN, Mrs. FEINSTEIN, Mr. GRAHAM, Mr. HARKIN, Mr. HOLLINGS, Mr. INOUYE, Mr. JOHNSON, Mr. KERRY, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mrs. LINCOLN, Ms. MIKULSKI, Mrs. MURRAY, Mr. REED, Mr. REID, Mr. ROBB, Mr. ROCKEFELLER, Mr. SARBANES, Mr. SCHUMER, and Mr. WELLSTONE):

S. 2541. A bill to amend title XVIII of the Social Security Act to provide a prescription drug benefit for the aged and disabled under the Medicare Program, to enhance the preventative benefits covered under such program, and for other purposes; to the Committee on Finance.

MEDICARE EXPANSION FOR NEEDED DRUGS (MEND) ACT OF 2000

Mr. DASCHLE. Mr. President, today I am pleased to join with 34 of our Senate Democratic colleagues in introducing the Medicare Expansion for Needed Drugs Act, a bill to mend Medicare by adding a long overdue prescription drug benefit.

I want to begin by thanking all the people who have brought us to this point.

Senator DORGAN and many of our other colleagues have held numerous hearings in Washington, and around the country on the issue of Medicare prescription drug coverage. I thank my colleagues and all who came to the hearings.

I know that they heard from people at those hearings they would not have otherwise heard from. The testimony they heard was virtually unanimous at each of these hearings, that Medicare must now, this year, be expanded to include necessary coverage.

I also thank all of the seniors, pharmacists, doctors, and others who took the time to educate us on this important matter. Their wisdom has made this a better bill.

In addition, I thank the President—for keeping the issue of Medicare prescription drugs on the national agenda, and for providing the framework for our proposal.

I thank the many organizations representing seniors and consumers who told us about the terrible strain paying for prescription drugs places on seniors and their families.

Most of all, I thank the many seniors from all across America who told us about their struggles to pay for prescription drugs.

I want to share with you one example from my State.

Fran Novotny is a 70-year-old retired nurse from Hill City, SD. She takes prescription medications every day to control diabetes, hypertension, and asthma. She has also had bypass surgery.

Every month, she gets a Social Security check for $616.

Every month, she spends about $550 on prescriptions.

She has a small pension, but it doesn't add up to much. So she is quickly depleting her entire life savings. After it is gone, she has no idea how she will pay for her medications.

Her story, and many others like it, are the reason we must move forward and enact a Medicare prescription drug benefit this year. We must make sure that Fran Novotny—and the millions of seniors like her—can afford their prescriptions—and their grocery bills and their rent and their clothing and their utility bills.

The average Medicare beneficiary fills 18 prescriptions a year.

Yet three-in-five Medicare beneficiaries lack decent, dependable coverage for prescription drugs. And more than one-third of all Medicare beneficiaries—more than 15 million seniors—have no prescription drug coverage at all.

This is not a problem faced only by the poorest beneficiaries. More than half of all Medicare beneficiaries without coverage have incomes above 150 percent of poverty,

That is why two-thirds of the Democratic caucus has joined in introducing this bill to make prescription drug coverage available and affordable to all Medicare beneficiaries.

Our plan is universal.

Every single Medicare beneficiary who wants the coverage has it under this bill.

Second, our plan is voluntary.

It is not a requirement that you sign up for this legislation. If you have a good plan, use it. If you have a good company, stay with it. If you have a plan that works for you, for whatever reason, this plan encourages you to stay right where you are. But if you do not have coverage, if you need coverage and cannot get it anywhere else, this bill will make it available to you for the first time.

Every Medicare beneficiary can choose to participate, whether he or she is in traditional, fee-for-service Medicare or a Medicare Plus Choice plan. Retirees who already have private prescription drug coverage can keep it. It is up to them.

We also provide incentives to employers to provide and maintain drug coverage. We do not want to see the people who are now providing it to their employees or retirees dropping these people once this plan becomes available, so we have encouraged, we have incentivized businesses to do that.

Our plan provides meaningful coverage.

Medicare would cover half of beneficiaries' discounted prescription drug bills, up to $5,000 a year. That means that Fran Novotny—who spends $550 a month on prescription drugs—would be able to save at least $275 a month. That $275 a month will make a real difference in her life.

Our plan also provides catastrophic coverage for people who need to take very expensive drugs that can cost $5,000, or $10,000 a year, or more. It is our hope that after a Medicare beneficiary has paid the first $3,000 or $4,000 in catastrophic care costs, Medicare would pick up the balance.

Our program is also affordable.

Beneficiaries would pay premiums to cover about half the cost of the program. Medicare would contribute the other half.

Seniors with incomes between 135 percent and 150 percent of poverty would receive assistance with their premiums. Those with incomes below 135 percent of poverty would receive assistance with premiums and copays.

Our plan would give seniors bargaining power that they just don't have today.

The problem today isn't just that seniors end up paying out-of-pocket expenses for their prescriptions, they also pay a lot more for those out-of-pocket costs. On average, seniors pay twice as much for their medications as big insurance companies and HMOs do today.

The fact that seniors face the highest prices at the drugstore is, frankly, wrong. Our plan gives seniors the bargaining power that comes with numbers.

Another thing our plan does—which is very important to many of us in rural areas—is to include special protections to make sure that Medicare beneficiaries who live in rural communities have the same affordable, timely access to prescription drugs as everyone else.

It gives the Secretary of Health and Human Services the authority to offer pharmacists incentives to cover rural communities and other hard-to-serve areas. Every American should be able to get affordable prescription drugs—when they need them—whether they live in a big city or a small town.

Our plan mirrors the best practices used in the private sector.

For beneficiaries in traditional Medicare, prescription drug coverage would be delivered by private entities that negotiate prices with drug manufacturers. This is the same mechanism used by private insurers.

Beneficiaries in Medicare Plus Choice plans would get their prescription drug coverage through their Plus Choice plan.

Finally, the bill recognizes that we need to shift the focus of Medicare from simply treating illness, to keeping beneficiaries well.

While prescription drug coverage is an important first step in this effort, there are likely other changes we should make. So this bill sets up a process for Congress to consider further benefit changes—to enhance prevention—on an expedited basis. I want to thank Senator GRAHAM for his leadership on this important issue.

On the issue of broader Medicare reform, I would like to see prescription drugs pass as part of a larger package of reforms and modernizations, and I believe this bill and its benefit is consistent with such efforts.

I'm also pleased to report that our bill is supported by an array of important groups: The National Council of Senior Citizens; the Committee to Preserve Social Security and Medicare; National Council on the Aging; the Older Women's League; the AFL–CIO; The National Community Pharmacists Association; Families USA; Consumers Union; the Leadership Council of Aging Organizations; the Association for Homes and Services for the Aging; the National Association of Area Agencies on Aging; and AARP.

We hope we will have support from our Republican colleagues, too.

Prescription drug coverage for all seniors is an issue on which we cannot afford to procrastinate. The cost of delay is too great—in lost opportunities, lost health, and lost lives.

In 1965, when Medicare was created, it didn't include prescription drug coverage. Neither did most private insurance plans. Today, virtually all private health plans offer some sort of prescription drug coverage—but not Medicare.

It is time—it is past time—to close this gap. Prescription drugs are an integral part of medicine today. They ought to be an integral part of Medicare. Period.

Now—before the Baby Boomers retire, and the problems are still manageable—is the time to strengthen Medicare. Now, while our economy is strong, and we have a surplus, is the time to add a universal, voluntary, and affordable prescription drug benefit to Medicare.

Mr. President, I ask unanimous consent that at this point the text of the bill be printed in the RECORD.

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

S. 2541

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Expansion for Needed Drugs (MEND) Act of 2000''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
TITLE I—PRESCRIPTION DRUG BENEFIT PROGRAM
Sec. 101. Prescription drug benefit program.
''PART D—PRESCRIPTION DRUG BENEFIT FOR THE AGED AND DISABLED
''Sec. 1860. Establishment of prescription drug benefit program for the aged and disabled.
''Sec. 1860A. Scope of benefits.
''Sec. 1860B. Payment of benefits; benefit limits.
''Sec. 1860C. Eligibility and enrollment.
''Sec. 1860D. Premiums.
''Sec. 1860F. Prescription Drug Insurance Account.
''Sec. 1860G. Administration of benefits.
''Sec. 1860H. Employer incentive program for employment-based retiree drug coverage.
''Sec. 1860I. Appropriations to cover Government contributions.
''Sec. 1860J. Prescription drug defined.''.
Sec. 102. Medicaid buy-in of medicare prescription drug coverage for certain low-income individuals.
''Sec. 1860E. Special eligibility, enrollment, and copayment rules for low-income individuals.''.
Sec. 103. Catastrophic prescription drug coverage benefit.
Sec. 104. Comprehensive immunosuppressive drug coverage for transplant patients.
Sec. 105. GAO study and biennial reports on competition and savings.
Sec. 106. MedPAC study and annual reports on the pharmaceutical market, pharmacies, and beneficiary access.
TITLE II—ENHANCED MEDICARE PREVENTION PROGRAM
Sec. 201. MedPAC biennial report.
Sec. 202. National Institute on Aging study and report.
Sec. 203. Institute of Medicine 5-year medicare prevention benefit study and report.
Sec. 204. Fast-track consideration of prevention benefit legislation.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Prescription drug coverage was not a standard part of health insurance when the medicare program under title XVIII of the

Social Security Act was enacted in 1965. Since 1965, however, drug coverage has become a key component of most private and public health insurance coverage, except for the medicare program.

(2) At least ⅔ of medicare beneficiaries have unreliable, inadequate, or no drug coverage at all.

(3) Seniors who do not have drug coverage typically pay, at a minimum, 15 percent more than people with coverage.

(4) Medicare beneficiaries at all income levels lack prescription drug coverage, with more than ½ of such beneficiaries having incomes greater than 150 percent of the poverty line.

