votes on amendments, they have made this final vote on this conference report the single vote that will allow the congressional pay raise to happen. A Member who wants to prevent a congressional pay raise before we have a raise in the minimum wage has this one opportunity to vote against it.

It is for these reasons that I will vote against this conference report.

MORNING BUSINESS

Mr. BENNETT. Mr. President, I ask unanimous consent there now be a period for the transaction of morning business with Senators permitted to speak for up to 10 minutes each.

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

PRESCRIPTION DRUGS: IN THE BIG TENT OR A SIDE SHOW

Mr. GRAHAM. Mr. President, this is the third in a series of five statements I am making on the issue of providing a prescription drug benefit for senior Americans. This continues the discussion I began last Thursday on the subject of how to modernize the Medicare program into one which will meet the needs of 21st century seniors in America.

Last week, we discussed the need to fundamentally reform the Medicare program by shifting its focus from treating acute illness to promoting and maintaining wellness, essentially converting the Medicare program from one which has an orientation towards dealing with the disease or the results of an accident after they have occurred—a sickness system—to one that attempts to maintain the highest quality of health—a wellness system.

We discussed the fact that access to affordable prescription medications is crucial to the success of a health care system based on keeping seniors healthy, well, and active. And virtually every modality that is established to maintain the highest state of good health for seniors involves access to prescription drugs.

Additionally, we discussed that, in the long run, providing seniors with access to those components of an effective wellness system, such as preventive screening, medical procedures, and appropriate prescription drug therapies, can yield significant savings for the Medicare program and thus for the American taxpayer as well as providing the enormous benefits to the senior of good health and the active lifestyle that that will allow.

Let's look at the case of osteoporosis. Osteoporosis is a disease characterized by low bone mass, deterioration of bone tissue, leading to bone fragility and increased susceptibility to fractures, particularly of the hip, spine, and wrist.

Osteoporosis is a major public health threat for 28 million Americans. Eighty percent of those 28 million Americans are women. Osteoporosis is responsible for more than 1.5 million fractures annually in the United States. Included in this 1.5 million are 300,000 hip fractures, 700,000 vertebra fractures, 250,000 wrist fractures, and more than 300,000 fractures in other parts of the anatomy. Estimated national direct expenditures, including those for hospitals and nursing homes, for osteoporosis and related fractures is $14 billion a year.

The National Academy of Sciences and the National Institutes of Health agree that osteoporosis is highly preventable. A combination of a healthy lifestyle, with no smoking or excessive alcohol use, and bone density testing and medication and hormone therapies can keep men and women prone to this disease well and free of the debilitating, sometimes fatal, effects of fractures. Seniors and near seniors must have access to screening, counseling, and appropriate medication to keep this ''silent killer'' at bay.

One of the most common prescriptions for osteoporosis prevention is a treatment referred to as Fosamax. The annual cost of Fosamax is approximately $750. Contrast that with a hip replacement where the surgery and followup therapy will cost the Medicare program and taxpayers over $8,000.

It makes both programmatic and economic sense that these preventive interventions be included under the big tent of Medicare. They should be treated as all of the other benefits that 98 percent of those eligible for Medicare enjoy today.

Let me restate the fact that Part B of Medicare—that is the part that, among other things, covers physicians and outpatient services—is a voluntary program that seniors must elect to get the benefits and to pay the monthly premiums for participation in Part B. How many seniors in America who are eligible for that component of Medicare in fact make that election and pay that monthly fee to get those benefits? The answer: 98 percent of eligible seniors voluntarily elect to participate in Part B of Medicare.

Seniors trust and rely on Medicare. As a result, virtually all who are eligible to join voluntarily elect to do so. When the Federal Government decides that it should participate in providing a prescription drug benefit for American seniors, that benefit is best placed under the same big tent of the Medicare program.

Now, this is not a unanimous opinion. Some of my Senate colleagues believe that a prescription drug benefit should be left outside the tent, left to a sideshow status, if you will. In order to determine which way is truly the best way, the main tent of Medicare or a sideshow, it is important to answer some key questions.

