hundreds of millions of dollars in ad campaigns to try to preserve the status quo, which has resulted in our senior citizens, our most vulnerable portion of our population, paying the highest prices of anyone in our society and anyone in the world for prescription medications, I think and I know the gentleman from Texas (Mr. RODRIGUEZ) thinks that we need to talk about it on the floor of this House.

This ad campaign must be exposed, the hundreds of millions of dollars that the big drug companies are spending to try to be sure that they defeat our efforts to pass meaningful prescription drug coverage for our seniors as a part of the Medicare program. That effort that they are making is wrong, and I hope that our seniors will see through it when they get these telegrams, when they see these newspaper ads, when they watch the television screens with characters like Flo that the gentlewoman from Illinois (Ms. SCHAKOWSKY) mentioned, they will understand that they are seeing an ad that is designed to perpetuate a system that makes senior citizens of this country pay the highest prices in the world for prescription drugs that they need.

I thank all of my colleagues for joining with us tonight and being a part of this effort to talk about this important issue. I am looking forward to hearing from the gentleman from Iowa (Mr. GANSKE), our next speaker in the last portion of our Special Orders, who has been outspoken on this issue and has a unique insight as a medical doctor into the problem of prescription drugs for seniors.

PRESCRIPTION DRUG COVERAGE

The SPEAKER pro tempore (Mr. TOOMEY). Under the Speaker's announced policy of January 6, 1999, the gentleman from Iowa (Mr. GANSKE) is recognized until midnight as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, this is a photo of William Newton, age 74, of Altoona, Iowa, a constituent in my district whose savings vanished when his late wife Waneta, whose picture he is holding, needed prescription drugs that cost as much as $600 per month.

''She had to have them. There was no choice'', Mr. Newton said. ''It's a very serious situation and it isn't getting any better because drugs keep going up and up.''

When James Weinmann of Indianola, Iowa, and his wife, Maxine, make their annual trip to Texas, the two take a side trip as well. They cross the border to Mexico and load up on prescription drugs, which are not covered under their Medigap policies. Their prescription drugs cost less than half in Mexico than what they cost in Iowa.

Mr. Speaker, this problem is not localized to Iowa. It is everywhere. The problem that Dot Lamb, an 86-year-old Portland, Maine, woman who has hypertension, asthma, arthritis and osteoporosis has paying for her prescription drugs is all too common. She takes five prescription drug that cost over $200 total each month, over 20 percent of her monthly income. Medicare and her supplemental insurance do not cover prescription drugs.

Mr. Speaker, I recently received this letter from a computer savvy senior citizen who volunteers at a hospital that I worked at before coming to Congress.

''Dear Congressman GANSKE, after completing a University of Iowa study on Celebrex 200 milligrams for arthritis, I got a prescription from my M.D. and picked it up at the hospital pharmacy. My cost was $2.43 per pill with a volunteer discount.

''Later on the Internet I found the following:

''I can order through Pharmaworld in Geneva, Switzerland after paying either of two American doctors $70 for a phone consultation, these drugs, at a price of $1.05 per pill plus handling and shipping.

''I can order these drugs through a Canadian pharmacy if I use a doctor certified in Canada, or my doctor can order it on my behalf through his office for 96 cents per pill plus shipping.

''I can send $15 to a Texan and get a phone number at a Mexican pharmacy which will send it without a prescription at a price of 52 cents per pill.''

This constituent closes his letter to me by saying, ''I urge you, Dr. GANSKE, to pursue the reform of medical costs and stop the outlandish plundering by pharmaceutical companies.''

Well, Mr. Speaker, I want to be very clear, I am in favor of prescription drugs being more affordable, not just for senior citizens, but for all Americans.

Let us look at the facts of the problem and then discuss some of the solutions.

There is no question that prices of drugs are rising rapidly. A recent report found that the prices of the 50 top-selling drugs for seniors rose much faster than inflation. Thirty-three of the 50 drugs rose at least one and a half times inflation. Half of the drugs rose at least twice as fast as inflation. Sixteen drugs rose at least three times inflation. Twenty percent of the top 50 selling drug for seniors rose at least five times inflation.

The prices of some drugs are rising even faster. Furosemide, a generic diuretic, rose 50 percent just in 1999. Klorcon 10, a brand-name drug, rose 43.8 percent.

This was not a 1-year phenomena. Thirty-nine of these 50 drugs have been on the market for at least 6 years. The prices of three-fourths of this group rose at least 1.5 times inflation. Over half rose at twice inflation. More than 25 percent rose at three times inflation. Six drugs rose at over five times inflation. Lorazepam rose 27 times inflation and Furosemide 14 times inflation.