(5) The number of private firms offering retiree health coverage is declining.

(6) Medigap premiums for drugs are too expensive for most beneficiaries and are highest for older senior citizens, who need prescription drug coverage the most and typically have the lowest incomes.

(7) The management of a medicare prescription drug benefit should mirror the practices employed by private entities in delivering prescription drugs. Discounts should be achieved through competition.

(8) All medicare beneficiaries should have access to a voluntary, reliable, affordable outpatient drug benefit as part of the medicare program that assists with the high cost of prescription drugs and protects them against excessive out-of-pocket costs.

(9) The addition of a medicare drug benefit should be consistent with an overall plan to strengthen and modernize the medicare program.

TITLE I—PRESCRIPTION DRUG BENEFIT PROGRAM

SEC. 101. PRESCRIPTION DRUG BENEFIT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—PRESCRIPTION DRUG BENEFIT FOR THE AGED AND DISABLED

''ESTABLISHMENT OF PRESCRIPTION DRUG BENEFIT PROGRAM FOR THE AGED AND DISABLED

''SEC. 1860. (a) IN GENERAL.—There is established a voluntary insurance program to provide prescription drug benefits in accordance with the provisions of this part for individuals who are aged or disabled or have end-stage renal disease and who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

''(b) NONINTERFERENCE.—In administering the prescription drug benefit program established under this part, the Secretary may not—

''(1) require a particular formulary or institute a price structure for benefits;

''(2) interfere in any way with negotiations between private entities and drug manufacturers, or wholesalers; or

''(3) otherwise interfere with the competitive nature of providing a prescription drug benefit through private entities.

''SCOPE OF BENEFITS

''SEC. 1860A. (a) IN GENERAL.—The benefits provided to an individual enrolled in the insurance program under this part shall consist of—

''(1) payments made, in accordance with the provisions of this part, for covered prescription drugs (as specified in subsection (b)) dispensed by any pharmacy participating in the program under this part (and, in circumstances designated by the private entity, by a nonparticipating pharmacy), including any specifically named drug prescribed for the individual by a qualified health care professional regardless of whether the drug is included in a formulary established by the private entity if such drug is certified as medically necessary by such health care professional, up to the benefit limits specified in section 1860B; and

''(2) charging by pharmacies of the negotiated price—

''(A) for all covered prescription drugs, without regard to such benefit limit; and

''(B) established with respect to any drugs or classes of drugs described in subparagraphs (A) through (D) or (F) of section 1927(d)(2) that are available to individuals receiving benefits under this title.

''(b) COVERED PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—Covered prescription drugs, for purposes of this part, include all prescription drugs (as defined in section 1860J(1)), including smoking cessation agents, except as otherwise provided in this subsection.

''(2) EXCLUSIONS FROM COVERAGE.—Covered prescription drugs shall not include drugs or classes of drugs described in subparagraphs (A) through (D) and (F) through (H) of section 1927(d)(2) unless—

''(A) specifically provided otherwise by the Secretary with respect to a drug in any of such classes; or

''(B) a drug in any of such classes is certified to be medically necessary by a health care professional.

''(3) EXCLUSION OF PRESCRIPTION DRUGS TO THE EXTENT COVERED UNDER PART A OR B.—A drug prescribed for an individual that would otherwise be a covered prescription drug under this part shall not be so considered to the extent that payment for such drug is available under part A or B, including all injectable drugs and biologicals for which payment was made or should have been made by a carrier under section 1861(s)(2) (A) or (B) as of the date of enactment of the Medicare Expansion for Needed Drugs (MEND) Act of 2000. Drugs otherwise covered under part A or B shall be covered under this part to the extent that benefits under part A or B are exhausted.

''PAYMENT OF BENEFITS; BENEFIT LIMITS

''SEC. 1860B. (a) PAYMENT OF BENEFITS.—There shall be paid from the Prescription Drug Insurance Account within the Supplementary Medical Insurance Trust Fund, in the case of each individual who is enrolled in the insurance program under this part and who purchases covered prescription drugs in a calendar year, an amount, not to exceed 50 percent of the applicable limit under subsection (b), equal to 50 percent of the negotiated price for each such covered prescription drug or such higher percentage as is proposed by a private entity pursuant to section 1860G(d)(7), if the Secretary finds that such percentage will not increase aggregate costs to the Prescription Drug Insurance Account.

''(b) BENEFIT LIMITS.—

''(1) CALENDAR YEARS 2002 THROUGH 2009.—For purposes of subsection (a), the limit under this subsection is—

''(A) for each of calendar years 2002, 2003, and 2004, $2,000;

''(B) for each of calendar years 2005, 2006, and 2007, $3,000;

''(C) for calendar year 2008, $4,000; and

''(D) for calendar year 2009, $5,000.

''(2) CALENDAR YEAR 2010 AND SUBSEQUENT YEARS.—For purposes of subsection (a), the limit under this subsection for calendar year 2010 and each subsequent calendar year is equal to the greater of—

''(A) the limit for the preceding year adjusted by the percentage change in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the preceding year; or

''(B) the limit for the preceding year.

''ELIGIBILITY AND ENROLLMENT

''SEC. 1860C. (a) ELIGIBILITY.—Every individual who, in or after 2002, is entitled to hospital insurance benefits under part A or enrolled in the medical insurance program under part B is eligible to enroll, in accordance with the provisions of this section, in the insurance program under this part, during an enrollment period prescribed in or under this section, in such manner and form as may be prescribed by regulations.

''(b) ENROLLMENT.—

''(1) IN GENERAL.—Each individual who satisfies subsection (a) shall be enrolled (or eligible to enroll) in the program under this part in accordance with the provisions of section 1837, as if that section applied to this part, except as otherwise explicitly provided in this part.

''(2) SINGLE ENROLLMENT PERIOD.—Except as provided in section 1837(i) (as such section applies to this part), 1860E, or 1860H, or as otherwise explicitly provided, no individual shall be entitled to enroll in the program under this part at any time after the initial enrollment period.

''(3) SPECIAL ENROLLMENT PERIOD FOR 2002.—

''(A) IN GENERAL.—An individual who first satisfies subsection (a) in 2002 may, at any time on or before December 31, 2002—

''(i) enroll in the program under this part; and

''(ii) enroll or reenroll in such program after having previously declined or terminated enrollment in such program.

''(B) EFFECTIVE DATE OF COVERAGE.—An individual who enrolls under the program under this part pursuant to subparagraph (A) shall be entitled to benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as otherwise provided in this part, an individual's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—In addition to the causes of termination specified in section 1838, an individual's coverage under this part shall be terminated when the individual retains coverage under neither the program under part A nor the program under part B, effective on the effective date of termination of coverage under part A or (if later) under part B.

''PREMIUMS

''SEC. 1860D. (a) ANNUAL ESTABLISHMENT OF MONTHLY PREMIUM RATES.—

''(1) IN GENERAL.—The Secretary shall, during September of 2001 and of each succeeding year, determine and promulgate a monthly premium rate for the succeeding year in accordance with the provisions of this subsection.

''(2) ACTUARIAL DETERMINATIONS.—

''(A) DETERMINATION OF ANNUAL BENEFIT COSTS.—The Secretary shall estimate annually for the succeeding year the amount equal to the total of the benefits that will be payable from the Prescription Drug Insurance Account for prescription drugs dispensed in such calendar year with respect to enrollees in the program under this part. In calculating such amount, the Secretary shall include an appropriate amount for a contingency margin.

''(B) DETERMINATION OF MONTHLY PREMIUM RATES.—

''(i) IN GENERAL.—The Secretary shall determine the monthly premium rate with respect to such enrollees for such succeeding year, which shall be 1/12 of the share specified in clause (ii) of the amount determined under subparagraph (A), divided by the total number of such enrollees, and rounded (if such rate is not a multiple of 10 cents) to the nearest multiple of 10 cents.

''(ii) ENROLLEE AND EMPLOYER PERCENTAGE SHARES.—The share specified in this clause, for purposes of clause (i), shall be—

''(I) one-half, in the case of premiums paid by an individual enrolled in the program under this part; and

''(II) two-thirds, in the case of premiums paid for such an individual by a former employer (as defined in section 1860H(f)(2)).

''(3) PUBLICATION OF ASSUMPTIONS.—The Secretary shall publish, together with the promulgation of the monthly premium rates for the succeeding year, a statement setting forth the actuarial assumptions and bases employed in arriving at the amounts and rates determined under paragraphs (1) and (2).

''(b) PAYMENT OF PREMIUMS.—

''(1) PAYMENTS BY DEDUCTION FROM SOCIAL SECURITY, RAILROAD RETIREMENT BENEFITS, OR BENEFITS ADMINISTERED BY OPM.—

''(A) DEDUCTION FROM BENEFITS.—In the case of an individual who is entitled to or receiving benefits as described in subsection (a), (b), or (d) of section 1840, premiums payable under this part shall be collected by deduction from such benefits at the same time and in the same manner as premiums payable under part B are collected pursuant to section 1840.

''(B) TRANSFERS TO PRESCRIPTION DRUG INSURANCE ACCOUNT.—The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer premiums collected pursuant to subparagraph (A) to the Prescription Drug Insurance Account from the appropriate funds and accounts described in subsections (a)(2), (b)(2), and (d)(2) of section 1840, on the basis of the certifications described in such subsections. The amounts of such transfers shall be appropriately adjusted to the extent that prior transfers were too great or too small.

''(2) DIRECT PAYMENTS TO SECRETARY.—

''(A) ADDITIONAL PAYMENT BY ENROLLEE.—An individual to whom paragraph (1) applies (other than an individual receiving benefits as described in section 1840(d)) and who estimates that the amount that will be available for deduction under such paragraph for any premium payment period will be less than the amount of the monthly premiums for such period may (under regulations) pay to the Secretary the estimated balance, or such greater portion of the monthly premium as the individual chooses.

