

“(b) LIMITATION BASED ON ADJUSTED GROSS INCOME.—The amount of the credit which would (but for this subsection) be allowed under this section for the taxable year shall be reduced (but not below zero) by an amount which bears the same ratio to such amount of credit as the excess of the taxpayer’s adjusted gross income for such taxable year over the exemption amount (as defined in section 59B(d)) bears to such exemption amount.”.

(2) TECHNICAL AMENDMENTS.—

(A) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period “or from section 35 of such Code”.

(B) The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

“Sec. 35. Cost-sharing expenses under MediKids program.

“Sec. 36. Overpayments of tax.”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2002.

(d) REPORT ON LONG-TERM REVENUES.—Within 1 year after the date of enactment of this Act, the Secretary of the Treasury shall propose a gradual schedule of progressive tax changes to fund the program under title XXII of the Social Security Act, as the number of enrollees grows in the out-years.

ORDER FOR ADJOURNMENT

Mr. GRASSLEY. Mr. President, we want to make sure there is time this evening for Senators BINGAMAN and LEVIN to give their remarks. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order, following the remarks of Senator BINGAMAN and Senator LEVIN.

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

The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I thank the chairman of the committee. I appreciate the chance to speak briefly on this bill. It is a very important piece of legislation. I congratulate the Senator from Iowa on the hard work he has put into this legislation. I do not share his conclusion about it at this stage, but I certainly admire the work he has put in and admire the good job he does as chairman of the committee on which I serve.

When the 2000 Presidential campaign was underway, I saw one of the debates between then-Governor Bush and then-Vice President Gore. Both of them in that debate endorsed the enactment of a prescription drug benefit for seniors for Medicare beneficiaries. I remember thinking when I saw that, this is one good thing that will come out of this campaign in the next few years, no matter who wins. But what I had in mind as a prescription drug benefit was a very different animal than what we have in these 1,100 pages that have been referred to repeatedly.

What I had in mind was a benefit where Medicare beneficiaries would be able to sign up for a prescription drug benefit. It would be voluntary. They

could sign up or not. They could then pay a monthly premium. They would get a card. They could take that card, go to the pharmacy and get their prescription drugs. They might have to pay a copay. They might have to pay some deductible. But it was basically the adding of a prescription drug benefit to Medicare. That is what I thought both candidates were talking about.

That is not what we have in these 1,100 pages. Had we decided to enact that, it could have been done in a much smaller document.

I regretfully have to oppose the conference report for H.R. 1 as it comes before us tonight and tomorrow.

I will cite six reasons I have come to that conclusion. The first reason is that the bill, in my view, over time, will undermine traditional Medicare.

The second reason is that the bill requires the Government to overpay private health plans by tens of billions of dollars.

The third reason is that the bill actually will harm many senior citizens who are intended to benefit.

Fourth, the bill will increase drug costs rather than reducing them.

Fifth, the bill will dramatically increase the complexity and volatility of the Medicare system for many of our seniors.

Finally, the sixth point is that the bill will increase the financial burden on States and make it more difficult for each of our States to maintain the benefits they provide through their Medicaid programs to low-income patients.

Let me start with the problem that I see of this bill undermining traditional Medicare. Today, 88 percent of all of those 41 million people who are served by Medicare are enrolled in traditional Medicare. The major thrust of this bill is not to add a prescription drug benefit but instead to do what is euphemistically referred to as “modernize” Medicare.

Now, there are definitely some things we should do to modernize Medicare. I would agree with that. But as that term is used in this discussion, most of the time it is a code word, meaning that we should move people—seniors and disabled individuals—out of traditional Medicare into the private health care system. That is what is meant by a lot of our colleagues when they talk about modernizing Medicare.

There are two good reasons for moving people out of traditional Medicare into the private health care system, as I see it. I could certainly favor doing that if we could accomplish these purposes. The first, obviously, would be to make the program more efficient and save money—save some taxpayer dollars by moving these people out of the Government plan into a private plan.

The second, of course, would be if we could improve services, increase the satisfaction of Medicare beneficiaries by moving them into the private plan.

