of the House, the gentleman from Florida (Mr. STEARNS) is recognized for 5 minutes.

Mr. STEARNS. Mr. Speaker, I am here this afternoon to talk about the Patients' Bill of Rights. Is this legislation necessary? The issue of whether or not Americans enrolled in HMOs, health maintenance organizations, need passage of the patient protection in order to sue their plans is currently in conference here in Congress.

Today, I would like to call my colleagues' attention to a study by John S. Hoff. Mr. Hoff wrote this study for the Heritage Foundation, and he outlined some very compelling arguments about why passage of this legislation would result in more government control of our health care system.

It is interesting that we are having this debate, because, Mr. Speaker, I think the majority of Americans already made clear their views on more regulation for health care when the Clinton health care bill was overwhelmingly rejected.

The Heritage Foundation Backgrounder N1350 concludes that increased regulation, plus increased litigation will equal rising costs in health care and, ultimately, more uninsured Americans. The gentleman from Iowa (Mr. GANSKE), my good friend and colleague, has been very critical of this study and did a Special Order to refute the analysis of this health bill. I am not here to comment on his presentation; but my purpose is, more importantly, to talk about Mr. Hoff's analysis and why Mr. Hoff's analysis, I think, has credible evidence. So I am here to merely present the other side of the argument that opposes imposing further Federal Government regulations on health care plans and delivery of health care.

So according to Mr. Hoff, let us take each of the major items. He believes the Patients' Bill of Rights, in conference as we speak, increases regulation. If passed, it would impose detailed regulations by the Federal Government on health care plans and the delivery of health care. The question is, does anyone in this House think passing more government legislation will decrease the Government's involvement? In fact, I think most of us, every time we pass legislation that is going to increase government involvement, there is going to be more regulation. I think the regulation, as Mr. Hoff pointed out, is pervasive in this bill.

For example, private health plans normally evaluate medical services, treatments and procedures. Under the Patients' Bill of Rights, however, managed care plans and fee-for-service plans are allowed to conduct such utilization reviews only, only as specified by the Federal Government. The time allotted for a decision and the status of those making a decision are two examples of such specifications. Further regulation involves an appeals process for denial of coverage. The proposed legislation requires an internal appeals process that follows precise, regulatory details on each and every procedure.

It further requires a provision of external appeals of decisions made in the internal appeals process. The external appeal requires that the plan contract with an entity that is directly or indirectly certified by the Department of Health and Human Services, or the Department of Labor. So there we have it. We have both of these large agencies involved in conducting the reviews. I think this arrangement can lead to a situation in which the final determination of what is covered by a plan is made by an entity certified, regulated, and answerable only to the United States Government.

Mr. Speaker, the proposed legislation also leads to Federal intrusion into the physician-plan relationship. Under the Patients' Bill of Rights, provisions of contracts between plans and health care providers are void if they restrict or have the effect of restricting the provider's ability to advise a patient about their health status or medical treatment. The legislation further intrudes by precluding a plan from discriminating with respect to participation by providers or in payment to them on the basis of license or certification under State law.

Let us take another item. I mentioned earlier increased litigation. In addition to the increased burdens of regulation, this Patients' Bill of Rights in conference is talking about increased litigation. Each of the many regulations contemplated by the legislation will create legal rights that could be causes of action.

In addition to an increasing number of actions that plans may be liable, the legislation opens up employers themselves to the possibility of being sued for damages resulting from denial of coverage. While the bill purports to protect employers if they refrain from the exercise of discretionary authority to make a decision on a claim for benefits, courts have been willing and creative in finding ways around similar provisions.

Defenders of the legislation point to provisions which limit litigation. These provisions, however, apply to actions brought under ERISA claims only; they do not apply to state tort actions. Tort claims under state law may result in ''malpractice-type'' lawsuits with large jury awards awarded to sympathetic victims of faceless insurance companies.

Effect of increased regulation and litigation: According to the CBO, the House bill would increase health insurance premiums by 4.1 percent. This increase may lead to more than 1.2 million Americans losing employer-based health coverage. In addition to rising costs, the threat of malpractice suits and the exposure of employers to liability could lead to millions more Americans joining the ranks of the uninsured.

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ENACTING PRESCRIPTION DRUG BENEFITS FOR MEDICARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentleman from Pennsylvania (Mr. GREENWOOD) is recognized for 60 minutes as the designee of the majority leader.

Mr. GREENWOOD. Mr. Speaker, this evening some of my colleagues from the Committee on Commerce, as well as from the Committee on Ways and Means, are going to spend the next hour talking about a subject that is the subject of a lot of talk lately, and that is usually a good sign, because right before the Congress gets around to legislating, the level of rhetoric picks up and the amount of speeches on the floor increases. So I think we are getting actually very close to the point where we will, in fact, enact a prescription drug benefit for Medicare.

In 1965, when Medicare was created, it was a big step in the American health care history. Prior to that time, if one is a retiree, if one was elderly or if one was disabled and one could not afford their own health care, they did not have any. So in 1965, the Congress of the United States, in a historic moment, decided to provide Medicare coverage for the elderly and ultimately for the disabled, and then what it covered was that which is most obvious, hospitalization and visits to physicians. No one really gave serious consideration in 1965 to extending that Medicare benefit to prescription drugs, for a couple of reasons.

Number one, it was a huge step to do what the Congress did in 1965 in providing coverage for hospitalization and physicians; and, secondly, Americans were not relying upon prescription drugs anything like they are today. Today, we are blessed as a Nation, and indeed as a world by an industry that has created miracle drug after miracle drug; wonderful, brilliant scientists in laboratories who have cracked the mysteries of the human genome, who have cracked the mysteries of the human body physiology to the point where we can prescribe and create drugs for a variety of illnesses that used to not only cause great pain and suffering, but premature death. Today, if one does not have access in the year 2000, if one does not have access to a good prescription drug benefit plan, one simply does not have good access to good health care. So the Congress of the United States, although it has been talking for years about the need to provide this coverage, has heretofore, so far, not accomplished that.