''(B) PAYMENTS BY OTHER ENROLLEES.—An individual enrolled in the insurance program under this part with respect to whom none of the preceding provisions of this subsection applies (or to whom section 1840(c) applies) shall pay premiums to the Secretary at such times and in such manner as the Secretary shall by regulations prescribe.

''(C) DEPOSIT OF PREMIUMS.—Amounts paid to the Secretary under this paragraph shall be deposited in the Treasury to the credit of the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund.

''(c) CERTAIN LOW-INCOME INDIVIDUALS.—For rules concerning premiums for certain low-income individuals, see section 1860E.

''PRESCRIPTION DRUG INSURANCE ACCOUNT

''SEC. 1860F. (a) ESTABLISHMENT.—There is created within the Federal Supplemental Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Insurance Account' (in this section referred to as the 'Account').

''(b) AMOUNTS IN ACCOUNT.—

''(1) IN GENERAL.—The Account shall consist of—

''(A) such amounts as may be deposited in, or appropriated to, such fund as provided in this part; and

''(B) such gifts and bequests as may be made as provided in section 201(i)(1).

''(2) SEPARATION OF FUNDS.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplemental Medical Insurance Trust Fund.

''(c) PAYMENTS FROM ACCOUNT.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g).

''ADMINISTRATION OF BENEFITS

''SEC. 1860G. (a) IN GENERAL.—The Secretary shall provide for administration of the benefits under this part through a contract with a private entity designated in accordance with subsection (c), for enrolled individuals residing in each service area designated pursuant to subsection (b) (other than such individuals enrolled in a Medicare+Choice program under part C), in accordance with the provisions of this section.

''(b) DESIGNATION OF SERVICE AREAS.—

''(1) IN GENERAL.—The Secretary shall divide the total geographic area served by the programs under this title into at least 15 service areas for purposes of administration of benefits under this part.

''(2) CONSIDERATIONS.—In determining or adjusting the number and boundaries of service areas under this subsection, the Secretary shall seek to ensure that—

''(A) there is a reasonable level of competition among entities eligible to contract to administer the benefit program under this section for each area;

''(B) the designation of areas is consistent with the goal of securing contracts under this section with respect to the maximum feasible number of areas so designated; and

''(C) the designation of areas will foster the existence of a sufficient number of entities that are eligible and willing to administer the benefits under this part.

''(c) DESIGNATION OF PRIVATE ENTITY.—

''(1) AWARD AND DURATION OF CONTRACT.—

''(A) COMPETITIVE AWARD.—Each contract for a service area shall be awarded competitively in accordance with section 5 of title 41, United States Code, for a period (subject to subparagraph (B)) of not less than 2 nor more than 5 years.

''(B) REVIEW.—A contract for a service area shall be subject to an evaluation after 2 years.

''(2) ELIGIBLE PRIVATE ENTITIES.—A private entity eligible for consideration as a private entity responsible for administering the prescription drug benefit program under this part in a service area shall meet at least the following criteria:

''(A) TYPE.—The private entity shall be capable of administering a prescription drug benefit program, and may be a prescription drug vendor, wholesale and retail pharmacist delivery system, health care provider or insurer, any other type of entity as the Secretary may specify, or a consortium of such entities.

''(B) PERFORMANCE CAPABILITY.—The entity shall have sufficient expertise, personnel, and resources to perform effectively the benefit administration functions for such area.

''(C) FINANCIAL INTEGRITY.—The entity and its officers, directors, agents, and managing employees shall have a satisfactory record of professional competence and professional and financial integrity, and the entity shall have adequate financial resources to perform services under the contract without risk of insolvency.

''(3) PROPOSAL REQUIREMENTS.—

''(A) IN GENERAL.—An entity's proposal for award or renewal of a contract under this section shall include such material and information as the Secretary may require.

''(B) SPECIFIC INFORMATION.—A proposal described in subparagraph (A) shall include a detailed description of—

''(i) the schedule of negotiated prices that will be charged to enrollees;

''(ii) how the entity will deter medical errors that are related to prescription drugs; and

''(iii) proposed contracts with local pharmacy providers designed to ensure access, including compensation for local pharmacists' services.

''(4) EXCEPTIONS TO CONFLICT OF INTEREST RULES.—In awarding contracts under this subsection, the Secretary may waive conflict of interest rules generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(A) is not inconsistent with the purposes of the programs under this title and the best interests of enrolled individuals; and

''(B) will permit a sufficient level of competition for such contracts, promote efficiency of benefits administration, or otherwise serve the objectives of the program under this part.

''(5) MAXIMIZING COMPETITION.—In awarding contracts under this section, the Secretary shall give consideration to the need to maintain sufficient numbers of entities eligible and willing to administer benefits under this part to ensure vigorous competition for such contracts.

''(d) FUNCTIONS OF PRIVATE ENTITY.—The private entity for a service area shall (or in the case of the function described in paragraph (7), may) perform the following functions:

''(1) PARTICIPATION AGREEMENTS, PRICES, AND FEES.—

''(A) PRIVATELY NEGOTIATED PRICES.—Each private entity shall establish, through negotiations with drug manufacturers and wholesalers and pharmacies, a schedule of prices for covered prescription drugs.

''(B) AGREEMENTS WITH PHARMACIES.—Each private entity shall enter into participation agreements under subsection (e) with pharmacies, that include terms that—

''(i) secure the participation of sufficient numbers of pharmacies to ensure convenient access (including adequate emergency access); and

''(ii) permit the participation of any pharmacy in the service area that meets the participation requirements described in subsection (e).

''(C) LISTS OF PRICES AND PARTICIPATING PHARMACIES.—Each private entity shall ensure that the negotiated prices established under subparagraph (A) and the list of pharmacies with agreements under subsection (e) are regularly updated and readily available in the service area to health care professionals authorized to prescribe drugs, participating pharmacies, and enrolled individuals.

''(2) PAYMENT AND COORDINATION OF BENEFITS.—

''(A) PAYMENT.—Each private entity shall—

''(i) administer claims for payment of benefits under this part;

''(ii) determine amounts of benefit payments to be made; and

''(iii) receive, disburse, and account for funds used in making such payments, including through the activities specified in the provisions of this paragraph.

''(B) COORDINATION.—Each private entity shall coordinate with the Secretary, other private entities, pharmacies, and other relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals, including coordination of access to and payment for covered prescription drugs according to an individual's in-service area plan provisions, when such individual is traveling outside the home service area, and under such other circumstances as the Secretary may specify.

''(C) EXPLANATION OF BENEFITS.—Each private entity shall furnish to enrolled individuals an explanation of benefits in accordance with section 1806(a), and a notice of the balance of benefits remaining for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(3) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE.—Each private entity shall have in place effective cost and utilization management, quality assurance measures, and systems to reduce medical errors, including at least the following, together with such additional measures as the Secretary may specify:

''(A) DRUG UTILIZATION REVIEW.—A drug utilization review program conforming to the standards provided in section 1927(g)(2) (with such modifications as the Secretary finds appropriate).

''(B) FRAUD AND ABUSE CONTROL.—Activities to control fraud, abuse, and waste.

''(4) EDUCATION AND INFORMATION ACTIVITIES.—Each private entity shall have in place mechanisms for disseminating educational and informational materials to enrolled individuals and health care providers designed to encourage effective and cost-effective use of prescription drug benefits and to ensure that enrolled individuals understand their rights and obligations under the program.

''(5) BENEFICIARY PROTECTIONS.—

''(A) CONFIDENTIALITY OF HEALTH INFORMATION.—Each private entity shall have in effect systems to safeguard the confidentiality of health care information on enrolled individuals, which comply with section 1106 and with section 552a of title 5, United States Code, and meet such additional standards as the Secretary may prescribe.

''(B) GRIEVANCE AND APPEAL PROCEDURES.—Each private entity have in place such procedures as the Secretary may specify for hearing and resolving grievances and appeals brought by enrolled individuals against the private entity or a pharmacy concerning benefits under this part, which shall, to the extent the Secretary finds necessary and appropriate, include procedures equivalent to those specified in subsections (f) and (g) of section 1852.

''(6) RECORDS, REPORTS, AND AUDITS OF PRIVATE ENTITIES.—

''(A) RECORDS AND AUDITS.—Each private entity shall maintain adequate records, and afford the Secretary access to such records (including for audit purposes).

''(B) REPORTS.—Each private entity shall make such reports and submissions of financial and utilization data as the Secretary may require taking into account standard commercial practices.

''(7) PROPOSAL FOR ALTERNATIVE COINSURANCE AMOUNT.—

''(A) SUBMISSION.—Each private entity may submit a proposal for increased Government cost-sharing for generic prescription drugs, prescription drugs on the private entity's formulary, or prescription drugs obtained through mail order pharmacies.

''(B) CONTENTS.—The proposal submitted under subparagraph (A) shall contain evidence that such increased cost-sharing would not result in an increase in aggregate costs to the Account, including an analysis of differences in projected drug utilization patterns by beneficiaries whose cost-sharing would be reduced under the proposal and those making the cost-sharing payments that would otherwise apply.

''(8) OTHER REQUIREMENTS.—Each private entity shall meet such other requirements as the Secretary may specify.

''(e) PHARMACY PARTICIPATION AGREEMENTS.—

''(1) IN GENERAL.—A pharmacy that meets the requirements of this subsection shall be eligible to enter an agreement with a private entity to furnish covered prescription drugs and pharmacists' services to enrolled individuals residing in the service area.

''(2) TERMS OF AGREEMENT.—An agreement under this subsection shall include the following terms and requirements:

''(A) LICENSING.—The pharmacy and pharmacists shall meet (and throughout the contract period will continue to meet) all applicable State and local licensing requirements.