Let me just show this chart. Medicare cost growth: This relates to the

first of those two points. Medicare has historically controlled costs far better than either private health care plans have, or even better than the Federal Employees Health Benefits Program, FEHBP. We all take great pride in the FEHBP program and talk about how this is a great benefit and we should extend it to others.

Between 1969 and now, Medicare’s costs have increased at an annual rate of 8.9 percent a year, which stands in contrast to the 11 percent growth rate in the private health insurance arena and 10.6 percent growth rate in FEHBP. So the ideology of this drive to modernize Medicare or move people out of traditional Medicare into the private system does not match the evidence. In fact, the recent record is even more dramatic. Between 1996 and 2003, Medicare’s per capita growth was 4.2 percent compared to 5.9 percent for private health plans and 5.3 percent for FEHBP.

Medicare wins the contest going away. But maybe some are willing to pay higher costs, so this chart should make that point. The red line shows the increase in costs from 1970 to the end of the century in private insurance. The blue line shows the increase in the cost of Medicare. They have both gone up, but Medicare has gone up less rapidly. We might still be willing to pay more—pay the amount required to put people on this red line if, in fact, we had greater patient satisfaction by doing so.

There is a recent study by the Commonwealth Fund, published in Health Affairs, and it is reflected on this chart. It is hard to read because the colors are too similar. What is reflected is that of those with private health insurance, there were 51 percent of those who were satisfied, and 62 percent of those in traditional Medicare were satisfied with their coverage. That is the case, despite the fact that Medicare benefits are less generous and its beneficiaries are more elderly and disabled and have higher health needs than individuals in the private health care system.

So the bill seeks to move people out of traditional Medicare into private health plans. It does so by dramatically overpaying the private health plans.

Let me move to my second point. Since managed care is not more efficient than traditional Medicare, the conference report concludes that the way to get people into these private health plans is to spend billions of dollars in overpayment to those plans.

The legislation begins by setting its benchmark for payments to private plans at 109 percent of what Medicare fee for service would have to spend for those beneficiaries. It does so in other ways as well, including giving health plans money that Medicare otherwise would pay to a disproportionate share of hospitals, to graduate medical education, and the cost of veterans retiree health care.

It makes no sense to me to subsidize and pay health plan payments that Medicare intends, or could have, for safety net hospitals or teaching hospitals or veterans retirees. These HMOs do not provide unpaid services to the poor. They do not educate our Nation's medical students. They do not provide health care to our veterans. Yet the conference report provides payment for such services.

It makes no sense, but it is intended to camouflage the fact that private health plans cannot compete with traditional Medicare if they merely receive the amount traditional Medicare spends to provide these services to beneficiaries. So that is not enough.

The other thing that is done is that we, in this bill, provide a \$10 billion to \$12 billion stabilization fund. That stabilization fund essentially is money that the Secretary of Health and Human Services has available to add to what private plans are receiving and further advantage them over the traditional Medicare system if he or she determines that that is necessary in order to keep them providing services to this portion of our population.

Of course, the other issue that I think is extremely important is that these private health plans, under the legislation, are fully free to engage in practices that allow them to enroll healthy Medicare beneficiaries and shift the sicker and the more costly or elderly beneficiaries into the Medicare system. They do this by adjusting their benefits. They do this by designing their benefit packages and marketing them to the healthy segments of the society.

Some might ask how do they do this. I will give you an example. Some private plans impose a higher cost share for services such as chemotherapy or renal dialysis than traditional Medicare in order to encourage those who have contracted cancer or renal failure to enroll, to leave the private plan and to go back into traditional Medicare.

Proponents of the bill say what they are trying to do by getting these private plans involved is to foster competition. Obviously, we all favor competition, but I do not see that it is particularly competitive for us to provide this kind of very major subsidy.

When you add together the 109 percent payment to the private plans and the risk selection in which they are permitted to engage, private plans will be paid an estimated 25 percent more than the cost of traditional Medicare for each enrollee, for each beneficiary. This amounts to \$1,920 more per enrollee in the year 2006.