Prilosec is one of the two top-selling drugs prescribed for seniors. The annual cost for this 20-milligram gastrointestinal drug, unless one has some type of drug discount, is $1,455. For a widow at 150 percent of poverty, that means she is living on $12,525 a year, the annual cost of Prilosec for acid reflux disease alone will consume more than one in $9 of this senior's total budget.

What about a woman who has diabetes, hypertension and high cholesterol? She requires these drugs. Her drug costs would consume up to 18.3 percent of her income.

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My friend from Des Moines, the Iowa Lutheran Hospital volunteer senior citizen, knows, as do the Weinmans from Indianola, from their shopping trips in New Mexico for prescription drugs, that drug prices are much higher in the United States than they are in other countries. A story from USA Today comparing U.S. drug prices to prices in Canada, Great Britain, and Australia for the 10 best selling drugs verifies that drug prices are higher here in the U.S. than they are overseas.

For example, Prilosec is two to two-and-a-half times as expensive in the U.S. as it is in Canada, Britain or Australia. Prozac is two to two-and-three-quarter times as expensive in the United States, at $2.27 per pill, as compared to Canada at $1.07, Britain at $1.08, and Australia 82 cents. Lipitor was 50 to 92 percent more expensive. Prevasid was as much as four times as expensive in the United States, at $3.13 per pill, than it was in Canada, Britain or Australia. Look, the drug only costs 83 cents in Australia. Only one drug, Epogen, was cheaper in the U.S. than in the other countries.

Now, high drug prices have been a problem for the past decade. Two General Accounting Office studies from 1992 and 1994 showed the same results. Comparing prices for 121 drugs sold in the U.S. and Canada, prices for 98 were higher in the United States. Comparing 77 drugs sold in the U.S. and the United Kingdom, 86 percent of the drugs were priced higher in the United States. And three out of five were more than twice as high.

Now, drug companies claim that drug prices are so high because of research and development costs, and I do want to say that there is great need for research. For example, around the world we are seeing an explosion of antibiotic resistant bacteria, like tuberculosis, for which we will need research and development for new drugs. A new report by the World Health Organization outlines this concern about infectious diseases.

However, data from PhRMA, the pharmaceutical trade organization that I saw presented in Chicago about 1 month ago, showed little increase in research and development, especially in comparison to significant increases by the pharmaceutical companies in advertising and marketing. Since the 1997 FDA reform bill, advertising by drug companies has gotten so ubiquitous that the news line, Healthline,

recently reported that consumers watch on average nine prescription drug commercials a day.

Look at this chart, which shows 1998 figures for the big six drug companies. In every case marketing, advertising, sales, and administration costs exceed research and development. So, for example, if we look at Merck, Merck had, as a percent of revenue, 15.9 percent go to marketing. They only had 6.3 percent of their income go to research and development. Pfizer spent nearly 40 percent on marketing of their income and only 17.1 percent on research and development.

In 1999, of the five companies with the highest revenues, four spent at least twice as much on marketing, advertising, and administration as they spent on research and development. Only one of the top 10 drug companies spent more on research and development than on marketing, advertising, and administration.

Administrative costs have not increased that much. The real increase has been in advertising. For the manufacturers of the top 50 drugs sold to seniors, profit margins are more than triple the profit rates of the other Fortune 500 companies. So we see for pharmaceutical companies 18 percent profit margins, we see for the other Fortune 500 companies profit margins of 5 percent.

Furthermore, as recently cited in The New York Times, of the 14 most medically significant drugs developed in the past 25 years, 11 had significant government financed, government financed, research. For example, Taxol is a drug developed from government-funded research which earns its manufacturer, Bristol-Myers-Squib, millions of dollars each year.

Now, Mr. Speaker, as I said at the start of this special order, I think the high cost of drugs is a problem for all Americans, not just the elderly. But many nonseniors are in employer plans and get a prescription drug discount. In addition, there is no doubt that the older one is the more likely the need for prescription drugs. So let us look at what type of drug coverage is available to senior citizens today.

Medicare pays for drugs that are part of treatments when the senior citizen is a patient in a hospital or in a skilled nursing facility. Medicare pays doctors for drugs that cannot be self-administered by patients, i.e. drugs that require intramuscular or intravenous administration. Medicare also pays for a few other outpatient drugs, such as drugs to prevent rejection of organ transplants, medicine to prevent anemia in dialysis patients, and oral anticancer drugs. The program also covers pneumonia, Hepatitis and influenza vaccines. The beneficiary is responsible for 20 percent coinsurance of these drugs.

About 90 percent of Medicare beneficiaries have some form of private or public coverage to supplement Medicare. But many with supplementary coverage have either limited or no protection against prescription drug costs, those drugs that one buys in a pharmacy with a prescription from their doctor.