Why can we do it today and why are we talking seriously about it today? We are talking about it today because the Congress, in fact, since the Republicans have taken over the majority of the Congress, have taken the necessary fiscal steps to end the endless deficit spending that our Nation was experiencing for so many years. We have balanced the budget. We have reformed Medicare itself to bring the costs into a reasonable level. We have reformed welfare, and we are going to save something on the order of $55 billion, or probably $200 billion over the next 5 years in welfare costs alone. We have

taken just this year, just in the last several months, we have taken Social Security finally off budget. We have said that no longer will we spend the Social Security surplus on a host of other causes, but, in fact, we will use Social Security payments only for Social Security and the rest of the surplus will be used to pay down debt; and we are now paying down the Nation's debt.

So finally, now that the budget is balanced, now that we are paying down debt, now that we have a surplus, we are in a position to responsibly, to responsibly provide a prescription drug benefit for Medicare for the Nation's elderly and for the disabled. About two-thirds of the Medicare population already has access to some kind of prescription drug benefit, but a fully one-third does not, and those are disproportionately low-income individuals.

What are our goals in doing this? Number one, we do want to provide affordable coverage to every American who is a Medicare beneficiary by virtue of their age or their disability. Secondly, we want to do that in a way that does not break the bank all over again. We do not want to create a runaway spending program that is unregulated and causes the Federal Government to go back into the bad old days of deficit spending and budgets in the red.

Thirdly, we want to reduce the cost of prescription drugs for everyone who is now paying the highest price. And today, if one does not have a prescription drug plan and a doctor provides a prescription, one walks into a pharmacy and they pay the highest price that anybody pays in the world, you may if you are all alone in the marketplace and do not have anyone to bargain for you.

Finally, we do want to make sure that when we have accomplished this, that the industries, the pharmaceutical companies and their brilliant scientists, the biological industry that is doing so much to create new miracle cures will be vital enough to continue to provide those products for us into the next generation, the drugs that will eventually cure cancer, that will cure AIDS and so many other ailments.

Mr. Speaker, I am joined this evening first off by a colleague from the Committee on Ways and Means who is working on a joint task force that the Speaker has put together, drawing on members of the Committee on Commerce on which I serve and the Committee on Ways and Means, the distinguished gentlewoman from Connecticut (Mrs. JOHNSON), who is an expert on health care, and I yield the floor to her.

Mrs. JOHNSON of Connecticut. Mr. Speaker, it is a pleasure to be with my colleague tonight to discuss the issue of Medicare covering prescription drugs. It is extremely important that we change the law so that Medicare will cover prescription drugs, because modern medicine, modern medical care, without medicines, is an oxymoron. We cannot have good medical care if we cannot buy prescription drugs that both cure illness now and manage long-term, chronic illnesses; really, as Americans, live longer. This issue of managing chronic illness is going to become a bigger and bigger issue and a more important one in our lives, and management of chronic illness is primarily a medication-based science.

We do have another chart here on the floor that I think is helpful in helping us discuss the problem of prescription drugs, because there is one very significant difference between the President's proposal in this area and the Republicans' proposal, the House Republicans' proposal. That is, if one looks there at the far end where the line goes way up, then one will see that for a small number of seniors, about 15 percent of seniors, 20 percent, the drug costs are extremely high, $6,000; $8,000; $10,000; $11,000 a year. People on fixed incomes, I mean the great majority, 85, 95, 99 percent of people on fixed incomes cannot handle $12,000; $11,000 in prescription drug costs a year.

So we need to look at two things. First of all, we do need to look at protecting all seniors from catastrophic costs, from those very high drug costs often that follow remarkable life-saving, life-preserving, quality-of-life-restoring cardiac surgery, cardiac surgical procedures that we are now capable of. So those very high-end drug costs, we need to protect our seniors against them. We also need to help those seniors that have the lowest incomes, to have a prescription drug benefit without facing the choice of food on the table, of decent shelter, and drugs; and one can see on this chart that the poorer beneficiaries who are under the current system are very much less likely to have drug coverage than, of course, our more affluent seniors. It is sort of a no-brainer, but the chart does show it.

So it is very important that that 37 percent that are living on less than $10,000 a year have not only the program available, but the premium coverage, the premium subsidies that they would need to have the drug coverage that is so critical, not only to their recovery from illness, but to their quality of life in living with chronic disease.

So our goal is both to provide prescription drug and total coverage, 100 percent coverage for low-income seniors, but also to protect 100 percent of all seniors from catastrophic drug costs. And then to create, for those seniors in between, affordable, insured drug policies that will guarantee that they will be able to have the drugs that are so critical to the quality of their lives.

Just to go back to the preceding chart for a minute, we can see from that that the great majority of seniors do not spend more than $2,000 on drugs; and 80 percent, if we follow that line out, if my colleague will follow that $2,000 line out, then it is clear that 80 percent of seniors do not have more than $2,000 in drug costs.

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And the great majority have a lot less than that, and about 90 percent do not have more than $4,000 in drug costs.

So we need to help that group, but we need to really also think about the number that have very high drug costs. Because, frankly, my fear is that that number is going to grow as we develop the kind of sophisticated drugs we need to cure cancer, to cure some of the difficult diseases that haunt our elder years, prevent Alzheimer's, those kinds of solutions. And it is very possible that at least for a year or two at a time, many seniors are going to be faced with $10,000, $12,000, $14,000 drug costs. So catastrophic coverage is absolutely an essential part of a prescription drug program.

Some people say to me, Why can we not have the government pay all of our drug costs, just like they pay all but 20 percent of office visits, all but the first day of hospital coverage? The answer to that, basically, is sadly very simple. It would bankrupt the Medicare program. And if we added all that spending on top of the current program, the younger generation would be spending more than half of their tax dollars on people over 65. It is simply sad but true.

Sometimes my colleagues do not like me to say that, but right now, 35 percent of all Federal spending goes to people over 65. So that means that our child, if we are a grandparent, our child in the tax force, all of their tax money going to Washington, one-third is going to subsidize the lifestyle of people over 65. If we do nothing, do not add prescription drugs, that will be up to 45 percent in 10 years. And very soon thereafter, if we add prescription drugs in with no participation from seniors, then over 50 percent of all of our tax dollars will be allocated to people over 65.

Frankly, we will not be able to provide the public education our children need. We will not be able to provide the seaports, the air traffic control system, the highways that our economy depends on.

So most seniors I know would not want that to happen. And, furthermore, many seniors I know have better drug benefit programs than Medicare could ever provide.