A third problem is the bill actually does harm. I mentioned what many of my colleagues have already mentioned, and that is the 2.7 million retirees who are expected to lose their prescription drug coverage once we enact this legislation.

Also, the Congressional Budget Office analysis says as to low-income beneficiaries, there are 3.4 million low-in-

come beneficiaries who will benefit from this; there are 6.4 million low-income beneficiaries currently enrolled in Medicaid who will be worse off. It is hard for me to see how that adds up to a major benefit for a lot of those people who are expecting a benefit under this legislation.

Let me talk a minute about drug costs. What will this bill do for drug costs? When I talk with seniors in my State, the No. 1 problem they cite to me when it comes to prescription drugs is the enormous growth in the cost of those drugs.

I have concluded, reluctantly, that not only will this legislation not bring down drug costs but it will actually cause them to go up. Surveys indicate that Medicare beneficiaries cite this as their No. 1 problem. The Congressional Budget Office has concluded the conference report will actually raise the price of drugs by 3.5 percent overall.

The legislation that is before us, this 1,100 pages, delivers to hundreds of private drug companies and HMOs an insurance-administered drug benefit that vastly dilutes the purchasing power of Medicare. Rather than Medicare purchasing the drugs in bulk to achieve significant savings, the medication splits Medicare's purchasing power into hundreds of purchasing pools and eliminates the significant leverage that Medicare could have in controlled costs.

This bill expressly prohibits Medicare from negotiating for prices. People need to focus on that. Here we are setting up a program where Medicare is going to pay for prescription drugs, and we are prohibiting Medicare from negotiating as to the price it is going to pay.

Consumers Union came out with a report last week saying the proposal's modest benefits, coupled with an expected high growth of prescription drug prices, could result in major disappointments for many of these Medicare beneficiaries. Medicare beneficiaries at most prescription drug expenditure levels will actually face higher out-of-pocket costs when they have coverage in 2007—that is one year after the bill is implemented—than they do in 2003 when they have no coverage.

That is an incredible finding, in my view. For example, it only provides people with a benefit of around \$1,000 for the first \$5,000 in prescription drug spending. When you couple that with weak cost containment provisions, the Consumer Union finds that the average out-of-pocket spending for beneficiaries rises to \$2,900 in 2000 compared to \$2,300 in 2003 for beneficiaries with absolutely no prescription drug coverage.

Let me also move to this final chart to talk about the problem of complexity and volatility. I heard some of the majority leader's comments earlier this evening. He indicated that one of the great advantages of this bill is that it would reduce paperwork. I would

love to understand that. How we can enact this enormous piece of legislation and see it reduce paperwork is a mystery to me.

This is a chart that was put together by the Medicare Rights Center. It tries to set out some depiction of how this is all going to work. I can't begin to explain it to you at this point, but I can tell you that you can study it for a great length of time and still not understand how it is going to work.

Most people receiving benefits through Medicare choose traditional Medicare. They like the stability of traditional Medicare.

The Washington Post today had a story about the problems beneficiaries who have enrolled in Medicare+Choice have encountered: the changing benefits that health plans offer on an annual basis; the changes in premiums and copayments; the problem of health plans coming in and out of the marketplace. We have had that problem in my State of New Mexico. Health plans come in, advertise, sign up a lot of people, and 6 months or a year later they announce they are not making money and they pull out. They send a letter to everybody and say: Sorry, we decided not to provide your benefits. Those people come to my office and say: What are we going to do?

This is a volatility in the system that most people on Medicare do not appreciate. I see that increasing dramatically under this legislation. How in the world we can see less paperwork, how in the world we can see less complexity and less volatility as a result of this bill escapes me.

A final point I want to make is the impact on States, expanding on this concept of "do no harm." This legislation has potentially major negative consequences for our States. In the first 3 years of the bill, the Congressional Budget Office estimates that the costs, or the unfunded liability of the bill to the States in their Medicaid programs, will be \$1.2 billion.