''(B) LIMITATION ON CHARGES.—Pharmacies participating under this part shall not charge an enrolled individual more than the negotiated price for an individual drug as established under subsection (d)(1), regardless of whether such individual has attained the benefit limit under section 1860B(b), and shall not charge an enrolled individual more than the individual's share of the negotiated price as determined under the provisions of this part.

''(C) PERFORMANCE STANDARDS.—The pharmacy shall comply with performance standards relating to—

''(i) measures for quality assurance, reduction of medical errors, and participation in the drug utilization review program described in subsection (d)(3)(A);

''(ii) systems to ensure compliance with the confidentiality standards applicable under subsection (d)(5)(A); and

''(iii) other requirements as the Secretary may impose to ensure integrity, efficiency, and the quality of the program.

''(f) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG PRIVATE ENTITIES.—During the period after the Secretary has given notice of intent to terminate a contract with a private entity, the Secretary may transfer responsibilities of the private entity under such contract to another private entity.

''(g) SPECIAL ATTENTION TO RURAL AND HARD-TO-SERVE AREAS.—

''(1) IN GENERAL.—The Secretary shall ensure that all beneficiaries have access to the full range of pharmaceuticals under this part, and shall give special attention to access, pharmacist counseling, and delivery in rural and hard-to-serve areas (as the Secretary may define by regulation).

''(2) SPECIAL ATTENTION DEFINED.—For purposes of paragraph (1), the term 'special attention' may include bonus payments to retail pharmacists in rural areas, extra payments to the private entity for the cost of rapid delivery of pharmaceuticals, and any other actions the Secretary determines are necessary to ensure full access to rural and hard-to-serve beneficiaries.

''(3) GAO REPORT.—Not later than 2 years after the implementation of this part the Comptroller General of the United States shall submit to Congress a report on the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in rural and hard-to-serve areas under this part together with any recommendations of the Comptroller General regarding any additional steps the Secretary may need to take to ensure the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in such areas under this part.

''(h) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—The Secretary is authorized to include in a contract awarded under subsection (c) such incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate, including—

''(1) bonus and penalty incentives to encourage administrative efficiency;

''(2) incentives under which private entities share in any benefit savings achieved;

''(3) risk-sharing arrangements related to benefit payments; and

''(4) any other incentive that the Secretary deems appropriate and likely to be effective in managing costs or utilization.

''EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE

''SEC. 1860H. (a) PROGRAM AUTHORITY.—The Secretary is authorized to develop and implement a program under this section called the 'Employer Incentive Program' that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription drug benefits to retired individuals and to maintain such existing benefit programs, by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

''(b) SPONSOR REQUIREMENTS.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified retiree prescription drug plan (as defined in subsection (f)(3)), a sponsor shall meet the following requirements:

''(1) ASSURANCES.—The sponsor shall—

''(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered by the sponsor is a qualified retiree prescription drug plan, and will remain such a plan for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Secretary and covered retirees—

''(i) at least 120 days before terminating its plan; and

''(ii) immediately upon determining that the actuarial value of the prescription drug benefit under the plan falls below the actuarial value of the insurance benefit under this part.

''(2) OTHER REQUIREMENTS.—The sponsor shall provide such information, and comply with such requirements, including information requirements to ensure the integrity of the program, as the Secretary may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENT.—

''(1) IN GENERAL.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall have payment made by the Secretary on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate employment-based health plan) of an incentive payment, in the amount determined as described in paragraph (2), for each retired individual (or spouse) who—

''(A) was covered under the sponsor's qualified retiree prescription drug plan during such quarter; and

''(B) was eligible for but was not enrolled in the insurance program under this part.

''(2) AMOUNT OF INCENTIVE.—The payment under this section with respect to each individual described in paragraph (1) for a month shall be equal to ⅔ of the monthly premium amount payable by an enrolled individual, as set for the calendar year pursuant to section 1860D(a)(2).

''(3) PAYMENT DATE.—The incentive under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

''(d) CIVIL MONEY PENALTIES.—A sponsor, health plan, or other entity that the Secretary determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an amount up to 3 times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

''(e) PART D ENROLLMENT FOR CERTAIN INDIVIDUALS COVERED BY EMPLOYMENT-BASED RETIREE HEALTH COVERAGE PLANS.—

''(1) ELIGIBLE INDIVIDUALS.—An individual shall be given the opportunity to enroll in the program under this part during the period specified in paragraph (2) if—

''(A) the individual declined enrollment in the program under this part at the time the individual first satisfied section 1860C(a);

''(B) at that time, the individual was covered under a qualified retiree prescription drug plan for which an incentive payment was paid under this section; and

''(C)(i) the sponsor subsequently ceased to offer such plan; or

''(ii) the value of prescription drug coverage under such plan became less than the value of the coverage under the program under this part.

''(2) SPECIAL ENROLLMENT PERIOD.—An individual described in paragraph (1) shall be eligible to enroll in the program under this part during the 6-month period beginning on the first day of the month in which—

''(A) the individual receives a notice that coverage under such plan has terminated (in the circumstance described in paragraph (1)(C)(i)) or notice that a claim has been denied because of such a termination; or

''(B) the individual received notice of the change in benefits (in the circumstance described in paragraph (1)(C)(ii)).

''(f) DEFINITIONS.—In this section:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(2) EMPLOYER.—The term 'employer' has the meaning given to such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of 2 or more employees).

''(3) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription drugs whose actuarial value to each retired beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the program under this part; and

''(B) does not deny, limit, or condition the coverage or provision of prescription drug benefits for retired individuals based on age or any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(4) SPONSOR.—The term 'sponsor' has the meaning given the term 'plan sponsor' by section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS

''SEC. 1860I. (a) IN GENERAL.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Prescription Drug Insurance Account, a Government contribution equal to—

''(1) the aggregate premiums payable for a month pursuant to section 1860D(a)(2) by individuals enrolled in the program under this part; plus

''(2) one-half the aggregate premiums payable for a month pursuant to such section for such individuals by former employers.

''(b) APPROPRIATIONS TO COVER INCENTIVES FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE.—There are authorized to be appropriated to the Prescription Drug Insurance Account from time to time, out of any moneys in the Treasury not otherwise appropriated such sums as may be necessary for payment of incentive payments under section 1860H(c).

''PRESCRIPTION DRUG DEFINED

''SEC. 1860J. As used in this part, the term 'prescription drug' means—

''(1) a drug that may be dispensed only upon a prescription, and that is described in subparagraph (A)(i), (A)(ii), or (B) of section 1927(k)(2); and

''(2) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act, and needles, syringes, and disposable pumps for the administration of such insulin.''.

(b) STUDY OF ANNUAL OPEN ENROLLMENT.—

(1) STUDY.—During 2002 and 2003, the Secretary shall conduct a study on the feasibility and advisability of establishing an annual open enrollment period for the program under part D (as added by subsection (a)). Such study shall reflect data reported by private entities administering benefits under such part and shall include—

(A) a review of the costs, effectiveness, and administrative feasibility of an annual open enrollment period for beneficiaries who—

(i) previously declined enrollment; or

(ii) who previously disenrolled and desire to reenroll;

(B) an evaluation of a premium penalty for late enrollment based on actuarially determined costs to the program of late enrollment; and

(C) a projection of the costs if open enrollment was allowed without a penalty.

(2) REPORT.—The Secretary shall prepare a report setting forth the outcome of the study and may include in the report a recommendation as to whether an annual open enrollment period should be implemented under such part.

(c) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO FEDERAL SUPPLEMENTARY HEALTH INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(A) in the last sentence of subsection (a)—

(i) by striking ''and'' after ''section 201(i)(1)''; and

(ii) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Insurance Account established by section 1860F'';

(B) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund),'';

(C) in the first sentence of subsection (h), by inserting before the period the following: ''and section 1860D(b)(4) (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund)''; and

(D) in the first sentence of subsection (i)—

(i) by striking ''and'' after ''section 1840(b)(1)''; and

(ii) by inserting before the period the following: '', section 1860D(b)(2) (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund)''.

(2) PRESCRIPTION DRUG OPTION UNDER MEDICARE+CHOICE PLANS.—

(A) ELIGIBILITY, ELECTION, AND ENROLLMENT.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(i) in subsection (a)(1)(A), by striking ''parts A and B'' inserting ''parts A, B, and D''; and

(ii) in subsection (i)(1), by striking ''parts A and B'' and inserting ''parts A, B, and D''.

(B) VOLUNTARY BENEFICIARY ENROLLMENT FOR DRUG COVERAGE.—Section 1852(a)(1)(A) of such Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under that part)'' after ''parts A and B''.

(C) ACCESS TO SERVICES.—Section 1852(d)(1) of such Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(i) in subparagraph (D), by striking ''and'' at the end;

(ii) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(F) the plan for prescription drug benefits under part D guarantees coverage of any specifically named covered prescription drug for an enrollee, when prescribed by a physician in accordance with the provisions of such part, regardless of whether such drug would otherwise be covered under an applicable formulary or discount arrangement.''.

(D) PAYMENTS TO ORGANIZATIONS.—Section 1853(a)(1)(A) of such Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended—

(i) by inserting ''determined separately for benefits under parts A and B and under part D (for individuals enrolled under that part)'' after ''as calculated under subsection (c)'';

(ii) by striking ''that area, adjusted for such risk factors'' and inserting ''that area. In the case of payment for benefits under parts A and B, such payment shall be adjusted for such risk factors as''; and

(iii) by inserting before the last sentence the following: ''In the case of the payments for benefits under part D, such payment shall initially be adjusted for the risk factors of each enrollee as the Secretary determines to be feasible and appropriate. By 2006, the adjustments would be for the same risk factors applicable for benefits under parts A and B.''.