Since the early 1980s, Medicare beneficiaries in some parts of the country have been able to enroll in HMOs which provide prescription drug benefits. Medicare pays the HMOs a monthly dollar amount for each enrollee. Some areas, like my State, Iowa, have had such low payment rates that no HMOs with drug coverage are available. This is typically a rural problem, but some metro areas also have inequitably low reimbursements.

And I should say that, parenthetically, I have led the fight to improve these unfair payment rates, which allow seniors living in Miami, for example, to get drug benefits that seniors living anywhere in Iowa or Nebraska or Minnesota do not. But I will return to this issue a little bit later in this talk.

Employers may offer their retirees health benefits that include prescription drugs, but fewer employers are doing so. From 1993 to 1997, prescription drug coverage of Medicare eligible retirees dropped from 63 percent to 48 percent. Beneficiaries with medigap insurance typically have coverage for Medicare's deductibles and coinsurance, but only three of the ten standard plans offer drug coverage. All three impose a $250 deductible.

Plans H and I cover 50 percent of the charges up to a maximum benefit of $1,250. Plan J covers 50 percent of the charges up to a maximum benefit of $3,000. The premiums for these plans are significantly higher than the other seven medigap plans because of the cost of the drug benefit.

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This chart shows the difference in annual cost to a 65-year-old woman for a Medigap policy with or without a drug benefit. For a Medigap policy of moderate coverage, she pays about $1,320 without a drug benefit and she pays $1,917 for a policy with a drug benefit. For extensive coverage, she would pay $1,524 for a policy without drugs but she would pay $3,252 in premiums for insurance with drug coverage.

Why is there such a price gap between policies that offer drug coverage compared to those that do not? Well, it is because the drug benefit is voluntary. Only those people who expect to actually use a significant quantity of prescriptions purchase a Medigap policy with drug coverage. But because only those with high costs choose that option, the premiums must be high to cover the costs of a high average expenditure for drugs.

So what is the lesson we can learn from the current program? Adverse selection tends to drive up the per capita cost of coverage unless the Federal Treasury simply subsidizes lower premiums. The very low income elderly and disabled Medicare beneficiaries are also eligible for payments of their deductible and co-insurance by their State's Medicaid program.

For these dual-eligibles, the most important service paid for by Medicaid is frequently the prescription drug plans offered by all States under their Medicaid plans.

There are several groups of Medicare beneficiaries who have a more limited Medicaid protection. Qualified Medicare beneficiaries, QMBs, otherwise known as QMBs, have incomes below the poverty line, that is $8,240 for a single person, $11,060 for a couple, and they have assets below $4,000 for a single person and $6,000 for a couple.

Medicaid pays their deductibles and their premiums. Specified low income Medicare beneficiaries, known as SLIMBs, have incomes up to 120 percent of the poverty line and Medicaid pays their Medicare Part B premium.

Qualifying individuals, one, have income between 120 and 135 percent of poverty. Medicaid pays only their Part B premium but not deductibles. And qualifying individuals, two, have income between 135 percent and 175 percent of poverty. Medicaid pays part of their Part B premiums.

Why am I going into these details? Because in a little bit I want to describe a way to help these people who are low income but not so low that they qualify for Medicaid drug benefit.

These QMBs and SLIMBs are not entitled to Medicaid's prescription drug benefit unless they are also eligible to full Medicaid coverage under their State's Medicaid program. QI–1s and QI–2s are never entitled to Medicaid drug coverage.

A 1999 Health Care Financing Administration report showed that, despite a variety of potential sources of coverage for prescription drugs, beneficiaries still pay a significant proportion of drug costs out of pocket and that about one-third of Medicare beneficiaries had no coverage at all.

It is also important to look at the distribution of Medicare enrollees by total annual prescription drug expenditures. This information will determine, based on the cost of the benefit, how many Medicare beneficiaries will consider the premium cost of a voluntary drug benefit insurance program worked it.

This chart from the Medicare Payment Advisory Commission, known as MPAC, in a report to Congress in 1999 shows that 14 percent of Medicare beneficiaries have no drug expenditures, 36 percent have expenditures of one dollar to $500 a year, 19 percent had drug expenditures from $500 to $1,000 a year, 12 percent from $1,000 to $1,500 a year, 14 percent from $1,500 to $3,000 a year, and 6 percent over $3,000.

But please note that 14 percent plus 36 percent means that 50 percent of Medicare beneficiaries today have less than $500 drug expenses annually. And if you add another 19 percent, 69 percent had drug expenses of less than $1,000 a year.

As we look at plans to change Medicare to better cover the cost of prescription drugs, we face some difficult

choices for which there is currently no consensus in the population or, for that matter, among policymakers.