We are, in effect, adding \$1.2 billion in costs to the Medicaid Program at a time when States have been begging for relief from the Federal Government due to the growing Medicaid costs that States have experienced because of the slow economy and the growing beneficiary roles.

States have had to make rather dramatic cuts in their Medicaid programs because of these changes, and this \$1.2 billion in additional costs to them will result in additional cuts in Medicaid.

There is a misconception, I believe, about this legislation, and that is, people think that because Medicare is taking over the payment for dual-eligibles—that is low-income individuals who are eligible for Medicaid but also old enough to be eligible for Medicare—since Medicare is going to take over that expense, people think this is going to save the States money.

First of all, until the year 2008 under this legislation, States do not receive any benefit from the Federal assumption of drug costs for dual-eligibles or

low-income beneficiaries who currently get their prescription drugs from Medicaid. That is 5 years from now before they receive any benefit. States expecting to get savings from this bill, in the words of the National Conference of State Legislatures, will be "deeply disappointed."

In addition, this report contains what is called the clawback or the reverse block grant. This is a new concept to me, but it is a fascinating one. Instead of the Federal Government giving a block grant to the States, the Federal Government legislates a requirement on the States to give the Federal Government a block grant.

It is through this clawback or reverse block grant the Federal Government demands that States pay the Federal Government for any savings the Federal Government estimates the States might gain from the new Medicare Program.

When we take the period between 2004 and 2013, the amount the States will have to pay back to the Federal Government is \$88.5 billion. Now, that is a big number, \$88.5 billion. The conference report requires States to write checks to the Federal Government in the amount of \$5.7 billion in 2006. This goes up to \$14.9 billion in 2013. Over that 7-year period, that is a 261 percent increase in the amount the States have to pay the Federal Government.

One may ask how they go up that much. It goes up that much because the Federal Government has built into this a 15 percent compounded inflation rate, and that is being imposed on the States. The States have nothing to say about it. If the States want to participate in Medicaid, they will pay that amount back to the Federal Government.

State general revenues, tax revenues, will not go up 15 percent annually during those 7 years. So States are rightfully upset by this clawback. They rightfully point out that they are being required to now pay an inflation rate for something they do not control. The clawback, or the reverse block grant, is increasing by 261 percent over 7 years.

What this is going to do is to put increased pressure on State budgets which will result in cuts in Medicaid, cuts in education, cuts in transportation. This should not be an acceptable outcome for those of us in the Senate. The bill we sent to the conference from the Senate loaded a \$10 billion burden on the States. Now that it has come back to us, it has an \$88 billion burden that we are loading on the States as part of this legislation.

I would add one other point about this burden. There is a group of 20 States that have a cap that is imposed upon them through Medicaid's disproportionate share hospital program. That cap says they can receive no more than 1 percent of the total Medicaid spending in their State. That compares to 8 percent, which is the national average.

The 20 States I am talking about are called low-DSH States. New Mexico is

one of those States. I authored legislation to increase that 1 percent to 3 percent, not to get it up to the national average, which would have been 8 percent, but to get it up to 3 percent. That would have allowed the disproportionate share hospitals in my State, instead of receiving \$9 million a year, to receive a total of \$45 million a year.

Unfortunately, the conference report cut the amount my State would receive from \$45 million down to \$10 million. Current law is \$9 million. Under this bill, we would go to \$10 million instead of going from \$9 million to \$45 million.

In sharp contrast, Louisiana's share of the Medicaid DSH funding goes from \$500 million to \$600 million next year. This is an unacceptable disparity, in my view. Louisiana's \$100 million increase is more than the \$43 million increase that is provided to all of the 20 low-DSH States combined. This precludes States such as mine from protecting their safety net hospitals and dealing with the fact that the uninsured rate in our States has increased by 4 million people over the last 2 years.

In conclusion, it is my view that Congress does its worst work under the circumstances we are being presented with tonight and tomorrow. It is late in the session. There is no time for adequate review of the 1,100 pages that have been put on each of our desks. We are being pushed up against a totally artificial deadline. This is not the end of the Congress. It is barely the middle of the Congress. There is no reason this bill has to be passed before we leave for Thanksgiving. We could either come back after Thanksgiving or we could take it up in January.