Question 1 is what do the customers, the seniors and the people who live with disabilities, what do they want? How would they prefer this program to be organized and administered? We all know the old saying that the customer is always right. This will surely be true for the new drug benefit that we will offer to Medicare beneficiaries. Congress must learn to ask and to listen—in health care terminology, to first diagnose before we proceed to prescribe.

This should have been the lesson learned from Congress' ill-considered decision to add catastrophic coverage to Medicare in the late 1980s. We prescribed before we listened. When we listen, seniors tell us they like the Medicare program. Ninety-eight percent of them voluntarily elect to participate. In 1998, the Kaiser Family Foundation found that 74 percent of seniors surveyed believed that Medicare was doing a good job serving their interests.

Seniors tell us that while Medicare is not perfect, it is convenient, affordable, and dependable. They never worry that the benefits will suddenly disappear or become too expensive. They like the universality of the Medicare program. No matter where they are—in Kansas, in Utah, or in Florida—the benefits are available and affordable. They don't want to worry, as they would in some plans, that an income of $16,000 a year would make them ''too wealthy'' to qualify for help.

Including the prescription drug benefit in Medicare would offer peace of mind. But don't take my word for it. Another recent poll conducted by the Kaiser Family Foundation and Harvard University showed that when seniors are given the choice of having the Federal Government administer a Medicare prescription drug benefit versus the alternative of having the Government help to pay for private insurance plans, 36 percent chose the private option; 57 percent of the respondents preferred to have the benefit as part of an expanded Medicare program.

We hear over and over in statements on the Senate floor and occasionally even in political ads that Americans will be better off if prescription drug benefits are not made part of the Medicare program. But when we listen to the people, not to just political rhetoric, what we find is that Medicare beneficiaries do not complain about Medicare. Rather, we hear a desire to expand Medicare to include real prescription drug benefits. We should listen to these voices of the customers.

Question 2: Will a true Medicare benefit or a program that relies on private and State insurers be the most reliable? Predictability, sustainability, reliability are important qualities for America's seniors. The bill I have introduced with Senators ROBB, BRYAN, CONRAD, CHAFEE, and JEFFORDS assures that all beneficiaries, including those in underserved and rural areas, would be guaranteed a defined, accessible, affordable, and stable benefit for the same monthly premium nationwide. Medicare would subsidize benefits directly and pay for prescription drug costs as any other Medicare benefit.

In contrast, the plan that is being proposed by Governor George W. Bush and by House Republicans and by some

Members of this body asserts that prescription medications are a sideshow act and should not be included under the big tent of Medicare. They have outlined plans and introduced legislation to accomplish that objective.

We have heard from our colleagues that seniors do not want big government involved in their prescription drug benefit. My colleagues have said that the Vice President's plan and even the plan that has been introduced by a bipartisan group of our colleagues is a one-size-fits-all plan without adequate choice. Governor Bush attacks the Vice President's plan in his latest television ad entitled ''Compare,'' saying that ''AL GORE's prescription drug plan forces seniors into a government-run HMO.''

I would like to quote from the New York Times of September 16, which analyzes this latest ad. This is what the New York Times has to say under the category of Accuracy:

> Health maintenance organizations are not popular, so it is not surprising that the commercial links Mr. Gore's prescription drug plans to HMOs. But to do so is to stretch the facts.
>
> Mr. Gore does not force the elderly to accept his new prescription drug benefit. It is voluntary. And Medicare recipients can stay in traditional plans where they choose their own doctors.
>
> Mr. Gore's plan does rely on private benefit managers to manage the program—just like private insurers do—which encourages use of generic drugs and less expensive brand names. But these are not HMOs.

Some critics argue that it is Mr. Bush's plan that would increase the number of older persons enrolling in managed care. Mr. Bush would give the people the ability to choose between the traditional Medicare program, including a new drug benefit and government-subsidized private insurance packages. A question is whether the premiums would rise for traditional Medicare, causing more people to choose managed care.

Mr. President, I ask unanimous consent that the article from the New York Times of September 16 be printed in the RECORD immediately following my remarks.

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

(See Exhibit 1.)