Mr. GREENWOOD. Mr. Speaker, if the gentlewoman would yield briefly on that point, the question is why should the Congress not just say to every retiree, everyone on Medicare, every beneficiary: we will pay 100 percent of all of your prescription drugs benefits. The answer is, in part as you said, the younger generation asked to pay that bill would be wiped out.

But, secondly, two out of three seniors today already have a prescription drug benefit, many of them provided by their former employer. As I travel to

the senior centers around my district I say, How many of you already have some kind of a prescription drug benefit? And there is a show of hands. How many of you receive them from your former employer? And a goodly number of hands go up. Usually, it is either the big Fortune 500 companies that were able to provide these generous benefits, or they worked for a governmental entity, a school district or a State or the Federal Government.

If we moved in and started to pay all the prescription drugs, employers would drop that coverage like a rock and all of a sudden the two-thirds of the seniors who already have a benefit, albeit maybe not the perfect one and we might be able to supplement their benefits, but those would all of the sudden be shifted from the private sector to the public sector and be enormously expensive.

Mrs. JOHNSON of Connecticut. That is a very, very important point. We do not want to shift costs from the private sector to the public sector, and we do not want to do it for another important reason. Many of the people who have coverage through former employers have very, very good coverage, and they have total choice of prescription or generic or whatever is best for them personally.

If we look at Medicaid, if we look at the big managed care plans, we tend to have the choice of those drugs offered in a formulary. Maybe that formulary, in other words the choices of drugs, will be good. Maybe it will not. In the Patients' Bill of Rights we are going to give certain rights to go outside the formulary, but they will have to be documented by health need. And sometimes we would just rather have the one that we believe is going to be the best for us.

That kind of total choice is not common in the plans that are out there now. And in order to provide a range of plans, in order to allow people who have that total choice through their employer to keep it, we need to provide many solutions so seniors have their choice of the kind of drug plan that will best suit them. We need to protect them from catastrophic costs. We need to guarantee that if there are a seniors out there with a $4,000, $6,000 annual income, they will have prescription drug coverage.

But we also need to provide the opportunity for all of our seniors who currently get coverage to keep that coverage, if they choose it; to join another plan, if they choose it. And we want to be sure, this is very important to me, we want to be sure that the prescription drug programs can be integrated into the managed care programs, because many managed care programs now are developing ways to manage chronic disease, and they are doing it much better than we were ever able to do it under fee-for-service.

Mr. Speaker, they are saying to people who are coming out of heart surgery: Listen, we will pay for your drugs, but you have to be part of this management protocol. Through that protocol, they cannot just follow the doctor's orders to take the medicine. They have to follow the doctor's orders to exercise. They to follow the doctor's orders to lose weight. But they are going to have help. They are going to have allies, and these programs that are providing allies to people are seeing people stopping smoking, not just for a month, not just for 2 months, but permanently. Changing their lifestyle.

So then, of course, the medicine does much better. The person does much better. So if we do everything our doctor says, we lose weight, exercise, and take the medicine, and we have allies to help us do that, then we are going to do better.

More and more plans are saying they will give their insured customers a better deal on drug coverage if they will take their responsibility to take a holistic approach to their health and take responsibility for their health.

So we want plans to have the opportunity to incentivize people and reward people for improving their own personal health, not just taking medicine, as important as that is.

Mr. GREENWOOD. Mr. Speaker, if the gentlewoman will yield, what is interesting, of course, is that no matter who we speak to in this town, talk to Republican Members of the House or Democratic Members of the House, Republican and Democratic Members of the Senate, the President, et cetera, we all agree on one thing: let us provide a prescription drug benefit to Medicare beneficiaries, and let us do it this year.

So there is wide agreement, which is historic. It has not really happened before. Now what happens? We have different opinions. The President has a plan. There are numerous plans in the House. Republicans in the House, like the gentlewoman from Connecticut and I, have a plan that we have proposed. And now we get into the business of deciding how to work these different ideas and merge them into one.

What I find so frustrating is that it is an election year. It is not only an election year for the entire House and a third of the Senate, but for the presidency of the United States. And this issue is so easy to demagogue. If we listen to C–SPAN regularly and listen to the rhetoric on the floor, it is easy to accuse the other party of not really caring about seniors, and of course that is nonsense. We would not be here doing this job if we were not interested in the welfare of our constituents, particularly the elderly and those disabled who do not have a prescription drug benefit.

So we are going to have a good discussion about methodology. How do we do this?

What we do, what the Republican House plan does is say let us use the insurance model, since we know that pouring money and paying everything ourselves will not work for the reasons we have discussed. Let us create an insurance model.

How do we do this? First off we want to make sure that that insurance premium is affordable for middle-class Americans. And as we look at this chart, again, insurance companies have been reluctant to provide affordable drug-only plans because of this end over here, because of that high end of the chart. Because they can sell a prescription plan tomorrow and the next day a brand-new drug comes out that costs a $1,000 or $2,000 or $3,000 a month; and it comes onto the market, and now the insurance company is losing money hand over fist.

What we have said in our plan is we will stop the loss at somewhere in this range, somewhere between $6,000 and $8,000 is about where we will cut off the insurance company's exposure to risk, and the Federal Government, through Medicare, will pay for all of that.

Now, we have a plan that only has to cover the first several thousand dollars of exposure, which most Americans will fall under that, and it becomes affordable.

Now, how does it become affordable to the lowest end of the socioeconomic ladder? What we would do is we would pay 100 percent of the premium for everyone below 150 percent of poverty. So the poor elderly and the poor disabled would get free insurance. Talk about giving everything for free, they would get the whole plan free at no cost. For those middle-class-and-above Americans, they would have a small, relatively affordable monthly premium that they could pay and could choose between plans out there in the market to buy the plan that is best for them.

An elderly person with very little in the way of prescription drugs might want a plan that has a low premium and a high deductible. If someone has a lot of expenditures, they might want a different plan. We enhance choice with our approach.

Mr. Speaker, that is our idea in a nutshell, and we can go on later about some of the details. The President has a plan, as I say. But for goodness sake, what must happen this year is that Republicans and Democrats, the Congress and the President have to get together and say: let us roll up our sleeves, let us get the best of your ideas, the best of our ideas, merge them into a bill, get it signed into law. Because at the end of this year, either we will have done that and done a tremendous service to the people of this country, President Clinton will have some legacy, something that Presidents want to have before they leave office, and the system will have worked.