I have a letter from the Democratic Governors Association which says: We urge you to reject any efforts to vote on this legislation before you know its full content and cost impact on your State and the people we both serve.

This is to all Members of the Senate from the Democratic Governors Association. They go on to say: Any rush to judgment without the necessary information may have both short- and long-term consequences that could prove to be irrevocably severe.

We do not know the consequences of this legislation that we are being urged to pass tomorrow. We owe it to senior citizens in this country to understand what we are doing. We owe it to the taxpayers of the country to buy health care services for seniors without overpaying for those health care services. We owe it to the public to do all we can to reduce health care costs. Unfortunately, we are doing none of these things if we take up this bill and pass it tomorrow.

I hope Senators will join me in voting not to send this bill to the President in its present form.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Mr. LEVIN. Mr. President, first, I commend the Senator from New Mex-

ico for his analysis of this bill. I listened to the last part of it and I thought it was exactly on point. I particularly would like to emphasize his last point, which is that this is not the end of the Congress, this is just the end of a session, or nearing the end of a session.

With 4 days' notice of a bill of this complexity—now, I think the bill itself is about 700 pages and there are hundreds of pages of commentary that go with it, but the idea that we should take up a bill of this complexity, when seniors are just having the first opportunity after 4 days to try to fathom what is in it, is a terrible mistake.

The Senator from New Mexico was exactly right in urging that we not rush to consider this bill tomorrow and to adopt this bill. It took a great deal of effort to create Medicare. It was not until 20 years after Harry Truman first proposed the idea of a guaranteed health benefit for seniors that President Lyndon Johnson signed the Medicare Program into law. It was fitting that Harry Truman was the program's first beneficiary. He paid his \$3 premium and he enrolled in Medicare in 1965.

We are confronting in this bill a turning away from Medicare's noble purpose. That purpose was to create an insurance pool for all seniors, where the risks and financial burdens are shared—not for the profit of insurance companies or pharmaceutical companies but for the common good. The legislation before us is a fundamental and ill-advised restructuring of Medicare under the guise of adding a prescription drug benefit to the program.

Many Members of Congress have worked for years to bring a Medicare prescription drug benefit to fruition. While the Senate-passed version of this bill had enough flaws to cause me, along with a number of colleagues, to vote against it, at least I was hopeful that some of these flaws would be corrected in the conference committee. Unfortunately, the prescription drug plan before us not only worsens the prescription drug program as adopted by the Senate, it has become a millstone dragging Medicare down with it.

The promise of a prescription drug plan is being used to begin the unraveling of Medicare. First, there are the dangers for seniors created by the prescription drug provisions themselves. The Congressional Budget Office estimates that up to 25 percent of retirees, with existing prescription drug coverage through a former employer, would lose that coverage under this bill's plan. That is about 2.7 million senior citizens who currently have good private insurance and are paying less now than they would have to under a Medicare prescription drug plan. That is 2.7 million retirees who will lose benefits, above and beyond the number of retirees who are projected to lose their benefits under the current trend of employers reducing prescription drug coverage for their retirees.

The tax subsidies for employers included in this conference report are not enough to entice employers to keep their drug coverage for those 2.7 million retirees.

Another fundamental flaw with the prescription drug benefit in this legislation is the lack of a guaranteed Medicare prescription drug plan. In the Senate bill, in the absence of two competing private plans offering a senior a prescription drug benefit, Medicare was the fallback. This approach was gutted in conference. Here is what the conference report provides. If one insurance company in a region offers a prescription drug benefit, regardless of how unattractive it is to seniors in terms of its premiums and copayments, both of which are left up to the insurance company, and if an HMO offers coverage in that region as a substitute to Medicare, no matter how unattractive that HMO is to seniors, and assuming that HMO also offers a prescription drug benefit, the senior will not be offered the fallback Medicare prescription drug benefit.