(E) CALCULATION OF ANNUAL MEDICARE +CHOICE CAPITATION RATES.—Section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''for benefits under parts A and B'' after ''capitation rate'';

(ii) in paragraph (6)(A), by striking ''rate of growth in expenditures under this title'' and inserting ''rate of growth in expenditures for benefits available under parts A and B''; and

(iii) by adding at the end the following new paragraph:

''(8) PAYMENT FOR PRESCRIPTION DRUGS.—The Secretary shall determine a capitation rate for prescription drugs—

''(A) dispensed in 2002, which is based on the projected national per capita costs for prescription drug benefits under part D and associated claims processing costs for beneficiaries under the original medicare fee-for-service program; and

''(B) dispensed in each subsequent year, which shall be equal to the rate for the previous year updated by the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual enrolled under part D.''.

(F) LIMITATION ON ENROLLEE LIABILITY.—Section 1854(e) of such Act (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR PROVISION OF PART D BENEFITS.—In no event may a Medicare+Choice organization include as part of a plan for prescription drug benefits under part D a requirement that an enrollee pay a deductible, or a coinsurance percentage that exceeds 50 percent.''.

(G) REQUIREMENT FOR ADDITIONAL BENEFITS.—Section 1854(f)(1) of such Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new sentence: ''Such determination shall be made separately for benefits under parts A and B and for prescription drug benefits under part D.''.

(H) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d) is amended by adding at the end the following new paragraph:

''(6) AVAILABILITY OF NEGOTIATED PRICES.—Each contract under this section shall provide that enrollees who exhaust prescription drug benefits under the plan will continue to have access to prescription drugs at negotiated prices equivalent to the total combined cost of such drugs to the plan and the enrollee prior to such exhaustion of benefits.''.

(3) EXCLUSIONS FROM COVERAGE.—

(A) APPLICATION TO PART D.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(B) PRESCRIPTION DRUGS NOT EXCLUDED FROM COVERAGE IF APPROPRIATELY PRESCRIBED.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) is amended—

(i) in subparagraph (H), by striking ''and'' at the end;

(ii) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(J) in the case of prescription drugs covered under part D, which are not prescribed in accordance with such part;''.

SEC. 102. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION DRUG COVERAGE FOR CERTAIN LOW-INCOME INDIVIDUALS.

(a) STATE OPTION TO BUY-IN DUALLY ELIGIBLE INDIVIDUALS.—

(1) COVERAGE OF PREMIUMS AS MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d) is amended in the second sentence of the flush matter at the end by striking ''premiums under part B'' the first place it appears and inserting ''premiums under parts B and D''.

(2) STATE COMMITMENT TO CONTINUE PARTICIPATION IN PART D AFTER BENEFIT LIMIT REACHED.—Section 1902(a) of such Act (42 U.S.C. 1396a) is amended—

(A) by striking ''and'' at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65)(B) and inserting ''; and''; and

(C) by adding at the end the following new paragraph:

''(66) provide that in the case of any individual whose eligibility for medical assistance is not limited to medicare or medicare drug cost-sharing and for whom the State elects to pay premiums under part D of title XVIII pursuant to section 1860E, the State will purchase all prescription drugs for such individual in accordance with the provisions of such part D, without regard to whether the benefit limit for such individual under section 1860B(b) has been reached.''.

(b) MEDICARE COST-SHARING REQUIRED FOR QUALIFIED MEDICARE BENEFICIARIES.—Section 1905(p)(3) of the Social Security Act (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and'' at the end; and

(C) by adding at the end the following new clause:

''(iii) premiums under section 1860D.''; and

(2) in subparagraph (D)—

(A) by inserting ''(i)'' after ''(D)''; and

(B) by adding at the end the following:

''(ii) The difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).''.

(c) MEDICARE DRUG COST-SHARING REQUIRED FOR MEDICARE-ELIGIBLE INDIVIDUALS WITH INCOMES BETWEEN 100 AND 150 PERCENT OF POVERTY LINE.—

(1) DEFINITIONS OF ELIGIBLE BENEFICIARIES AND COVERAGE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(x)(1) The term 'qualified medicare drug beneficiary' means an individual—

''(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A);

''(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (p)(2)(D)) is above 100 percent but below 150 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; and

''(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

''(2) The term 'medicare drug cost-sharing' means the following costs incurred with respect to a qualified medicare drug beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

''(A) In the case of a qualified medicare drug beneficiary whose income (as determined under paragraph (1)) is less than 135 percent of the official poverty line—

''(i) premiums under section 1860D; and

''(ii) the difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).

''(B) In the case of a qualified medicare drug beneficiary whose income (as determined under paragraph (1)) is at least 135 percent but less than 150 percent of the official poverty line, a percentage of premiums under section 1860D, determined on a linear sliding scale ranging from 100 percent for individuals with incomes at 135 percent of such line to 0 percent for individuals with incomes at 150 percent of such line.

''(3) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.''.

(2) STATE PLAN REQUIREMENT.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and'' at the end; and

(B) by adding at the end the following new clause:

''(v) for making medical assistance available for medicare drug cost-sharing (as defined in section 1905(x)(2)) for qualified medicare drug beneficiaries described in section 1905(x)(1); and''.

(3) 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE DRUG COST-SHARING.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following new paragraph:

''(7) except in the case of amounts expended for an individual whose eligibility for medical assistance is not limited to medicare or medicare drug cost-sharing, an amount equal to 100 percent of amounts as expended as medicare drug cost-sharing for qualified medicare drug beneficiaries (as defined in section 1905(x)); plus''.

(d) MEDICAID DRUG PRICE REBATES UNAVAILABLE WITH RESPECT TO DRUGS PURCHASED THROUGH MEDICARE BUY-IN.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended by adding at the end the following new subsection:

''(l) DRUGS PURCHASED THROUGH MEDICARE BUY-IN.—The provisions of this section shall not apply to prescription drugs purchased under part D of title XVIII pursuant to an agreement with the Secretary under section 1860E (including any drugs so purchased after the limit under section 1860B(b) has been exceeded).''.

(e) AMENDMENTS TO MEDICARE PART D.—Part D of title XVIII of the Social Security Act (as added by section 2) is amended by inserting after section 1860D the following new section:

''SPECIAL ELIGIBILITY, ENROLLMENT, AND COPAYMENT RULES FOR LOW-INCOME INDIVIDUALS

''SEC. 1860E. (a) STATE AGREEMENTS FOR COVERAGE.—

''(1) IN GENERAL.—The Secretary shall, at the request of a State, enter into an agreement with the State under which all individuals described in paragraph (2) are enrolled in the program under this part, without regard to whether any such individual has previously declined the opportunity to enroll in such program.

''(2) ELIGIBILITY GROUPS.—The individuals described in this paragraph, for purposes of paragraph (1), are individuals who satisfy section 1860C(a) and who are—

''(A)(i) eligible individuals within the meaning of section 1843; and

''(ii) in a coverage group or groups permitted under section 1843 (as selected by the State and specified in the agreement); or

''(B) qualified medicare drug beneficiaries (as defined in section 1905(v)(1)).

''(3) COVERAGE PERIOD.—The period of coverage under this part of an individual enrolled under an agreement under this subsection shall be as follows:

''(A) INDIVIDUALS ELIGIBLE (AT STATE OPTION) FOR PART B BUY-IN.—In the case of an individual described in subsection (a)(2)(A), the coverage period shall be the same period that applies (or would apply) pursuant to section 1843(d).

''(B) QUALIFIED MEDICARE DRUG BENEFICIARIES.—In the case of an individual described in subsection (a)(2)(B)—

''(i) the coverage period shall begin on the latest of—

''(I) January 1, 2002;

''(II) the first day of the third month following the month in which the State agreement is entered into; or

''(III) the first day of the first month following the month in which the individual satisfies section 1860C(a); and

''(ii) the coverage period shall end on the last day of the month in which the individual is determined by the State to have become ineligible for medicare drug cost-sharing.

''(b) SPECIAL PART D ENROLLMENT OPPORTUNITY FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In the case of an individual who—

''(1) satisfies section 1860C(a); and

''(2) loses eligibility for benefits under the State plan under title XIX after having been enrolled under such plan or having been determined eligible for such benefits;

the Secretary shall provide an opportunity for enrollment under the program under this part during the period that begins on the date that such individual loses such eligibility and ends on the date specified by the Secretary.

''(c) DEFINITION.—For purposes of this section, the term 'State' has the meaning given such term under section 1101(a) for purposes of title XIX.''.

(f) REMOVAL OF SUNSET DATE FOR COST-SHARING IN MEDICARE PART B PREMIUMS FOR CERTAIN QUALIFYING INDIVIDUALS.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv))is amended to read as follows—

''(iv) subject to section 1905(p)(4), for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;''.

(2) RELOCATION OF PROVISION REQUIRING 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR CERTAIN QUALIFYING INDIVIDUALS.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by subsection (c)(3), is amended—

(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7) the following new paragraph:

''(8) an amount equal to 100 percent of amounts as expended as medicare drug cost-sharing for individuals described in section 1903(a)(10)(E)(iv); plus''.

(3) REPEAL OF SECTION 1933.—Section 1933 is repealed.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2002.

SEC. 103. CATASTROPHIC PRESCRIPTION DRUG COVERAGE BENEFIT.

(a) RECOMMENDATIONS WITH RESPECT TO A MEDICARE CATASTROPHIC DRUG BENEFIT.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives detailed recommendations on structuring a catastrophic drug benefit for medicare beneficiaries.

(2) RECOMMENDATIONS DESCRIBED.—The recommendations under paragraph (1) shall—

(A) ensure coverage of the costs of prescription drugs above a specified level of out-of-pocket expenditures;

(B) conform to the administrative structure established in this Act;

(C) have a projected cost that does not exceed the amounts described in subsection (b)(3)(A); and

(D) take effect no later than January 1, 2003.

(3) FINAL REGULATIONS.—

(A) IN GENERAL.—If legislation of a medicare catastrophic drug benefit is not enacted that meets the requirements of paragraph (2) by June 1, 2001, the Secretary of Health and Human Services shall promulgate final regulations containing such standards no later than January 1, 2002.