On the other hand, if all we do is point our fingers at one another and try to take political advantage of the issue, shame on all of us. And what I recommend to the voters at the next election is vote us all out of office if we do not figure out how to work together collaboratively.

Mrs. JOHNSON of Connecticut. One of the reasons we are doing this Special

Order is to point out how terribly important it is that we address this problem for seniors and also to point out how much agreement there is. The President's proposal is really a proposal to cover 50 percent of the costs of the drug. There is no proposal out there, because it is so expensive, that recommends covering 100 percent of the costs of the drug.

I think people, sometimes when they hear us talk about covering prescription drugs under Medicare, they think we are talking about covering all of the costs. They think the President is talking about that.

The President's proposal is really very simple. He is talking about covering 50 percent of the cost up to about $2,500. In other words, the insured would cover $1,250 and the Government would cover $1,250. And they would not cover the first $1,250; they would cover 50 percent of each premium up to that. And I am not sure whether the limit in the President's program is $2,000 or $2,500.

But we can see from the chart that by having no coverage at all thereafter, that 20 percent of seniors that have the highest drug costs get very little help from the President's plan. But the House plan is, too, and I have not read another plan that is not a cost-sharing plan, usually 50–50.

I think what is slowing down the production of the final bill a little bit is the complexity of the stop-loss provision, of helping everybody to be protected from catastrophic loss. It is a matter of peace of mind. It is a matter of confidence and ease and security in our elder years to have stop-loss insurance and know that prescription drugs will never bankrupt us, just like long-term care insurance gives a peace of mind.

That is why we are working so hard this year to make long-term care premium costs deductible on income tax. We could do that. Then for a rather modest investment in a long-term care premium, we have the peace of mind of knowing that we will never have to spend down to poverty to pay for long-term care costs. And under prescription drugs, with a stop-loss provision, we will have the peace of mind of knowing that we will never be bankrupt by the costs of prescription drugs.

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So this is not a concept that the President opposes at all. We are all talking within provisions that we all know would be helpful to our seniors. We simply have to work out, not only their costs, but how they fit in with the real world, how we can protect seniors who already have good drug coverage and do not want it disturbed, how we do not want to encourage their employers to drop good coverage.

So we want to make sure that we do not compromise opportunities that seniors currently have but that we create new opportunities for seniors who either have no drug coverage or inadequate drug coverage.

It is really important for everyone listening to remember that, under both the Republican and the Democrat and the President's plan, because those are the two on the table now, that all seniors would be helped.

They would both be optional plans. They are voluntary. They are not mandatory. Seniors can elect them. That is why seniors who have other plans that they prefer can continue to benefit from those plans.

Mr. GREENWOOD. Mr. Speaker, reclaiming my time, as we have discussed a little bit, there have been criticisms of the plans. And one of those criticisms has been, what part of the debate has been, what are we really going to do to lower the cost of prescription drugs?

A lot of the debate and rhetoric that we have heard about this issue has been focused on strictly the cost of prescription drugs, how do we bring down the cost of prescription drugs.

There are those who think that the answer to that question is to have some sort of governmental price controls on prescription drugs. That is a pretty scary proposition, because once we start down the road of price controls in a free enterprise market like the American system, we run the risk of killing the very industries that are providing these miracle drugs.

So how do you do it? Well, the answer is that, for that one-third of the Medicare beneficiaries, the elderly and the disabled who do not have this coverage today, that one-third walks into a drug store with the prescription, they have an illness, they have an ailment, they are suffering from something, they go to their doctor, their doctor writes a prescription for them, they take that prescription, they go into the drug store, and they have to pay full retail price out of their pocket with nobody's helping them at all.

Of course that is the most expensive way one can buy a prescription drug. Some seniors order the drug. The pharmacists fills the prescription, hands them the bottle, and the price tag. When they see the price tag, which is often, it is not anything for one prescription to cost $100 or $200, they are embarrassed and have to walk away from the drug store and say I do not have that kind of money.

Others may be able to scrape together the money to pay for the drug. But then they take it home, and the label says take four times a day or six times a day, and maybe it is a prescription that they are going to need for the rest of their lives every month, week after week, for the rest of their lives, they know that they cannot afford to go back and fill that prescription over and over again.

So, instead of taking the pill four times a day, they will take it two times a day. That does not do them any good because the prescription is not providing the kind of physiological response that it was sustained to provide. So that senior is really held hostage, and those are the seniors we are trying to help.

So how do we help them and bring down the prescription drug costs at the same time, by allowing these elderly to join in a group health care plan. That is what we are doing, we are providing a group prescription drug plan for them that would cover large groups of Americans at a very affordable cost. Again, if one is low income at zero cost, if one is middle income and above at a very affordable monthly cost. Those individuals gain from the fact that they are now part of a big group.

The spokespersons for that group, the leaders of the insurance companies, the managers of the insurance companies will then negotiate with every pharmaceutical company as to what price they are willing to pay. That is how we bring down the cost of prescription drugs because we are now having the big insurance plans that are buying drugs for our seniors and for our disabled, negotiating tough prices with the pharmaceutical companies so that we get and they get affordable prices.

I have been joined now by the gentleman from Louisiana who is on the Committee on Ways and Means and on the Speaker's Task Force and has been the leader in drafting this prescription drug program.

Mr. Speaker, I yield to the gentleman from Louisiana (Mr. MCCRERY).

Mr. MCCRERY. Mr. Speaker, unfortunately, I have been in another meeting on another health care subject and not been able to hear the discussion so I do not know what has been said so far.

But I do want to compliment the President on coming forward with a plan. I do not want anything that I say here to say that I am not appreciative of the President getting in the mix and trying to put forward a prescription drug plan, because I think it is important that he be part of the process.

All of us, the President, the gentleman from Pennsylvania (Mr. GREENWOOD), I, Republicans, Democrats, I think, agree that, in order to have a modern Medicare program, we have got to have a prescription drug benefit. Thirty-five years ago when Medicare was created, prescription drugs were a very small part of the health care regimen of a senior citizen. So we took care of their hospital needs and their doctor needs, Part A and Part B, and that was fine for most seniors.

Today that has changed. Now if one takes care of the hospital bill and the doctor bill, in many cases, there is a third item, prescription drugs that constitutes a very large portion of that senior's health care needs, the health care regimen of that senior.