Mr. GRAHAM. Let's take another look at what Governor Bush and others in the House, as well as some of our colleagues, would offer to seniors. They would offer choice in their prescription drug plan, but the choice is not for seniors. It is for the private insurers, the States, and other entities that might choose to participate. HMOs which participate can choose to offer an affordable benefit or a prohibitively expensive one or no prescription drug benefit at all. According to the Health Care Maintenance Organization, this year some 900,000 Medicare beneficiaries who had signed up with a Medicare+choice HMO have seen those benefits yanked away, as the HMO terminates coverage.

Many others have seen their HMOs either eliminate the prescription drug benefit, as have many in my State of Florida, or they have seen that benefit substantially reduced.

The House Republicans' plan looks to private insurance to offer prescription drug policies to seniors. We have discussed time after time that the private insurance industry has said it doesn't want to offer these plans. Maybe a reason for their disinclination to offer these plans can be provided through the window of a type of plan which is very similar to the Republican House proposal.

Under the current law, there are various types of Medigap plans—plans that are provided by private insurers to fill gaps in the Medicare program. Three of these Medigap plans cover prescription drug benefits. All three of these have a $250 deductible and a 50/50 cost sharing for coinsurance.

Plans labeled ''H'' and ''I'' cover drugs up to $1,250 in total spending and plan ''J'' covers up to $3,000 in total spending. None of these three plans offer what is referred to as a stop-loss. There is never a point in the process where the beneficiary is not forced to continue to pay half of the cost of their drugs.

Now, what does Medigap charge to get these programs which limit coverage, in two cases, to $1,250, and in a third, $3,000, without a stop-loss provision? The average cost of these plans nationwide, per month, is $136. In my State of Florida, the average cost per month is $167. This gives you some idea of what seniors are going to be asked to pay should we go to a private insurance model as the means of providing prescription medication. These costs are well beyond what is affordable for most low-income and many middle-income seniors.

With the history of broad variation, high, and unpredictable premiums and sub-par benefit packages, it is unclear to me why a Medigap-like approach to designing a Medicare prescription drug benefit would be in the best interest of America's seniors.

Finally, there is now before us a proposal for an ''immediate fix'' for low-income seniors with incomes up to 150 percent of poverty in the form of block grants to States. Not only would this plan cover only a fraction of Medicare beneficiaries, it would provide a patchwork quilt of coverage for those individuals who did qualify for the benefit.

States could offer coverage consistent with their current Medicaid or State drug assistance programs, or could punt their programs to the Federal Government if they chose not to participate at all.

Seniors in some States would have coverage, but when they move to another State, they might have no coverage, or different coverage. It would be like Forrest Gump and his box of chocolates—seniors would never know just what kind of coverage they would get.

The reason that 98 percent of Medicare-eligible beneficiaries sign up for the Medicare program is that it provides reliable, quality coverage for everyone equally and everywhere in the United States of America. So why would we treat a prescription drug benefit differently than we do for the rest of Medicare benefits?

A third question is who is eligible under the program and what will they get?

There is a great deal of rhetoric about who will be eligible under the prescription drug plans being offered. For Mr. and Mrs. Jones, who make $11,000 a year—100 percent of poverty—both of the plans offered in the Senate and by Texas Governor Bush claim that their drug coverage will be completely paid for. But what will that coverage be?

In Texas, the Medicaid program only covers three prescription drugs a month. So Mr. and Mrs. Jones would be out of luck if they required more than that. But if they moved to Illinois, the program might only cover drugs for certain conditions, as is the case with that State's current drug assistance program.

A prescription drug benefit within Medicare, such as those proposed by my colleagues and myself in the Senate and the Vice President, would ensure coverage of all medically necessary prescription drugs based on need without a benefit cap. That is the kind of reliability that seniors need. And what of my own constituent, Elaine Kett.

Elaine Kett is a 77-year-old woman from Vero Beach. She is a widow living on a fixed income of approximately $20,000 a year. Like many of my constituents, Mrs. Kett sent me a list of all the prescription drugs that she takes to keep herself active and well. Every year, Elaine Kett makes sacrifices to ensure that she takes the medications she needs to live a normal active life. There are millions of seniors like Mrs. Kett in the United States today. None of them would be covered by a low income block grant to the states.