(B) CERTIFICATION BY OMB AND HCFA.—A final regulation promulgated by the Secretary under subparagraph (A) shall not take effect unless the Director of the Office of Management and Budget and the Chief Actuary of the Health Care Financing Administration certify that aggregate Federal expenses incurred in providing the catastrophic drug benefit under this section will not exceed $50,000,000,000 between fiscal years 2003 and 2010. If either certification is not provided, the Secretary shall submit a revised recommendation on structuring a catastrophic drug benefit to the appropriate committees of Congress under paragraph (1) no later than 30 days after the Secretary receives a notification that such certification will not be provided.

(b) CATASTROPHIC PRESCRIPTION DRUG COVERAGE RESERVE FUND.—

(1) ESTABLISHMENT OF RESERVE FUND.—There is established a reserve fund which shall be known as the ''Catastrophic Prescription Drug Coverage Reserve Fund'' (in this subsection referred to as the ''Reserve Fund'').

(2) AMOUNTS IN RESERVE FUND.—Subject to subparagraph (B), the Reserve Fund shall consist of such amounts as are appropriated to the Reserve Fund under paragraph (3).

(3) APPROPRIATION TO RESERVE FUND.—

(A) IN GENERAL.—

(i) FISCAL YEARS 2003 THROUGH 2010.—There are appropriated to the Reserve Fund for the period beginning with fiscal year 2003 and ending with fiscal year 2010, $50,000,000,000.

(ii) SUBSEQUENT FISCAL YEARS.—There are authorized to be appropriated to the Reserve Fund for each subsequent fiscal year, such sums as may be necessary to carry out the provisions of this section.

(B) AVAILABILITY.—Sums appropriated under subparagraph (A)(i) shall remain available, without fiscal year limitation, until expended.

SEC. 104. COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS.

(a) REVISION OF MEDICARE COVERAGE FOR IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) (as amended by section 227(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–354), as enacted into law by section 1000(a)(6) of Public Law 106–113) is amended by striking '', to an individual who receives'' and all that follows before the semicolon at the end and inserting ''to an individual who has received an organ transplant''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1832 of the Social Security Act (42 U.S.C. 1395k) (as amended by section 227(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–354), as enacted into law by section 1000(a)(6) of Public Law 106–113) is amended—

(i) by striking subsection (b); and

(ii) by redesignating subsection (c) as subsection (b).

(B) Subsections (c) and (d) of section 227 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–355), as enacted into law by section 1000(a)(6) of Public Law 106–113, are repealed.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to drugs furnished on or after the date of enactment of this Act.

(b) EXTENSION OF CERTAIN SECONDARY PAYER REQUIREMENTS.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following: ''With regard to immunosuppressive drugs furnished on or after the date of enactment of the Medicare Expansion for Needed Drugs (MEND) Act of 2000, this subparagraph shall be applied without regard to any time limitation.''.

SEC. 105. GAO STUDY AND BIENNIAL REPORTS ON COMPETITION AND SAVINGS.

(a) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study and analysis of the prescription drug benefit program under part D of the medicare program under title XVIII of the Social Security Act (as added by this title), including an analysis of—

(1) the extent to which the competitive bidding process under such program fosters maximum competition and efficiency; and

(2) the savings to the medicare program resulting from such prescription drug benefit program, including the reduction in the number or length of hospital visits.

(b) INITIAL REPORT.—Not later than September 1, 2001, the Comptroller General shall submit to Congress a report on the extent to which the competitive bidding process under the prescription drug benefit program under part D of the medicare program under title XVIII of the Social Security Act (as added by this title) is expected to foster maximum competition and efficiency.

(c) BIENNIAL REPORTS.—Not later than January 1, 2004, and biennially thereafter, the Comptroller General of the United States shall submit to Congress a report on the results of the study conducted under this section, together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.

SEC. 106. MEDPAC STUDY AND ANNUAL REPORTS ON THE PHARMACEUTICAL MARKET, PHARMACIES, AND BENEFICIARY ACCESS.

(a) ONGOING STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) shall conduct an ongoing study and analysis of the prescription drug benefit program under part D of the Social Security Act (as added by this title), including an analysis of the impact of the prescription drug benefit program on—

(1) the pharmaceutical market, including costs and pricing of pharmaceuticals, beneficiary access to such pharmaceuticals, and trends in research and development;

(2) franchise, independent, and rural pharmacies; and

(3) beneficiary access to prescription drugs, including an assessment of—

(A) out-of-pocket spending;

(B) generic and brand-name utilization; and

(C) pharmacists' services.

(b) REPORT.—Not later than January 1, 2004, and annually thereafter, the Medicare Payment Advisory Commission shall submit to Congress a report on the results of the study conducted under this section, together with any recommendations for legislation that such Commission determines to be appropriate as a result of such study.

TITLE II—ENHANCED MEDICARE PREVENTION PROGRAM

SEC. 201. MEDPAC BIENNIAL REPORT.

(a) IN GENERAL.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking ''and'' at the end;

(B) in subparagraph (D), by striking the period and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(E) by not later than January 1, 2002, and biennially thereafter, submit the report to Congress described in paragraph (7).''; and

(2) by adding at the end the following new paragraph:

''(7) EVALUATION OF ACTUARIAL EQUIVALENCE OF MEDICARE AND PRIVATE SECTOR BENEFIT PACKAGES.—

''(A) EVALUATION.—The Commission shall—

''(i) evaluate the benefit package offered under the medicare program under this title; and

''(ii) determine the degree to which such benefit package is actuarially equivalent to that offered by health benefit programs available in the private sector to individuals over age 65.

''(B) REPORT.—The Commission shall submit a report to Congress that shall contain—

''(i) a detailed statement of the findings and conclusions of the Commission regarding the evaluation conducted under subparagraph (A);

''(ii) the recommendations of the Commission regarding changes in the benefit package offered under the medicare program under this title that would keep the program modern and competitive in relation to health benefit programs available in the private sector; and

''(iii) the recommendations of the Commission for such legislation and administrative actions as it considers appropriate.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 202. NATIONAL INSTITUTE ON AGING STUDY AND REPORT.

(a) STUDIES.—The Director of the National Institute on Aging shall conduct 1 or more studies focusing on ways to—

(1) improve quality of life for the elderly;

(2) develop better ways to prevent or delay the onset of age-related functional decline and disease and disability among the elderly; and

(3) develop means of assessing the long-term development of cost-effective benefits and cost-savings benefits for health promotion and disease prevention among the elderly.

(b) REPORT.—Not later than January 1, 2006, the Director of the National Institute on Aging shall submit a report to the Secretary regarding each study conducted under subsection (a) and containing a detailed statement of research findings and conclusions that are scientifically valid and are demonstrated to prevent or delay the onset of chronic illness or disability among the elderly.

(c) TRANSMISSION TO INSTITUTE OF MEDICINE.—Upon receipt of each report described in subsection (b), the Secretary shall transmit such report to the Institute of Medicine of the National Academy of Sciences for consideration in its effort to conduct the comprehensive study of current literature and best practices in the field of health promotion and disease prevention among the medicare beneficiaries described in section 204.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for fiscal years 2001 through 2006 to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until September 30, 2005.

SEC. 203. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among medicare beneficiaries including the issues described in paragraph (2) and to submit the report described in subsection (b).

(2) ISSUES STUDIED.—The study required under paragraph (1) shall include an assessment of—

(A) whether each covered benefit is—

(i) medically effective; and

(ii) a cost-effective benefit or a cost-saving benefit;

(B) utilization of covered benefits (including any barriers to or incentives to increase utilization); and

(C) quality of life issues associated with both health promotion and disease prevention benefits covered under the medicare program and those that are not covered under such program that would affect all medicare beneficiaries.

(b) REPORT.—

(1) IN GENERAL.—Not later than 5 years after the date of enactment of this section, and every fifth year thereafter, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed statement of the findings and conclusions of the study conducted under subsection (a) and the recommendations for legislation described in paragraph (2).

(2) RECOMMENDATIONS FOR LEGISLATION.—The Institute of Medicine of the National Academy of Sciences, in consultation with the Partnership for Prevention, shall develop recommendations in legislative form that—

(A) prioritize the preventive benefits under the medicare program; and

(B) modify preventive benefits offered under the medicare program based on the study conducted under subsection (a).

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—On the day on which the report described in subsection (b) is submitted to the President, the President shall transmit the report and recommendations in legislative form described in subsection (b)(2) to Congress.

(2) DELIVERY.—Copies of the report and recommendations in legislative form required to be transmitted to Congress under paragraph (1) shall be delivered—

(A) to both Houses of Congress on the same day;

(B) to the Clerk of the House of Representatives if the House of Representatives is not in session; and

(C) to the Secretary of the Senate if the Senate is not in session.

SEC. 204. FAST-TRACK CONSIDERATION OF PREVENTION BENEFIT LEGISLATION.

(a) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this section; and

(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section 203(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such report shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Senate designated by the Majority Leader and Minority Leader.

(B) SPECIAL RULE.—If either House of Congress is not in session on the day on which such recommendations in legislative form are transmitted, the recommendations in legislative form shall be introduced as a bill in that House of Congress, as provided in subparagraph (A), on the first day thereafter on which that House of Congress is in session.

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or more committees, jointly to such committees for consideration of those provisions within their respective jurisdictions.

(c) CONSIDERATION.—After the recommendations in legislative form have been introduced as a bill and referred under subsection (b), such implementing bill shall be considered in the same manner as an implementing bill is considered under subsections (d), (e), (f), and (g) of section 151 of the Trade Act of 1974 (19 U.S.C. 2191).

(d) IMPLEMENTING BILL DEFINED.—In this section, the term ''implementing bill'' means only the recommendations in legislative form of the Institute of Medicine of the National Academy of Sciences described in section 203(b)(2), transmitted by the President to the House of Representatives and the Senate under section 203(c), and introduced and referred as provided in subsection (b) as a bill of either House of Congress.