So we all agree, and I think it is appropriate for all of us to be discussing how we best do this, including the President, Republicans, and Democrats. So I appreciate the President putting out a plan.

I think the President's plan is insufficient. In his defense, he was trying to craft a plan that would meet certain

budgetary guidelines. His plan spends about $34.5 billion over 5 years. He decided to put the bulk of that money into a benefit for low-income seniors and giving every senior a very minimal benefit. Let me tell my colleagues what I mean when I say ''minimal.''

Based on the figures provided by the White House for the premiums that a senior will have to pay, the level of the benefit, which is $2,000, once one reaches $2,000 of expenditures for prescription drugs, one's benefit is over under the President's plan.

So when one adds up the premium that a senior has to pay for the plan and the co-insurance requirement, which is 50 percent, basically a senior will pay $1,750 for $2,000 worth of drugs. Not a great deal.

But, again, in the President's defense, if one only has a limited amount of money to spend, in his case $34.5 billion over 5 years, and one provides 100 percent of the benefit to low-income seniors, there is not a lot left to give the average senior a benefit.

So I think the President's plan, while it is a good start, is insufficient. The glaring insufficiency in the President's plan is that he does not give any protection to extraordinarily high costs that seniors may have. So that if one has got a senior citizen who has done everything right his whole life, he worked hard, he paid his taxes, he saved for retirement, and then after he is 65 years old, he contracts some chronic disease that requires a very high level of drug maintenance, he bleeds those savings. Those savings are just gone.

That is not right. We ought to give seniors some protection against just financial ruin because of bad luck in health care and having very high prescription drug costs. Our Republican plan does that. That is why I think that we need to work with the White House, the White House needs to work with us.

We need to get a plan in law that gives seniors, not only low-income seniors, that basic benefit that both our plan and the President's plan does, but also some protection against those very high drug costs that are killing some of our seniors, not killing, they are staying alive because of those drugs, but it is bleeding their savings; and that is not right.

Mr. GREENWOOD. Mr. Speaker, reclaiming my time, just if I can comment on the gentleman's point for a moment. It has been my experience that, the older I get, the more cautious I become. As we go through life, we bump up against enough things that, by the time one reaches the age of 65 years of age and one is ready to retire one is not looking for any more risk. One wants to pretty much know what one's life is going to be like for one's golden years.

The problem that, the criticism that we do have with the President's plan is, as one said, one is sitting there with this big risk over one's head; and that is, maybe when one is 65 and when one is 66 and when one is 67, one will be able to have low drug costs that are under the $2,000 threshold, or I think the President's threshold increases over time. But still there is always a cap on it.

Now one day, one can come down with some terrible disease, and go to the doctor, and the doctor says, Guess what, the good news is there is a drug that will solve your problem and keep you alive for another, you know, another 5 or 10 years. But the bad news is it costs $10,000 or $20,000. Well, that senior suddenly has exposure to a risk that there was no way that he or she could have planned for.

So what we provide with our plan is the peace of mind, the peace of mind of knowing, no matter how expensive your prescription is, no matter whether you are on one drug or 10 or 15, you will be covered. The sky is the limit on one's coverage because that is where our plan comes in for everyone. Every American pays all of their costs above that ceiling.

Mr. MCCRERY. That is right, Mr. Speaker. I want to be honest here. We have come up with a conceptional plan that does the things that the gentleman from Pennsylvania and I have talked about.

We have not had the numbers crunched by the Congressional Budget Office. That is in the process of being done. We have worked with some actuaries who think we can do what we have described within the budgetary confines that we are working in, which is $40 billion over 5 years. But we do not know yet to what extent we can protect those seniors from those high costs. We have to wait until we get those numbers from the CBO.

But I believe that any plan that we include in Medicare ought to provide not only a basic benefit for low-income seniors and other seniors but also must include a stop-loss provision which protects that senior citizen from skyrocketing out-of-pocket costs that could bleed his lifetime savings. So we have got to wait and see what the numbers show.

But I think, from a conceptional standpoint, we ought to agree that we are going to provide a basic benefit which both our plan and the President's plan does, and that is protection against those very, very high drug costs. If it ends up costing more, then we have got to figure out a way to finance that.

But from a conceptional standpoint, I think any drug benefit that we include must have those two elements, a basic benefit for everybody, including low-income seniors and protection against those extraordinarily high drug costs that some seniors, a few seniors run into.

Mr. GREENWOOD. Mr. Speaker, as the gentleman from Louisiana talked about, the fundamental goal is to provide coverage for everyone. What has been discouraging and frustrating to me is that we have crafted this plan so that it benefits everyone regardless of income. If one is at the lowest end of the scale, we cover 100 percent of one's premiums. We think we can go up to 150 percent of poverty and cover that. The President's rhetoric and language has suggested that that is all we do, that we are only providing a benefit for the really poor; and it is really not the case.

Mr. MCCRERY. That is not the case, Mr. Speaker.

Mr. GREENWOOD. Mr. Speaker, the mechanism that we use by stopping the loss for everyone is what makes the premium affordable. Maybe the gentleman from Louisiana could share his thoughts on that as well, because that is so important to get straight with the American people.

Mr. MCCRERY. Mr. Speaker, it is fairly easy to explain, but not easily understood. Let me take a shot at it. It is really different from a stop-loss provision that I have talked about for an individual senior. That is a stop the loss out of his pocket.

What the gentleman from Pennsylvania is talking about is the Federal Government telling the insurance industry we will stop your losses for any seniors in, say, the top 2½ percent of expenditures for drugs. We know that that top 2½ percent of seniors in terms of their drug cost constitutes about 25 percent of the total drug expenditures for the senior population.

So if we give the insurance industry some reinsurance protection, so to speak, against those extraordinarily high-cost seniors, then they will be able to write a product, produce a product in the marketplace at a premium that will be substantially lower, perhaps as much as 25 percent lower than they could if we gave them no protection in a reinsurance way against those extraordinarily high-cost seniors.

□ 1730

So the gentleman is exactly right. By basically buying down the tail of those high cost seniors for the insurance industry, we allow them to write a product that is fairly predictable in terms of their cost, and we allow them to write those products at a premium that would be substantially lower than they could if we gave them no such stop-loss protection for the insurance industry.