Question Four: The final question, which approach would ensure that seniors have access to an affordable drug benefit—one which could be most effective in holding down the escalating prices of prescription medications?

Individuals like Mrs. Kett are not alone. We are all witnessing prescription drug prices climbing at record levels of over 17 percent per year. We are all aware of the fact that buying in bulk yields discounts. Those seniors without insurance plans that cover drugs are on their own in the market and are faced with the higher drug prices than those of us who have prescription drug coverage negotiated by a pharmacy benefit manager.

Tomorrow, we will discuss the impact of the high cost of prescription drugs on seniors—and what can and should be done to make prescription medications more affordable for seniors.

Mr. President, our families should be secure in the fact that prescription medications are included in the big tent of Medicare and are not treated as the bearded lady outside the big tent at the circus. For many seniors, prescription medications are the main event—and we should treat them as such. A prescription drug benefit in the Medicare program is not ''one size fits all,'' but rather one program for all. I look forward to discussing why a prescription drug benefit must not only be universal and accessible, but truly affordable.

Mr. President, when I give my fourth statement on this topic, I will elaborate on the question of which of the options that are before us inside the ''main tent'' of Medicare or the ''side tent'' of a separate non-Medicare administered prescription drug benefit, and which one will have the best opportunity of assuring affordability for America's seniors.

EXHIBIT 1

[From the New York Times, Sept. 16, 2000]

A THREE-PART ATTACK ON GORE

(By Alison Mitchell)

The Republican campaign of Gov. George W. Bush and Dick Cheney has begun broadcasting a commercial, ''Compare,'' in 18 states in its effort to take the offensive on the issues. It takes aim at Vice President Al Gore's stands on a prescription drug benefit in Medicare, on education and on tax cuts.

Producer Maverick Media.

On the screen. The 30-second commercial features statements about Mr. Gore's proposals in black on stark white background, counterposed with color pictures of Mr. Bush. It then shows pictures in color of Americans of different ethnicity, as it speaks of people who will not get a tax cut under Mr. Gore's $500 billion plan for tax relief.

The script. A female announcer: ''Al Gore's prescription plan forces seniors into a government-run H.M.O. Governor Bush gives seniors a choice. Gore says he's for school accountability, but requires no real testing. Governor Bush requires tests and holds schools accountable for results. Gore's targeted tax cuts leave out 50 million people—half of all taxpayers. Under Bush, every taxpayer gets a tax cut and no family pays more than a third of their income to Washington. Governor Bush has real plans that work for real people.''

Accuracy. Health maintenance organizations are not popular, so it is not surprising that the commercial links Mr. Gore's prescription drug plan to H.M.O.'s. But to do so it has to stretch the facts.

Mr. Gore does not force the elderly to accept his new prescription drug benefit. It is voluntary. And Medicare recipients can stay in traditional plans where they choose their own doctors. Mr. Gore's plan does rely on private benefit managers to manage the program—just like private insurers do—which encourages use of generic drugs and less expensive brand names. But these are not H.M.O.'s.

Some critics argue that it is Mr. Bush's plan that would increase the number of older people enrolling in managed care. Mr. Bush would give people the ability to choose between the traditional Medicare program including a new drug benefit and government-subsidized private insurance packages. A question is whether the premiums would rise for traditional Medicare, causing more people to choose managed care.

On schools, Mr. Bush and Mr. Gore both propose testing and different kinds of accountability measures, but Mr. Bush's proposal calls for tests that would cover more grades and be more frequent than does Mr. Gore's.

It is true that Mr. Bush's $1.3 trillion 10-year tax-cut plan would give a tax reduction to every income bracket while Mr. Gore's plan for $500 million in targeted tax cuts would give tax breaks only for purposes like college education or child care.