(e) COUNTING OF DAYS.—For purposes of this section, any period of days referred to in section 151 of the Trade Act of 1974 shall be computed by excluding—

(1) the days on which either House of Congress is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of Congress sine die; and

(2) any Saturday and Sunday, not excluded under paragraph (1), when either House is not in session.

Mr. KENNEDY. Mr. President, Senator DASCHLE, Senator MOYNIHAN, and I, and the majority of the members of our caucus are introducing legislation to provide prescription drug coverage under Medicare. It is a program supported not only by the Senate Democrats but by House Democrats and the President as well. Senior citizens deserve prescription drug coverage under Medicare. Democrats are committed to providing it and providing it this year.

It is long past time for Congress to mend the broken promise of Medicare. Medicare is a guarantee of affordable health care for every senior citizen, but that promise is being broken every day because Medicare does not cover prescription drugs. The need is urgent. Too many elderly citizens face an impossible choice between food on the table and medicine they need to stay healthy or to treat their illnesses. They take half the pills their doctors prescribe, or do not even fill a needed prescription at all because they cannot afford the high cost of the prescription.

They pay twice as much for the drugs they need because they pay full price, while almost everyone with private insurance pays less because of negotiated discounts. Too many seniors end up in the hospital at immense cost to Medicare because they cannot afford the drugs they need, or can't afford to take them correctly.

Opponents say we cannot afford this coverage, in spite of the budget surplus. The issue is priorities. Health care for the elderly is more important than new tax breaks for the wealthy.

Others say this coverage should be available only to the elderly who are poor. But senior citizens want Medicare, not welfare. They should not be forced into poverty in order to obtain the medications they need.

The ongoing revolution in health care makes this coverage more essential now than ever. Coverage of prescription drugs under Medicare is as critical today as coverage of hospital and doctor care. Senior citizens need help now. The President knows it, Democrats and the House and Senate know it, senior citizens know it, and so do their children and grandchildren.

Congress should listen to their choices. The time for excuses is over. The time for action is now.

I will take a few moments of the Senate's time to review where we are on the issue of Medicare and Medicare coverage. This chart shows the number of senior citizens who have prescription drug coverage.

Senior citizens lack affordable, reliable, quality coverage.

The only group of senior citizens who have coverage today that is reliable, affordable, and dependable are the 4 million seniors covered under Medicaid. Today, we have 12 million senior citizens who effectively have no coverage at all; that is a third of all of our senior citizens. Eleven million seniors have employer sponsored coverage, and I will come back to that because employer sponsored coverage is disappearing.

Three million seniors have coverage under Medicare HMOs, 4 million are covered under Medigap—and we will examine that particular phenomenon—4 million under Medicaid, and 3 million now switched plans during the year or have other coverage.

We have a about a third who have no coverage whatsoever. Another third have employer-sponsored coverage, but we are finding that this coverage is declining rapidly. Medicare HMO coverage is also declining, and Medigap coverage is often unaffordable. That is the current situation. Let's look a little further. If we look at the income of senior citizens, what we see is that 57 percent of senior citizens have incomes under $15,000; 21 percent have incomes above $15,000 but under $25,000. If you add those together, obviously 78 percent are below $25,000. Elderly people in our country have very modest means—very, very modest means.

The average income for a person over 65 is just above $13,000. The cost of coverage is going up. I just showed a chart of the different types of coverage we had, pointing out one-third of our senior citizens have no coverage, and another third have health coverage that is related to their former job. The next chart shows firms offering retiree health coverage.

The chart indicates coverage ''drops 25 percent.''

There was a 25-percent drop in employers covering prescription drugs for their retirees in the 3 years from 1994 to 1997. This is a dramatic reduction in coverage.

Remember I showed the other chart that said a third had coverage through employer sponsored retiree benefits? This shows that the number of firms offering retiree health benefits is dropping absolutely dramatically.

We saw there were a number of our senior citizens, about 4 million, who had coverage through Medicare HMOs. Look at what is happening to Medicare HMO coverage. It is inadequate and unreliable.

First of all, the drug benefit is offered only at the option of HMOs, so some HMOs offer coverage and others do not. More than 325,000 Medicare beneficiaries lost their HMO coverage this year. That is because the HMOs moved out of the areas where those seniors live. Seniors lost their coverage. Look at this: 75 percent of Medicare HMOs will limit prescription drug coverage to less than $1,000 this year. That is an increase of 100 percent in the number of HMOs capping coverage since 1998. And 32 percent of Medicare HMOs have imposed caps of less than $500 this year. So even though you have 4 million Americans who have prescription drug coverage through Medicare HMOs, what you find out is there is a cap on the amount of prescription drugs they are able to receive. After that, they pay for all prescription drugs themselves.

What the trend is, the dramatic trend, is that the dollar cap is going down and down, with a third of HMOs having a cap of $500. Many seniors in Medicare HMOs will exceed the cap. What we find is that Medicare HMO prescription drug coverage is increasingly inadequate and increasingly unreliable.

There is a dramatic reduction in the number of employers providing coverage for retirees, and a dramatic increase in the amount of money that individual seniors are paying out-of-pocket, even if they have some coverage under their HMO.

The third group I pointed out were those who had Medigap coverage, drug coverage which basically is unaffordable. These are sample Medigap premiums for a 75-year-old. In Delaware, just over $2,600; just under $2,000 in New York and Iowa; and just under $2,400 in Maine and Mississippi.

Against that background, what has been happening to the cost of drugs? The average seniors income is just above $13,500. A third of all of our seniors have no coverage; another third are losing it dramatically. We find that 4 million of the remaining have increasingly limited coverage due to caps, so they are paying more and more out of pocket. Medigap, which is another way they are able to get some coverage, is going right up through the roof. So they are being hard-pressed, and all at a time that 78 percent of all the elderly people have incomes below $25,000.

Let's see what is happening to the cost of prescription drugs. Since 1995, drug costs have been growing at double-digit rates. On this chart: Percent increases in drug costs. Let's look at the increase in the cost of the drugs: almost 10 percent in 1995, 10 percent in 1996, 14 percent in 1997, almost 16 percent in 1998, 16 percent in 1999.

Let's compare that to the Consumer Price Index for all goods. It is 2.5 percent in 1995, it is 3.3 percent in 1996, 1.7 percent in 1997—1.7 percent cost-of-living increase and look at the cost of the prescription drugs— 14 percent. In 1998 it is 1.6, and 2.7 in 1999, and look at the cost of these drugs.

This is not just a peripheral issue for our seniors. When we passed the Medicare program in 1964, as we heard so eloquently today from both our leader on this side, Senator DASCHLE, and Congressman GEPHARDT, we had a lot of the same kinds of criticisms that are being made now against this program: This is the beginning of a takeover by the Federal Government; this is the beginning of socialism.

Of course, they were wrong then and we were right because the Medicare program has worked. But one area we did not take care of was prescription drugs because private coverage at that time did not provide for drug coverage.

I daresay prescription drugs are as necessary for our senior citizens today as hospital care or doctor care.

Prescription drugs coverage is necessary for elderly people. Yet it is left out. In a very important way, our Medicare system is not living up to its guarantee—for the men and women who fought in the wars and brought this country out of the depths of the Depression and have educated their children—to live their golden years with a degree of security and peace with respect to their health care needs under Medicare. We are now finding now with that major gap—today, more than 95 percent of the private sector provides prescription drug coverage although they are dropping it for retirees—that Medicare does not provide prescription drug coverage. It is a major gap.

We are saying: Let's fill that gap; let's meet our commitment to our seniors; let's include under Medicare a program that is going to be worthy of our names and which is absolutely essential if we are going to have our seniors—our parents and grandparents—live in the peace, dignity, and security they deserve.

That is why we believe the program ought to be voluntary, there ought to be coverage for all, it ought to provide basic coverage and have catastrophic coverage, and it ought to be affordable.

The President has embraced and endorsed the program, and it is endorsed by the overwhelming majority of our caucus in the Senate and in the House of Representatives, and it is strongly supported by our leader and Mr. GEPHARDT.

The President in the Rose Garden today asked our Republican friends to join in this effort to pass this legislation this year. We have to pass something that is going to be meaningful and worthy of our efforts. He invited our Republican friends to join us in this effort and outlined the program and spelled out the details as well as the cost of this program.

When we pass this program and send it to the President's desk, we in the Congress will say: Why did it take us so long? Every day we delay passing this program, millions of our fellow citizens are being asked to make decisions about their very lives which they should not have to make. That is wrong. We ought to respond. We know how to do it. The question is whether we have the will.

We are going to insist this Senate and House of Representatives address this issue in this Congress. We give those assurances to the American people, and we invite our friends on the other side of the aisle to join us in meeting our responsibilities to our senior citizens.

Mr. BIDEN. Mr. President, I am pleased today to join Senator DASCHLE and 31 of my colleagues in introducing the Medicare Expansion for Needed Drugs Act. This important legislation would expand the Medicare program to provide outpatient prescription drug coverage for seniors and other Medicare beneficiaries.

This bill is long overdue, one might say 35 years overdue. When Medicare was first crafted in the mid 1960's, life-saving medicine tended to be focused on surgical procedures: appendectomy, mastectomy, and so forth. Medications were being increasingly used to treat serious medical conditions, such as antibiotics to treat infections. However, for most illnesses, the medicine cabinet contained few options.

The advances that have been made in the past 4 decades in the use of pharmaceuticals are nothing short of phenomenal. Diseases that were incurable by any means are now cured by drugs alone. For example, in 1965, childhood leukemia was inevitably fatal. Now, thanks to new medicines, it is almost always curable.