Mr. GREENWOOD. And since Americans are not used to buying drug-benefit insurance, this is a little alien to them. But if we think about buying automobile insurance, if we went to buy automobile insurance that would provide liability coverage for $10 million, that would be expensive. The premium that we would pay on a monthly basis or annual basis would be quite expensive to get that coverage. And if it were unlimited, if we had unlimited liability protection, of course it would be unaffordable and the insurance industry would have a hard time putting a price on that.

That is almost the way it is with prescription drugs now, because we cannot

predict the exposure with these new modern expensive drugs. So what we are saying here is, if it was automobile insurance and the Federal Government said we will cover everything over, let us say $50,000 of liability, then we know that the premium is going to go way down and we would have the coverage covered by the Federal Government. It is the same thing here. By the Federal Government, by our House Republican plan proposing to pay for that top, from the cap to the sky being the limit, suddenly now we have an affordable product that every American can afford to purchase.

Mr. MCCRERY. That cap that the gentleman is talking about, though, is an after-the-fact determination according to the actual costs in the industry. So at the end of a year, what we do is we go back and look at the cost for drugs for all seniors, and then we determine above what level constitutes the top 2.5 percent of expenditures. It might be $10,000; it might be $12,000; it might be $15,000; it might be $7,000. Somewhere, though, we will reach a point where all expenditures above that by all seniors constitutes the top 2.5 percent of expenditures.

So a plan knows very quickly how many seniors it has with expenditures over that $10,000 level or $12,000 level. They report that to the Federal Government. The Federal Government ships them a check basically for those seniors and the costs for those seniors above that level. It is doable. It is kind of an after-the-fact risk adjustment that we can do, and we are hopeful that the insurance industry will be comfortable with that kind of risk adjustment mechanism and will write products in the marketplace that will give seniors a choice of products and give the basic benefits that we have talked about.

Mr. GREENWOOD. And when this plan is enacted into law, as we hope that it will be this year, the average middle-class American who does not have a prescription plan now, who has one next year because of this program, will wonder, okay, so what was in this for me? What did I get out of this? They will know what they got out of this when they go to write their check for their insurance to cover their prescription plan. That check will be a heck of a lot smaller. The amount they have to write that check for will be very small compared to what it would be if we had not decided to cover this top end of the exposure.

Mr. MCCRERY. I agree. And I thank the gentleman for allowing me to participate in the discussion on the prescription drug plan for seniors.

Our good friend and colleague, the gentleman from California (Mr. THOMAS), the chairman of the Subcommittee on Health of the Committee on Ways and Means, has joined us. So with the gentleman's permission, I am going to go back to my other health care meeting and turn it over to the gentleman from California.

Mr. GREENWOOD. By all means. I thank the gentleman for his participation and would now yield to the gentleman from California, who is, in my mind, the leader on this issue in the House of Representatives, and has been leading us for a number of years now.

Mr. THOMAS. I thank the gentleman very much, one, for taking the time and, two, for beginning to get into the details.

This does become somewhat complex for most people, but the key point that we need to have everyone understand is that if we were discussing, as the gentleman indicated, automobile insurance or homeowner insurance, and we peeled back what most people know about the insurance business, it is pooled risk. And it would get into exactly the same kind of discussion that we are getting into here.

One of the reasons that we are doing it is to create a comfort level, I believe, notwithstanding all the details, that what we are trying to do is to create a product that takes care of the real concerns of seniors. It is not the first dollar that we spend on prescription drugs; it is that last dollar. And we do not know when it is and we do not know how much it is going to be. That is what insurance is all about: pooling the risk in a way that everyone can afford to protect themselves against that last dollar, no matter how much it is going to be. And that is what we are trying to create.

There are others, for example the President, who said let us just set up a prepayment plan. Everyone will know how much they are going to get. And he has a plan that eventually gets to like $5,000; but it is $2,000, and that is all anyone is going to get no matter what their costs are. That is better than what we have today. There is no question it is better than what we have today. But if we are going to put a plan in place, I think the gentleman and myself and others who have been working on this agree, including Democrats who have been working with us, is let us try to do this the best we can.

The way we really need to deal with prescription drug cost is to take care of the low income and create a risk structure that allows the private sector to write the product. Now, why in the world are we always saying let us get the private sector into this process? It is very simple. If we take a look at prescription drug insurance today, there is value brought by those people who are managing the prescription drug programs. It is so specialized that even people who offer ordinary health care, and if they include prescription drugs, will hire these people to run their prescription drug portion.

One, taking drugs, especially taking more than one drug, becomes risky business if there are not knowledgeable pharmacists and others to help in the management of taking those drugs. Sometimes drugs that would be lifesaving are not worth very much if we only participate in a portion of the regimen; if we leave pills in the bottles; if we do not follow the directions; if we do not take them in a timely fashion. Seniors are one of the groups that have the least support of any group in assisting in taking drugs. This is one of the real value-added features brought by one of these programs.

We keep talking dollars and cents. Dollars and cents is important, but availability, deliverability and proper usability of drugs is very, very critical. That just comes as a kind of a free aspect of putting this kind of a plan in place.

The other thing that we have to remember is that seniors have been very knowledgeable in this whole process. I have become quite enamored with their ability to realize that when someone promises something for nothing, they know they cannot get something for nothing. And what we are trying to do is put a plan in place that will assist those who, through no fault of their own, do not have the wherewithal to pay for it; and those seniors who, through no fault of their own, cannot afford the enormously high cost of the drugs that happen to meet their particular health needs. And for those who would like to have the protection, whether or not they fall into one of those other groups, to be able to participate in a minimally reasonable fashion, I think, is a proposition that most seniors would be interested in.

I know that the idea is enormously popular to promise people that they will not be involved financially and they will not be involved administratively or behaviorally. But, frankly, I think the seniors have been appreciative of our open approach, which says all parts of the society are at fault and all parts of the society are the solution. The pharmaceutical industry is part of the problem, and they are also part of the solution. The insurance industry, the same. Members of Congress, the same. The children of our seniors, the same. And, of course, the seniors themselves.

It has to be a positive, cooperative effort that builds a plan that not only works today but, more importantly, 5 and 10 years from now when those biotech drugs come on the line that are more expensive and, through no fault of our own, the cost is something we could not handle. There must be an insurance product available for seniors. More importantly, not that it is just available, but that we have created a system that allowed us to get into it at a time when the costs were reasonable, where now that they are not reasonable that we are covered. It is simply something that needs to be done.