There are many questions to answer. Here are a few: Should the coverage be for the entire Medicare population or for low income seniors? Should it be comprehensive or for catastrophic? What should be the level of benefit cost sharing by the recipients? Will there be any cost controls on the cost of drugs? Should we deal with this problem about drug costs for the Medicare population only or should we try to figure out some provisions for everyone? How much money can the Federal Treasury devote to this subsidy? Can we really predict the cost of the benefit?

Now, Mr. Speaker, the desire to add a prescription drug benefit is not new. It was discussed at the inception of Medicare back in 1965 and many times since then. The reason why adding a prescription benefit is such a hot issue now is that there has been an explosion in new drugs available, huge increases in demand for these drugs, and significant increase in the cost of these drugs in just the past few years. Many of these drugs are life-preserving, such as some of those that my own father takes.

Before I discuss the Democratic and Republican proposals, I think it is instructive to look at what happened the last time Congress tried to do something about prescription drugs and Medicare. This is because the outcome of reform in 1988 has seared itself into the minds of the policymakers who were in Congress then and who are committee chairman now.

The Medicare Catastrophic Coverage Act of 1988 would have phased in catastrophic prescription drug coverage as part of a larger package of benefit improvements. Under the Medicare Catastrophic Coverage Act of 1988, catastrophic prescription drug coverage would have been available in 1991 for all outpatient drugs subject to a $600 deductible, 50 percent co-insurance.

The benefit was to be financed through a mandatory combination of an increase in Part B premium and a portion of the new supplemental premium which was to be imposed on higher income enrollees.

It is also important to note that the Congressional Budget Office estimated the cost for this at $5.7 billion initially and only 6 months later the cost estimates had more than doubled because both the average number of prescriptions used by enrollees and the average price had risen more than previously estimated.

This plan back in 1988 passed the House by a margin of 328–72, and President Reagan enthusiastically signed into law this largest expansion of Medicare in history. The only problem was that, once seniors learned their premiums were going up, they hated the bill.

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They even started demonstrating against it. Scenes of Gray Panthers hurdling themselves on to Ways and Means chairman Dan Rostenkowski's car were broadcast to the Nation. Angry phone calls from senior citizens flooded the Capitol switchboards. So the very next year this House voted 360 to 66 to repeal the Medicare Catastrophic Coverage Act of 1988, and President Bush then signed the largest cut in Medicare benefits in history, and this experience left scars on the political process that are evident in today's Democratic and Republican proposals.

What was the lesson? Well, Dan Rostenkowski wrote an article for the Wall Street Journal on January 17 of this year that should be required reading for every Member of this Congress. Remember, he was the chairman of the Committee on Ways and Means in 1988. His most important point was this: The 1988 plan was financed by a premium increase for all Medicare beneficiaries. Rosti says in his op-ed piece, ''We adopted a principle universally accepted in the privates insurance industry: People pay premiums today for benefits they may receive tomorrow.''

Apparently the voters did not agree with those principles. By the way, the title of his op-ed piece is ''Seniors Won't Swallow Medicare Drug Benefits.''

Former Ways and Means Chairman Rostenkowski does not think seniors have changed since 1988, and apparently the drafters of the Democratic and the Republican bills agree with him, because the key point the spokesmen for each of these bills makes to seniors is that their respective plans are voluntary.

While there are shortcomings in both plans, I think before I briefly describe each plan let me acknowledge the hard work that some members have put into these bills. The House Republican plan is estimated to cost seniors $35 to $40 a month in 2003, with possible projected rises of 15 percent a year. Premiums could vary among plans. There would be no defined benefit plan, and insurers could offer alternatives of ''equivalent value.'' There would be a $250 deductible, and the plan would then pay half of the next $2,100 in drug costs. After that expense, patients are on their own, until out-of-pocket expenses reach $6,000 a year when the government pays the rest.

The GOP plan would pay subsidies to insurance companies for people with high drug costs. If subscribers did not have a choice of at least two private drug plans, then a ''government plan'' would be available. A new bureaucracy called the Medical Benefits Administration would oversee these private drug insurance plans.

Under the Republican plan, the government would pay for all premiums and nearly all beneficiaries' share of covered drug costs for people with incomes under 135 percent. For people with incomes from 135 to 150 percent of the poverty level, premium support would be phased out. It is assumed that drug insurers would use generic drugs to control costs.

The cost of the GOP plan is estimated to be $37.5 billion over 5 years, and about $150 billion over 10 years, though the Congressional Budget Office is having a hard time predicting costs because there is no standard benefit definition.

The premiums under the Clinton plan were estimated to cost those seniors who sign up, remember, this is a voluntary plan, like the GOP plan, about $24 a month in the year 2003, rising to $51 a month in 2010. However, the Clinton Administration now talks about adding $35 billion in expenses for a catastrophic component like the GOP plan, which would make premiums higher.