Score card. With its tag line, ''Governor Bush has real plans that work for real people,'' the spot suggests that Mr. Gore is not credible and neither are his programs. But Mr. Bush has his work cut out for him. Many polls show that voters trust the Democratic candidate more on health care and education. And while Mr. Bush may have the Republican's traditional advantage when it comes to tax-cutting, right now tax cuts are not one of the top concerns of voters.

IN MEMORY OF MURRAY ZWEBEN, FORMER SENATE PARLIAMENTARIAN

Mr. DASCHLE. Mr. President, over the weekend we were saddened to learn of the death of Murray Zweben. Murray was chosen by the late Floyd Riddick to be his assistant in the Parliamentarian's office in 1965. He followed ''Doc'' Riddick in that post and became the Senate Parliamentarian in 1975. He served in that capacity for 6 years and left in 1981. The Senate recognized his exemplary service in 1983 by elevating him to parliamentarian emeritus. After he left the Senate, Murray worked in private law practice and played as much tennis as his schedule would permit. Those of us who knew Murray and his extraordinary ability to fly through the New York Times crossword puzzle, in ink no less, will miss him. Our thoughts and prayers go out to his wife Anne, and his children Suzanne, Lisa, Marc, John, and Harry.

SUBMITTING CHANGES TO H. CON. RES. 290 PURSUANT TO SECTION 218

Mr. DOMENICI. Mr. President, section 218 of H. Con. Res. 290 (the FY 2001 Budget Resolution) permits the Chairman of the Senate Budget Committee to make adjustments to the allocation of budget authority and outlays to the Senate Committee on Armed Services, provided certain conditions are met.

Pursuant to section 218, I hereby submit the following revisions to H. Con. Res. 290:

[By fiscal years; in millions of dollars]

Current Allocation to Senate Armed Services Committee:	
2001 Budget Authority	$50,139
2001 Outlays	50,129
2001–2005 Budget Authority	267,298
2001–2005 Outlays	266,974
Adjustments:	
2001 Budget Authority	50
2001 Outlays	50
2001–2005 Budget Authority	400
2001–2005 Outlays	400
Revised Allocation to Senate Armed Services Committee:	
2001 Budget Authority	50,189
2001 Outlays	50,179
2001–2005 Budget Authority	267,698
2001–2005 Outlays	267,374

THE MADRID PROTOCOL IMPLEMENTATION ACT

Mr. LEAHY. Mr. President, we are fast approaching the end of this Congress and we have much unfinished business. While there are many items of importance to the American people that remain undone, I will speak today about a single bill that has been languishing for some time despite the fact that it is wholly uncontroversial. That bill is S. 671, the Madrid Protocol Implementation Act.

This bill is important to American businesses, both big and small. As the International Trademark Association explained in a letter to me on February 9, 2000 on behalf of its 3,700 member companies and law firms, ''the practical benefits of the Madrid system, such as ease of applying and renewing trademark registrations internationally, will be of tremendous benefit to U.S. companies'' and, in particular, the benefits to ''small, entrepreneurial companies which do not have the financial means to seek separate national registrations for their trademarks in every country where they wish to do business.'' The bill and the Protocol are also supported by the American Intellectual Property Law Association and the Information Technology Association of America.

I first introduced this legislation in the 105th Congress as S. 2191 and again in this Congress in March, 1999. The Judiciary Committee reported S. 671, favorably and unanimously, on February 10, 2000. Unfortunately, the legislation has been languishing on the Senate calendar for the past eight months. In the House of Representatives, Congressmen COBLE and BERMAN sponsored and passed an identical bill, H.R. 769, on April 13, 1999. This marked the third time and the third Congress in which the House of Representatives had passed this bill.

There is no opposition to S. 671, nor to the substantive portions of the underlying Protocol. The White House recently forwarded the Protocol to the Senate for its advise and consent after working to resolve differences between the Administration and the European Community, EC, regarding the voting rights of intergovernmental members of the Protocol in the Assembly established by the agreement. These differences over the voting rights of the European Union and participation of intergovernmental organizations in this intellectual property treaty are now resolved in accordance with the U.S. position. Specifically, on February 2, 2000, the Assembly of the Madrid Protocol expressed its intent ''to use their voting rights in such a way as to ensure that the number of votes cast