I appreciate the gentleman taking the time not just to talk about prescription drugs, because we are focusing on that as a new addition to Medicare, paid for, by the way, and I do not think we say this often enough because people do not realize it, the $40 billion that the Republican leadership has laid on the table to cover the prescription

drug and the modernization cost for the next 5 years is money that we have saved from the Medicare program. We are not taking it from taxpayers. We are not robbing current programs that need money to pay for this. And we are not simply saying that it is a revenue-neutral game and that if we pay money for drugs it is coming out of hospitals or doctors or some other health care costs.

It is money that was saved because of the changes in the program that we have put in place that we are reinvesting. The leadership has said let us put this money back into Medicare that we saved from Medicare, but let us put it back in in a new way in which we get an even better benefit out of the dollars that we have spent. And to that end, part of the other program that we are advocating is that as we add prescription drugs, we do not just tack it on to a system that now says we get drugs and we get health care.

Because the way medicine is delivered today, as the gentleman well knows, and those of us who have looked at it for some time, and especially those seniors who have participated in the health system, drugs and old-fashioned, as we say, health care have merged. We cannot deliver health care today without, as I say, an integrated approach with prescription drugs.

So as importantly, in my opinion, as adding prescription drugs to Medicare is the extra care and attention we are trying to provide to creating a system that integrates this new benefit in with the other benefits that are defined and guaranteed in the Medicare program in such a way that seniors are now going to receive health care just the way the rest of the society receives health care. Frankly, they are a decade or more behind because we do not have this integrated prescription drug aspect to seniors' Medicare health care. It is overdue. It needs to be put into effect, and it needs to be integrated. And that is what we are trying to do.

Mr. GREENWOOD. I think what is important, as we compare the President's plan to the House Republican plan to other plans that may be in the Senate and elsewhere, what is important to understand is that there are some similarities. The low-income folks in both plans would have no cost and would have access, for the first time many of them, to a prescription drug plan.

Mr. THOMAS. If the gentleman will yield, not only are they similar but they are identical. No one should say that the President's plan or our plan treats low income differently, because we treat them exactly the same. They get complete coverage.

Mr. GREENWOOD. That is a very good point. And then for every one of the elderly and the disabled above that 150 percent of poverty, under both plans there will be out-of-pocket expenses. Under both plans, whether paying for a premium in our case, or whether paying 50 percent of the cost of every drug, there is cost out of pocket. So the middle class and above will have to pay something for their prescription plan.

We have two systems by which we try to figure out how to make that most manageable, most affordable, most flexible, and to provide the most security at the end of the day from catastrophic, potentially ruinous costs, where someone would have to choose between literally selling their home to buy the medicine they need or doing without and having their life foreshortened as a result.

In the course of this debate, in fact in the course of this last almost hour here, I think my colleagues and I have been very careful. Not once have we questioned the motives of the President or the motives of the other party. We have started with the assumption that every Member of Congress in the House and the Senate, that the President and the Congress have the same goal, to provide affordable health care. What I think the public needs to watch for and be most critical of is not the fact that we have differences of opinion and not be judgmental about a Member who takes this tack or that tack, but rather be judgmental about Members of Congress or other politicians or the President, to the extent that he does it, when they begin to question the motives of the other party. Because if we avoid that, we will get this job done.

Certainly the President has some ideas that are worthy of our consideration and we have some worthy of his. And certainly if we are going to get this done, at some point in the process there is going to be an amalgamation of the President's best ideas and our best ideas, and we ought to be able to learn from each other.

□ 1745

Mr. THOMAS. Mr. Speaker, the gentleman makes an excellent point. Because, as everyone knows, we can take a fixed amount of money and spend it a number of different ways. And, in essence, that is what we do. The amount that we lay out for prescription drugs is about the same amount roughly as the President. But their goal was to achieve a slightly different payment balance.

We place the emphasis on low income as the President does, but we talk about making sure that those out-of-pocket payments that are unexpected and too high to pay for fall under an insurance umbrella on shared risk.

The President has chosen to take a bit more of that subsidy and some of the earlier basic costs to create, which I think, in fairness, we could say one size fits some because those who have the very high cost would not be served by that system, but that there is a consequence in the way we write the program. And it is entirely possible that, for the middle-income person who is not low income and who does not have the extra high drug costs at that moment in time they occupy that position, they may in fact be paying more than they would under the President's plan for roughly the same support.

But most of us know and the seniors certainly do, at some time or other over the course of the rest of their lives they are going to fall into the category where they are going to get expenses for drugs, hopefully on a temporary basis, that they cannot afford to pay. That is what we are trying to protect against.

We believe it can be done today. Not 5 years from now, not 7 years from now, not 8 years from now, but today.

So our discussion, as my colleague points out, will quite rightly be how do we best construct a program to meet the most important and dangerous concerns that seniors face; and that will be, hopefully, the policy discussion that we are engaged in.

My colleague is quite rightly proud of the product that we are moving forward. My goal, frankly, in the next several days is to be able to stop using the phrase ''the Republican plan.''

I have engaged in a number of discussions with Democrats both here in the House and in the Senate. Some of them I think could be described honestly as excited about the idea once they understand the policy direction that we are trying to go, not only excited but supportive about it and will be able to talk about the bipartisan plan that the Congress is moving forward as a legitimate contender, one we believe most appropriate to meet seniors' needs and that we will be dealing with this on a policy level and not a political level.

I thank the gentleman from Pennsylvania (Mr. GREENWOOD) for taking the time and for allowing me to participate.

Mr. GREENWOOD. Mr. Speaker, reclaiming my time, I thank the gentleman from California (Mr. THOMAS) for his participation and his leadership, as usual.

The experience that I had not too long ago was I visited a senior center and asked a group of my elderly constituents whether they had or had not coverage and what their experiences were.

I met a woman who told me that she was taking 18 different prescription drugs and that she was working three jobs in order to pay for those drugs because she had no coverage. And at the end of the day the question for those Americans is not is this a Republican plan, is this a Democratic plan, is this the President's plan, is this the Congress's plan, but the question at the end of the day is can the Republicans and the Democrats in the House and the Senate and the Congress and the President figure out how to solve this problem so we do not have a single elderly person in America, not a single disabled person in America having to make that awful choice between their health and their finances so that they do not get to the point where they have to say to a doctor, do not bother writing that prescription for me because I

cannot afford to pay it, or taking a prescription home and not being able to take all of the pills that they need to take in a given day and not being able to renew that prescription because of their inability to afford it.