Under the Clinton plan, Medicare would pay half the cost of each prescription, and there would be no deductible. Maximum Federal payment would be $1,000 for $2,000 worth of drugs in 2003, rising to $2,500 for $5,000 worth of drugs in 2009.

The government would assume the financial risk for prescription drug insurance, but it would hire private companies to administer benefits and negotiate discounts from drug manufacturers. It would aid the poor similar to the GOP House plan and would try to control costs by the use of pharmaceutical benefit managers. As pharmaceutical companies buy up these benefit managers, one wonders about conflicts of interest and whether any discounts will really occur.

But here is a crucial point: In order to cushion the cost of the sicker with premiums from the healthier, both plans calculate premiums premised on about 80 percent participation of all those in Medicare.

Now, the partisan attacks on the Clinton plan and on the GOP plan are already starting. Democrats say Republicans are putting seniors in HMOs, HMOs provide terrible care, and this is not fair to seniors.

Republicans say the Democratic plan is a one-size-fits-all plan that is too restrictive, too confusing and puts the politicians and Washington bureaucrats in control. This is from a House Republican Conference source.

Now, I could criticize each of these plans in depth, but I do not have that much time left. Suffice it to say that the details of each of these plans is very important as to how they would work; for that matter, if they would work.

The GOP bill's legislative language just became available a few days ago, so I have been reading the 150 page document over the past few days. I believe that if you let plans design all sort of benefit packages, as does the GOP plan, it becomes very difficult for seniors to be able to compare apples to apples, to compare equivalency of plans in terms of value. I also think that plans can tailor benefits to cherry pick healthier, less expensive seniors and game the system.

Representatives of the insurance industry seemed to share that opinion in

a hearing before my committee. In my opinion, a defined benefit package would be better. I have concerns about the financial incentives that the House Republican bill would offer insurers to enter markets in which no drug plans are available. Would these incentives encourage insurers to hold out for more money? I have doubts that the private insurance industry will ever offer drug only plans.

In testimony before my committee, Chip Kahn, President of the Health Insurance Association of America, testified that drug only plans will not work. In testimony before the Committee on Commerce on June 13, 2000, Mr. Kahn said, ''Private drug only coverage would have to clear insurmountable financial regulatory and administrative hurdles simply to get to the markets. Assuming that it did, the pressures of ever increasing drug costs, the predictability of drug expenses, the likelihood that the people most likely to purchase this coverage will be the people anticipating the highest drug claims, would make drug only coverage virtually impossible for insurers to offer to seniors at an affordable premium.'' Mr. Kahn predicted that few, if any, insurers would offer that kind of product.

I could similarly criticize several particulars of the Democratic bill, but, in the spirit of bipartisanship, I want to expand on what I think is the fundamental flaw in both plans, and that is what is called adverse risk selection.

If the Clinton plan has comparable costs for a stop loss provision of catastrophic expenses, the premium costs will be comparable to the GOP plan. Under these bills, a person who signs up for drug insurance will pay about $40 per month, or roughly $500 per year. After the first $250 out-of-pocket costs for the deductible, the enrollee would need to have twice $500 in drug costs, or $1,000, in order to be getting a benefit that is worth more than the cost of the premiums for the year.

Put it another way: The enrollee must have $250 for the deductible, plus $1,000, or $1,250 in annual drug costs, in order to get half of the rest of his drug expenses, up to a maximum of $2,100 paid for by the plan.

Who then will sign up for these plans? Well, those seniors with over $1,250 in annual drug expenses. Those with less than that would end up paying more in premiums than they are currently paying.

Remember the MedPAC data from the last year that I showed you earlier in this speech? Sixty-nine percent of seniors spend less than $1,250 per year on drug costs. Remember also that the premiums are premised on a 80 percent participation rate. I think it is highly doubtful that anywhere near 80 percent of seniors will sign up for either of these plans, and if only those with high drug costs sign up for these plans, then we know what will happen by looking at the current Medigap policies. Only three plans have any prescription drug coverage, and they are expensive because of unfavorable selection. Only 7.4 percent of beneficiaries enrolled in standard Medigap plans were in these drug coverage plans, plans H, I and J.

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Now, one way to avoid adverse risk selection in a voluntary benefit system would be to offer the drug benefit for one time only when a beneficiary enrolls in Medicare. Even with that restriction, there would still be some adverse selection in that some seniors already have high drug costs at age 65 when they enter Medicare and would be more likely to join such a program.

Now, this mandatory provision is not in either plan. The authors of the GOP bill recognize the adverse risk selection problem and they try to address it by saying that if a beneficiary does not sign up for the drug insurance program on initial registration for Medicare, then thereafter, when he or she wants to sign up for the drug insurance program, the premium would be ''experience-based'' and potentially more costly. The theory is that the threat of higher premiums would act as an inducement to seniors with no or low drug costs to sign up initially.