In addition, in many instances new medications have enabled us to avoid the need for surgical treatment altogether. In 1965, intractable pain from stomach ulcers was a common indication for surgery. In 2000, we have highly effective medications to cut down on stomach acid, which have virtually eliminated the need for that kind of surgery. Not only that, but since we have discovered that most stomach ulcers are really due to a bacterium, we can cure the condition entirely with antibiotics.

However, all too often, the elderly and disabled cannot take advantage of these major advances in drug treatment because the Medicare program does not pay for outpatient prescription drugs. How ridiculous is that?: that the group in our society that is the sickest, that could benefit most from these medications, is the one group that is denied access to them.

You would be hard pressed to name another health program in this country that doesn't pay for outpatient prescription drugs. Virtually all private health plans do. Even looking at the Federal government: Medicaid, Tricare, the VA, the Federal Employees Health Benefits Program, they all pay for prescription drugs. Only Medicare, the medical program for the elderly and disabled, is singled out for special limitations.

What is the consequence of this Medicare limitation? Just two weeks ago, the New York Times had a cover story on the plight of Albert Russell, a retiree who lives on an $832 Social Security check. Mr. Russell is nearly blind from glaucoma, a condition in which the pressure inside the eye is too high. When the new drug Xalatan was released in 1996, Mr. Russell's eye doctor tried it and found that it was just what Mr. Russell needed; it reduced the pressure in his eyes better than the alternatives. The problem was the cost of the drug: $1 per day. After several years on the medicine, Mr. Russell could no longer afford the cost, so he had to stop taking the medicine. Of course, Medicare would not pay for such an outpatient prescription drug. In an attempt to save Mr. Russell's vision, his eye doctor recommended an alternative: an expensive eye surgery. For Mr. Russell, the surgery would not be as effective as the medication, but there was one big factor in its favor: Medicare would have no reluctance about paying for the surgery. So, as compared to surgery, the medication would be better and easier for Mr. Russell, and probably cheaper in the long run for the taxpayer, but under the current Medicare situation, this common sense solution is out-of-bounds. This situation must be changed.

So what's in this bill for consumers? The bill makes prescription drug coverage voluntary and available to all Medicare beneficiaries. There is no deductible required, and there is an out-of-pocket cap that puts an absolute maximum limit on how much one person will have to pay for drugs in any given year. Participants pay a monthly premium, and the government splits the cost of drugs 50/50 with the beneficiary (up to a gradually increasing limit). There is absolutely no question that this bill is an important improvement for the health of our seniors.

I think it is important to keep in mind what this bill is not. First, it is not perfect. The coverage for prescription drugs is not in parity with coverage for alternative medical treatments, such as surgery. This difference reflects cost constraints, but I am optimistic that this aspect can be addressed in future legislation.

Second, this bill is not for everyone. Individuals who have better coverage of prescription drugs than is afforded in this bill, perhaps through an employer-sponsored retiree health plan, can keep that coverage. In fact, employers will be offered subsidies to encourage them to maintain prescription drug coverage for their retirees.

Third, this bill is not a prelude to price controls on drugs. The legislation makes no mention of or need for price controls, and it is not our intention to propose or implement price controls. This bill deals primarily with access to pharmaceuticals, not their cost. The high cost of medications is a concern to many of us in this country, but that is a very complex problem that is not, and should not be, addressed in this bill.

Finally, this bill is not the comprehensive overhaul of the Medicare program that we all agree is needed. The 1965 program needs to be brought up to new millennium standards to make it easier for the program to keep up with rapid future advances in medical technology. The benefit package (including enhanced preventive measures), the financing of graduate medical education, the provider payment mechanisms; these are all items that must be addressed. But not in this bill. Seniors need help now with prescription drugs, and they cannot wait the months or years that it will take to complete the needed comprehensive revision of Medicare.

Mr. President, I encourage all of my colleagues on both sides of the aisle to work together to enact this legislation and to make sure that our Medicare beneficiaries aren't relegated to a second class health care system.

Mr. ROBB. Mr. President, I wanted to say a few words about the Medicare Expansion for Needed Drugs, or MEND Act, which our leader, Senator DASCHLE introduced today. The MEND Act an important first step toward modernizing Medicare through the creation of a voluntary, affordable, universal prescription drug benefit.

While the bill has many elements that I support, I am also interested in looking at ways that we might create a prescription drug bill that distributes its benefits for senior citizens in a more targeted way. I am working with several of my colleagues on the Finance Committee to create such a bill, and hope to introduce it in the next two weeks. With it, we will have two strong options for giving our seniors the help they so desperately need with the skyrocketing costs of prescription drugs.

Mr. President, I applaud the minority leader for his determination in working to help our nation's seniors with the high cost of prescription drugs, and for his efforts in bringing this bill to the floor.

ADDITIONAL COSPONSORS

S. 345

At the request of Mr. GREGG, his name was added as a cosponsor of S. 345, a bill to amend the Animal Welfare Act to remove the limitation that permits interstate movement of live birds, for the purpose of fighting, to States in which animal fighting is lawful.

S. 515

At the request of Mr. AKAKA, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 515, a bill to amend the Packers and Stockyards Act of 1921, to make it unlawful for any stockyard owner, market agency, or dealer to transfer or market nonambulatory livestock, and for other purposes.

S. 662

At the request of Mr. L. CHAFEE, the names of the Senator from North Carolina (Mr. HELMS) and the Senator from Arizona (Mr. MCCAIN) were added as cosponsors of S. 662, a bill to amend title XIX of the Social Security Act to provide medical assistance for certain women screened and found to have breast or cervical cancer under a federally funded screening program.

S. 664

At the request of Mr. L. CHAFEE, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 664, a bill to amend the Internal Revenue Code of 1976 to provide a credit against income tax individuals who rehabilitate historic homes or who are the first purchasers of rehabilitated historic homes for use as a principal residence.

S. 818

At the request of Mr. DEWINE, the name of the Senator from Arizona (Mr. MCCAIN) was added as a cosponsor of S. 818, a bill to require the Secretary of Health and Human Services to conduct a study of the mortality and adverse outcome rates of medicare patients related to the provision of anesthesia services.

S. 890

At the request of Mr. WELLSTONE, the names of the Senator from Nebraska (Mr. KERREY) and the Senator from Hawaii (Mr. INOUYE) were added as cosponsors of S. 890, a bill to facilitate the naturalization of aliens who served with special guerrilla units of irregular forces in Laos.

S. 1053

At the request of Mr. BOND, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 1053, a bill to amend the Clean Air Act to incorporate certain provisions of the transportation conformity regulations, as in effect on March 1, 1999.

S. 1155

At the request of Mr. ROBERTS, the names of the Senator from Montana (Mr. BAUCUS) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of S. 1155, a bill to amend the Federal Food, Drug, and Cosmetic Act to provide for uniform food safety warning notification requirements, and for other purposes.

S. 1163

At the request of Mr. BENNETT, the names of the Senator from Louisiana (Ms. LANDRIEU), the Senator from Alabama (Mr. SHELBY), the Senator from Connecticut (Mr. LIEBERMAN), the Senator from Michigan (Mr. ABRAHAM), and the Senator from California (Mrs. BOXER) were added as cosponsors of S. 1163, a bill to amend the Public Health Service Act to provide for research and services with respect to lupus.

S. 1368

At the request of Mr. TORRICELLI, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1368, a bill to amend the Forest and Rangeland Renewable Resources Planning Act of 1974 and related laws to strengthen the protection of native biodiversity and ban clearcutting on Federal land, and to designate certain Federal land as ancient forests, roadless areas, watershed protection areas, special areas, and Federal boundary areas where logging and other intrusive activities are prohibited.

S. 1747

At the request of Mr. BENNETT, the name of the Senator from Washington (Mr. GORTON) was added as a cosponsor of S. 1747, a bill to amend the Federal Election Campaign Act of 1971 to exclude certain Internet communications from the definition of expenditure.

S. 1805

At the request of Mr. KENNEDY, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1805, a bill to restore food stamp benefits to aliens, to provide States with flexibility in administering the food stamp vehicle allowance, to index the excess shelter expense deduction to inflation, to authorize additional appropriations to purchase and make available additional commodities under the emergency food assistance program, and for other purposes.

S. 1886

At the request of Mr. INHOFE, the name of the Senator from Virginia (Mr. ROBB) was added as a cosponsor of S. 1886, a bill to amend the Clean Air Act to permit the Governor of a State to waive the oxygen content requirement for reformulated gasoline, to encourage development of voluntary standards to prevent and control releases of methyl tertiary butyl ether from underground storage tanks, and for other purposes.

At the request of Mr. INHOFE, the name of the Senator from Ohio (Mr. VOINOVICH) was withdrawn as a cosponsor of S. 1886, supra.

S. 1921

At the request of Mr. CAMPBELL, the names of the Senator from Vermont (Mr. JEFFORDS) and the Senator from Hawaii (Mr. AKAKA) were added as cosponsors of S. 1921, a bill to authorize the placement within the site of the Vietnam Veterans memorial of a plague to honor Vietnam veterans who died after their service in the Vietnam war, but as a direct result of that service.

S. 1933

At the request of Mr. THOMPSON, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 1933, a bill to amend the Internal Revenue Code of 1986 to permit the consolidation of life insurance companies with other companies.

S. 2031

At the request of Mr. DODD, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 2031, a bill to amend the Fair Labor Standards Act of 1938 to prohibit the issuance of a certificate for subminimum wages for individuals with impaired vision or blindness.

S. 2044

At the request of Mr. CAMPBELL, the name of the Senator from Nevada (Mr. BRYAN) was added as a cosponsor of S. 2044, a bill to allow postal patrons to contribute to funding for domestic violence programs through the voluntary purchase of specially issued postage stamps.

S. 2274

At the request of Mr. GRASSLEY, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 2274, a bill to amend title XIX of the Social Security Act provide families and disabled children with the opportunity to purchase coverage under the medical program for such children.

S. 2299

At the request of Mr. L. CHAFEE, the name of the Senator from Kansas (Mr.