Let me put that another way. We begin with the fact that private insurance companies offering a prescription drug policy under this bill could charge whatever premiums and copayments they want. If only one private prescription drug plan exists in a region, regardless of how unappealing it is, and one HMO offering a prescription drug plan also exists in that region, a senior has the choice of purchasing the bad prescription drug plan or leaving Medicare to join an HMO that he or she does not want to join, in order to get that prescription drug benefit. Forcing seniors to make the choice between staying in traditional Medicare or leaving Medicare and joining an HMO they otherwise would not join in order to get a prescription drug benefit is a thinly disguised attempt to unravel and privatize Medicare. That is a choice no senior citizen in America should have to make.

Also troubling is the fact that the private company which offers the prescription drug benefit, and the company which offers the managed care alternative to Medicare, can be one and the same under the provisions of this bill. In addition, the prescription drug benefit in the legislation before us has a large gap in the prescription drug coverage. Once a senior's total drug spending reaches about \$2,500 for the year, he or she will have to pay 100 percent of the cost of their prescriptions until their total drug spending reaches \$3,600. This has come to be called the donut hole. This coverage gap will leave many seniors to pay the full cost of prescriptions at a time when they most need assistance. I know of no other insurance program that is so unfairly structured in that way.

Adding insult to injury, while there is a gaping hole in coverage, there is no gap in the requirement to pay premiums. That obligation continues, even during the period that benefits are halted.

One of the most disturbing aspects of this legislation is the fact that private insurance companies can use the purchasing power of their large number of beneficiaries to negotiate lower prescription drug prices, but Medicare is prohibited from doing so. This is one of the most unacceptable ways this bill protects private insurance companies and prescription drug companies from fair competition from Medicare, all at the expense of seniors and American taxpayers.

Ask veterans how much prescription drugs cost at VA hospitals compared to their local pharmacy. Many of the drugs the VA offers are as little as half the price. The reason is the VA buys drugs in large quantities from drug manufacturers and has leverage in negotiating the prices. Instead of buying the 30-day supply of pills for someone on Medicare, why not allow Medicare to buy thousands of 30-day supplies at once for a fraction of the cost? That makes a lot of sense, but it is prohibited under this bill.

The conferees left out some other real solutions to address the high cost of prescription drugs. Both the House and Senate-passed versions included a provision to allow seniors to buy drugs in other countries at lower prices, so-called reimportation provision. However, these provisions have been stripped from the final bill. Even though the House and Senate have voted to allow reimportation with strong bipartisan votes, the conferees ignored these votes. More important, they ignored the problem of high prescription drug costs. Americans pay more for prescription drugs than any people in the world. U.S. taxpayers' dollars help to subsidize the research and development of many prescription drugs. Yet drug companies then sell them abroad for less. Because this bill does not address the high cost of prescription drugs, needed medicine will still be inaccessible for millions of our citizens.

Unfortunately, the prescription drug benefit in this bill is what Newt Gingrich envisioned for the future of the entire Medicare Program. The former House Speaker said that he wanted Medicare to wither on a vine. To slowly chip away at the foundation of Medicare until it crumbles with a private network of managed care and drug companies eventually replacing Medicare is what he envisioned.

Apparently AARP, which once stood for preserving social insurance for America's seniors, agrees with Mr. Gingrich. The AARP executive director and CEO wrote the forward to the former Speaker's book entitled "Saving Lives and Saving Money," and later commented that "Newt's ideas are influencing how we at AARP are thinking about our national role and in our advocating for system change."

With this bill, the chief cooks of the Republican Party are following Newt Gingrich's "wither on a vine" recipe for the future of Medicare.

The six so-called premium support demonstration projects created by this bill are the opening act for the privatization of Medicare. Proponents argue that Medicare's costs won't come down without a private sector competitor. But this bill, while purporting to promote competition between Medicare and private insurers, tilts the playing field against Medicare. First, there is a \$12 billion so-called stabilization fund, which is in reality a slush fund. It is a slush fund for insurance companies to subsidize their policies. The \$12 billion in slush money is not available to traditional Medicare, only to the private insurance companies.