Mr. Speaker, if only everyone acted with such prudence now, we would not be dealing with the need for this bill. Unfortunately, the low participation in the current voluntary Medigap programs indicates that unless seniors must sign up initially, a large number will not. They will wait until they need drugs, and then they will complain vociferously to Congress about their high premiums and we will be right back where we started. Since other seniors will have a prescription drug benefit, there will be enormous pressure on legislators to subsidize the seniors who are tardy in signing up for a drug program and that, of course, will significantly increase the cost of the program.

Another way to control adverse risk selection is to try to devise a risk adjustment system. These adjustment systems are very hard to design and implement. It remains to be seen whether risk adjustment systems already on the books for other parts of Medicare are going to work. A similar benefit package helps control adverse risk selection. Consumers are able to select plans based on price and quality rather than benefits. If plans are allowed wide variation in benefits, some plans may be more likely to attract low-cost beneficiaries. The GOP plan has some weak community rating and guaranteed issue provisions in acknowledgment of this problem, but these provisions depend on oversight by a new Medical Benefits Administration, and the Inspector General already tells us how hard it is to oversee adverse risk selection in Medicare HMOs.

We could, of course, mandate enrollment. That was the approach of the Medicare Catastrophic Coverage Act in 1988, and we saw what happened to that law. To say that mandatory enrollment has little appeal to policymakers in an election year I think is an understatement.

Finally, we could avoid adverse selection for a voluntary benefit like prescription drug coverage if we just subsidized the benefits so much that seniors simply share very little of the cost. The benefit becomes cost-effective for the vast majority, regardless of health, because it is such a good deal. But this could lead to a $400 billion or $500 billion subsidy.

It again reminds me of the article by Mr. Rostenkowski. As Rosty said in his op-ed piece, ''The problem was, and still is, a lack of money.'' Yes, we have a projected surplus, but the 10-year costs of a more highly subsidized drug coverage could, in my opinion, even double or triple the cost of both proposals.

There are many reasons why, even in this time of plenty, that is hard to do. First, we have a bipartisan commitment not to use the Social Security surplus funds. Second, we have people in this country that have no insurance at all, much less drug coverage. Third, Medicare is closer to insolvency than it was back in 1988. Should not our first priority be to protect the current Medicare program?

Well, given these constraints, what can we do to help seniors and others with high drug costs? I have a 10-step modest proposal for helping seniors and others with their drug costs.

First, allow qualified Medicare beneficiaries, those QMBs, and specified low-income Medicare beneficiaries, SLIMBs, and qualifying individuals with an additional phaseout group up to 175 percent of poverty to qualify for State Medicaid drug programs. States could continue to use their current administrative structures and implementation could be done quickly. About one-third of Medicare beneficiaries would be eligible, especially those most in need, and the drug benefit would encourage those who qualify to actually sign up. A key feature of this program would be that the State programs are entitled to the best price that the manufacturer offers any purchaser in the United States. Judging from estimates of the bipartisan Medicare Commission, this expansion of benefits would probably cost about $60 billion to $80 billion over 10 years.

Second, Congress could fix the funding formula that puts rural States and certain low reimbursement urban areas at such a disadvantage in attracting Medicare-Plus plans that offer drug coverage.

Third, in response to my constituents who want to purchase their drugs in Canada, Mexico or Europe, we could stop the Food and Drug Administration from intimidating seniors and others with threats of confiscation of their purchases. The FDA has sent notices to people that importing drugs is against the law. The FDA should not send warning notices regarding the importation of a drug without providing to the

person involved a statement of the underlying reasons. The gentleman from Minnesota (Mr. GUTKNECHT), my colleague, has introduced legislation called the Drug Import Fairness Act of 1999, and Congress should pass that common sense legislation.

Fourth I think we should at least fully debate the bill of the gentleman from Maine (Mr. ALLEN), the Prescription Drug Fairness for Seniors Act. The idea is simple. It would allow pharmacists to buy drugs for Medicare beneficiaries at the best price available to the Federal Government, typically the Veterans' Administration price, or the Medicaid price. It creates no new bureaucracy. There is no significant cost to the government. It gives Medicare beneficiaries negotiated lower prices, such as customers of Aetna, Cigna, and other private plans receive the benefit of negotiated lower prices.

Fifth, I think we should enact full tax deductibility for the self-insured retroactive to January 1, 2000.

Sixth, there are 11 million children without any health insurance. Many of them qualify, 7 million of them qualify for Medicaid, and the State Children's Insurance programs. We ought to get those kids in. That gives them prescription drugs as well.