I am convinced that, at the end of the day, Republicans and Democrats will join together on this, we will negotiate a bill with the President and it will mark the point in our history, the history of Medicare, of which we all can be proud.

Mr. Speaker, I yield to the gentleman from Kentucky (Mr. FLETCHER). I am glad to have him here to join. He has been a real leader in this issue, as well, and I am glad to have his participation.

Mr. FLETCHER. Mr. Speaker, we just came from a meeting, but I did want to get in at the few minutes left and certainly participate. We have got 1 minute remaining it looks like.

First of all, I think it is very important and I am very encouraged by this plan. I think it is essential. Health care without prescription drugs in this modern age is really not health care.

I give my colleagues an illustration. In assisted living, I was visiting with some seniors who talked about a gentleman living there. For the first half of the month, he was a perfect gentleman. The last half of the month, he was a tyrant in the place. The problem was he could only afford the first half of the month's prescription drugs.

We see a number of seniors like this. So I think it is very important we put $40 million aside versus the President's $28 billion over the 5 years. His does not start for 3 years. We are toward the target at making sure it is affordable, available, and optional. So I think it is an outstanding plan that targets those that really need it and it is essential.

Again, health care without prescription drugs is really not health care in this day and age with the way prevention and chronic disease management has become the major portion of health care versus acute care, which we had back when Medicare was first developed.

So I wanted to come and just certainly say I think, hopefully, we can get good bipartisan support. We did in a bill that I filed back last year, we got bipartisan support, which is very similar in concept. So I am very encouraged by this and look forward to us being able to get something done. There are a number of seniors out there that need this and it is going to be very important for their health and future.

Mr. GREENWOOD. Mr. Speaker, the gentleman from Kentucky (Mr. FLETCHER) is one of the few physicians in America who has chosen to leave his practice behind temporarily and come to serve in Congress. His leadership is greatly appreciated.

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PRESCRIPTION DRUG BENEFIT

The SPEAKER pro tempore (Mr. THUNE). Under the Speaker's announced policy of January 6, 1999, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, I intend tonight with some of my Democratic colleagues to also take up the issue of prescription drug benefit under Medicare.

I must say that I was pleased to hear that my Republican colleagues on the other side of the aisle were concerned about the issue. I certainly do not doubt their sincerity in raising the issue, but I am very concerned about the proposal that the Republican leadership has put forward and I express that concern because I do not believe that it will actually do anything to provide a prescription drug benefit to most American seniors.

I say that with heavy heart because I really believe that this is one of the most important issues that we need to address in this Congress, and I believe that we will not get a prescription drug benefit unless we get it on a bipartisan basis. And so, we do need to have Republicans and Democrats work together.

But it is also important to point out distinctions and to make it clear that the Republican leadership proposal that has been set forth really does not do anything to help most senior citizens and in fact is just, in my opinion, a way to show concern in an election year to give the impression that somehow this issue is going to be addressed in an effective way when it will not if the Republican plan were to be adopted.

Let me just summarize, if I could before I yield to my colleague, some of the problems with the Republican plan.

First of all, it will leave millions of seniors uncovered. Their proposal would do nothing to assist more than half of all Medicare beneficiaries who currently lack prescription drug coverage because it provides assistance only to beneficiaries with annual incomes of under $12,600. Seniors with modest incomes above $12,600 would receive absolutely nothing under the Republican plan.

The benefit will fail to be an affordable option even if it is available. And if enacted, the Republican proposal would mark the first time in the program's history that Medicare would not provide coverage for all American seniors.

Now, I say that because, basically, what they are proposing is a private insurance plan, not a Medicare benefit. Every time that we have expanded Medicare to provide more coverage, it has been a benefit that has been available to everyone under Medicare either as a guarantee or as a voluntary benefit that they can opt into by paying a premium, as they do right now under part B for their doctor's care, for example.

Well, all of a sudden we have a proposal which really is not Medicare at all but is, basically, saying that the Federal Government will subsidize for low-income people a private drug insurance plan. We do not believe that those plans will ever be available.

So one of my chief criticisms is that this is not really a Medicare benefit at all, this is not really Medicare at all, this is simply a private insurance plan which even most of the insurance companies say will simply not be available for most seniors.

Also, even for those seniors who would be perhaps able to take advantage of what the Republicans are proposing, it does not even guarantee, if you will, the coverage for many of those who have an absolute need. The Republican plan relies on these private insurers to voluntarily offer a drug only benefit.

In testimony before the Congress, even the insurance industry itself had expressed skepticism about the effectiveness of this approach.

The other thing is, one of the key issues that has come up in the context of the prescription drug issue and that the Democrats, particularly my colleague the gentleman from Maine (Mr. ALLEN) has pointed out, is the need for access to lower prices.

Price discrimination is a major issue here. What happens is that the seniors that are in an HMO or have access to some larger plan maybe through the Government, like the veterans' plan or whatever, they are getting lower prices. The senior who goes out and tries to buy the prescription drug on their own, they are charged a lot more.

Well, there is nothing in the Republican proposal that would provide access for the average senior citizen to discounts on prescription drugs that these larger plans, the people in the HMOs and the people in the veterans' plan, obtain.

I mean, one of the advantages that we have with our Democratic plan is that we try to address that issue of price discrimination and make it so that everyone who is in the Medicare program would have the benefit of those same types of discounts.

Also, and this is the last thing I want to say on the issue of why this Republican plan really is nothing that is going to help the average senior, it is not really funded.

Earlier this year the Republicans promised that they would commit $40 billion for a prescription drug benefit. Their own budget resolution dedicated as little as $20 billion to pay for this weak and limited plan that would leave so many seniors without coverage.

Moreover, the lack of their willingness to release 10-year numbers on their prescription drug proposal raises serious concerns that their tax policy consumes virtually all revenue necessary to adequately fund a drug benefit in the future.

My point is the Republicans continue to advocate a huge tax cut that primarily benefits corporations and wealthy individuals. They do not leave any money left for this type of Medicare prescription drug plan that would