Second, the claims of the insurance industry that they will and must accept every senior who applies are disingenuous. Here is why. Private insurers will have the flexibility to alter and change their plans, to be able to cherry-pick the healthy senior. For example, if an insurance company designed a program with a very low monthly premium but with high copayments and high deductibles, this would be an incentive for a healthy senior to enroll, someone who could risk having to pay high copayments and deductibles because he or she has relatively infrequent medical treatment. Less healthy seniors, whose frequent medical treatments make it difficult or impossible for them to pay high copayments and high deductibles, would be left for the Medicare program to cover. This is privatization plus. It simply cannibalizes Medicare. Subsidizing insurance companies and allowing them to cherry-pick the beneficiary population means that insurance companies will be profiting mightily, while leaving the U.S. taxpayer to pick up the tab of insuring the less profitable population.

How did we arrive at this ill-conceived legislation? Democrats were all but shut out of the conference committee which wrote this bill. Only two Democrats were allowed to participate in the conference negotiations. This massive shift in Medicare's approach and purpose was delivered publicly to us about 4 days ago. In this bill's 700 pages are provisions to dismantle Medicare as we know it, replacing it with a network of private insurers and drug companies whose goal is making a profit.

There is a fundamental difference between private industry and government: Private companies fail if they do not make money, while government fails if we do not help citizens—especially those that cannot help themselves.

I have heard from many of my constituents in the State of Michigan who need help in getting affordable prescription drugs. Let me read you a few excerpts from letters that I have received on this issue. One constituent writes:

I am writing for your support for the Medicare Program. Please provide a Medicare drug benefit that is comprehensive, affordable and secure. Do not undermine Medicare

as a defined benefit program through privatizing it.

Another constituent writes:

We do not want a drug bill that eliminates or reduces our current prescription plan that we now have . . . When I retired . . . this plan was part of my benefit package and we felt that it is their obligation to continue it, and the cost of our drugs should not be passed on to the tax payers.

I get hundreds of messages a week like that from constituents with concerns over the privatizing of Medicare and the possible loss of existing prescription drug benefits. It is estimated that this bill, if it becomes law, would cause 138,000 seniors in Michigan currently receiving prescription drug benefits to lose some or all of those benefits. And 90,000 seniors in my State who are Medicaid beneficiaries with a current prescription drug coverage will be worse off if this bill becomes law than they are under current law.

A fundamental restructuring of Medicare of this magnitude demands careful and thoughtful deliberation. The conference report contains a large amount of new material not included in either

the House-passed or Senate-passed bills. Hastily acting on this legislation is fundamentally unfair to millions of seniors who want and deserve to be treated fairly. I predict that when seniors become familiar with this bill's details, there will be a crescendo of opposition.

The siren song you hear now principally from our Republicans colleagues is that competition is necessary to drive the cost of health care down. The reality of this bill is not competition but government subsidies for insurance companies while allowing them to carve out the most profitable segment in the business—caring for the healthiest—leaving the seniors with greatest need as the responsibility of the Federal government. Privatizing the most profitable part with a subsidy is not competition; it is a huge gift to private companies at the expense of the U.S. Treasury.

Supporters of this legislation say they are harnessing the power of the marketplace to drive down prices. The reality is just the opposite. They are hobbling the Medicare program in the

prescription drug program by letting the private provider use its purchasing power to drive down its drug prices, but not letting Medicare do the same; and in the dismantling of Medicare, by pushing people out of Medicare into private HMOs in order to obtain a prescription drug benefit.

The bill before us will begin undoing 37 years of progress in Medicare. It is an ill-advised assault on the one program that guarantees medical care to our most vulnerable population, our senior citizens. An historic opportunity is being squandered if we adopt this bill. Our Nation's seniors deserve better. I yield the floor.

ADJOURNMENT UNTIL 9 A.M.
TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9 a.m. tomorrow morning.

There being no objection, the Senate, at 10:45 p.m., adjourned until Monday, November 24, 2003, a 9 a.m.