Seventh, many pharmaceutical companies offer programs where they provide drugs free to low-income individuals. These company programs are to be commended, but we need to do a better job, and maybe the FDA could do this, of getting that information to those low-income beneficiaries to take advantage of those pharmaceutical companies' programs.

Eighth, 16 States have pharmaceutical assistance programs targeted to Medicare beneficiaries. Some of these programs could serve as models for State grant programs. The gentleman from Florida (Mr. BILIRAKIS) has a bill that would do this. We ought to look at that. I think the QMB-SLIMB solution is a little quicker and more certainly implemented, but at least we could have a debate on that.

Ninth, I believe that Congress should revise the FDA Reform Act of 1997. At a minimum, drug companies should be required to fully discuss major potential complications of their drugs in their radio and television advertising.

Tenth, finally, I think Congress should actually get signed into law a combination of the above in a bipartisan fashion. Yes, this approach is more limited than either that of President Clinton or the House GOP plan. But a more comprehensive drug plan should, in my opinion, be a part of overall Medicare reform where all of the pieces fit together so as to do no harm to any one part while benefiting another. It will not do Iowa seniors much good to have an unlimited drug benefit if they do not have a local hospital to go to.

Finally, Mr. Speaker, this is a very complicated issue. I believe that we should follow regular order. That means a bill in the hopper, hearings on the bills, subcommittee markups with amendments and debate, full committee markups, all of the committees of jurisdiction looking at the bill. Regular order is not just for the members on the committee, it is for everyone in this House to see the process and to fully understand an issue. I am sorry to say that that regular order is not happening.

Mr. Speaker, we are going to see a bill rushed to the floor next week. I would advise my colleagues to be very careful. I am sure that television archives preserve the image of unhappy Chicago citizens surrounding Dan Rostenkowski's car when he visited a decade ago to explain why he thought the Medicare reform bill was a good bill. Let us continue regular order.

Finally, I remain committed to seeing a bill signed into law. Mr. Speaker, let us just make sure that it is a good one.

Mr. Speaker, this is a photo of William Newton, 74, of Altoona, Iowa, a constituent in my district whose savings vanished when his late wife, Waneta, whose picture he is holding, needed prescription drugs that cost as much as $600 per month.

''She had to have them—there was no choice,'' Newton said. ''It's a very serious situation and it isn't getting any better because drugs keep going up and up.''

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''Dear Congressman Ganske . . . after completing a University of Iowa study on Celebrex 200 mg. for arthritis, I got a prescription from my MD and picked it up at the hospital pharmacy. My cost was $2.43 per pill with a volunteer discount!

''Later on the Internet I found the following:

a. I can order [these drugs] through a Canadian pharmacy if I use a doctor certified in Canada or my doctor can order it ''on my behalf'' through his office for 96 cents per pill, plus shipping.

b. I can order [these drugs] through Pharmaworld, in Geneva, Switzerland, after paying either of two American doctors $70 for a phone consultation, at a price of $1.05 per pill, plus handling and shipping.

c. I can send $15 to a Texan and get a phone number at a Mexican pharmacy which will send it without a prescription . . . at a price of 52 cents per pill.

This constituent closes his letter to me by saying, ''I urge you, Dr. Ganske, to pursue the reform of medical costs and stop the outlandish plundering by pharmaceutical companies.''

Well, Mr. Speaker, I want it to be very clear. I am in favor of prescription drugs being more affordable, not just for senior citizens, but for all Americans.

Let's look at the facts of the problem and then discuss some solutions.

There is no question that prices for drugs are rising rapidly. A recent report found that the prices of the 50 top-selling drugs for seniors rose much faster than inflation. 33 of the 50 drugs rose in price at least one and one-half times inflation. Half of the drugs rose at least twice as fast as inflation. Sixteen drugs rose at least three times inflation and twenty percent rose at least four times the rate of inflation.

The prices of some drugs are rising even faster. Furosemide, a generic diuretic, rose 50% in 1999. Klor-con 10, a brand name drug, rose 43.8%.

This was not a one-year phenomenon. 39 of these fifty drugs have been on the market for at least 6 years. The prices of three-fourths of this group rose at least 1.5 times inflation, over half rose at twice inflation, more than 25% increased at three times inflation and six drugs at over five times inflation. Lorazepam rose 27 times inflation and furosemide 14 times inflation!

Prilosec is one of the two top-selling drugs prescribed for seniors. The annual cost for this 20-milligram gastrointestinal drug, unless you have some type of drug discount, is $1,455. For a widow at 150% of poverty ($12,525 income per year), the annual cost of Prilosec alone will consume more than one in nine dollars of the senior's total budget. (chart)

My friend from Des Moines, the Iowa Lutheran Hospital volunteer senior citizen, as do the Weinman's from Indianola from their shopping trips in Mexico for prescription drugs, knows that drug prices are much higher in the United States than they are in other countries.

A story from USA Today comparing U.S. drug prices to prices in Canada, Great Britain, and Australia for the test best-selling drugs, verifies that drug prices are higher here in the U.S. than overseas. For example, Prilosec is two to two-and-one-half times as expensive in the U.S.; Prozac was two to two-and-three-quarters as expensive; Lipitor was 50 to 92% more expensive; and Prevacid was as much as four times more expensive. Only one drug, Epogen, was cheaper in the U.S. than in other countries.

High drug prices have been a problem for the past decade. Two GAO studies, from 1992 and 1994, showed the same results. Comparing prices for 121 drugs sold in the U.S. and Canada, prices for 98 of the drugs were higher in the U.S. Comparing 77 drugs sold in the U.S. and the United Kingdom, 86% of the drugs were priced higher in the U.S. and three out of five were more than twice as high.

The drug companies claim that drug prices are so high because of research and development costs. And, I do want to say that there is great need for research. For example, around the world we are seeing an explosion of antibiotic resistant bacteria, like tuberculosis, for which we will need research and development for new drugs. A new report by the World Health Organization outlines this concern about infectious diseases.

However, data from PhRMA, the pharmaceutical trade organization, that I saw presented in Chicago about one month ago, showed little increase in R&D, especially in comparison to significant increases in advertising and marketing by the pharmaceutical companies. Since the 1997 FDA reform bill, advertising by drug companies has gotten so ubiquitous that Healthline recently reported that consumers watch, on average, nine prescription drug commercials a day!

Look at this chart which shows 1998 figures for the big drug companies. In every case, marketing, advertising, sales, and administrative costs exceed research and development costs. In 1999, four of the five companies with the highest revenues spent at least twice as much on marketing, advertising and administration as they spent on research and development. Only one of the top ten drug companies spent more on R&D than on marketing, advertising, and administration. Administration costs haven't increased much—the real increase has been in advertising.

For the manufacturers of the top 50 drugs sold to seniors, profit margins are more than triple the profit rates of other Fortune 500 companies. The drug manufacturers have a profit rate of 18% compared to approximately 5% for other Fortune 500 companies. Furthermore, as recently cited in the New York Times, of the 14 most medically significant drugs developed in the past 25 years, 11 had significant government financed research. For example, Taxol is a drug developed from government funded research which earns its manufacturer, Bristol-Myers-Squib, millions of dollars each year.

As I said at the start of this Special Orders speech, I think the high cost of drugs is a problem for all Americans, not just the elderly, but many non-seniors are in employer plans and get a prescription drug discount. In addition, there is no doubt that the older one is, the more likely the need for prescription drugs. So let us look at what type of drug coverage is available to senior citizens today.

Medicare pays for drugs that are part of treatment when the senior citizen is a patient in a hospital or skilled nursing facility. Medicare pays doctors for drugs that cannot be ''self-administered'' by patients, i.e. drugs that require intramuscular or intravenous administration. Medicare also pays for a few other outpatient drugs such as drugs to prevent rejection of organ transplants, medicine to prevent anemia in dialysis patients, and oral anticancer drugs. The program also covers pneumonia, hepatitis, and influenza vaccines. The beneficiary is responsible for 20% of the coinsurance for these drugs.

About 90% of Medicare beneficiaries have some form of private or public coverage to supplement Medicare, but many with supplementary coverage have either limited or no protection against prescription drug costs, those drugs one buys in a pharmacy with a prescription from your doctor.

Since the early 1980's Medicare beneficiaries in some parts of the country have been able to enroll in HMOs which provide prescription drug benefits. Medicare pays the HMOs a monthly dollar amount for each enrollee. Some areas like Iowa have had such low payment rates that no HMOs with drug coverage are available. This is typically a rural problem, but some metro areas also have inequitably low reimbursements.

Parenthetically, I have led the fight to improve these unfair payment rates which allow seniors living in Miami, for example, to get drug benefits that seniors living anywhere in Iowa or Nebraska or Minnesota don't. But I'll return to this issue later.

Employers may offer their retirees health benefits that include prescription drugs but fewer are doing so. From 1993–1997, prescription drug coverage of Medicare-eligible retirees dropped from 63% to 48%.

Beneficiaries with Medigap insurance typically have coverage for Medicare's deductibles and coinsurance, but only three of the ten standard plans offer drug coverage. All three impose a $250 deductible. Plans H and I cover 50% of the charges up to a maximum benefit of $1,250. Plan J covers 50% of the charges up to a maximum benefit of 3,000. The premiums for these plans are significantly higher than the other seven Medigap plans because of the cost of the drug benefit.

This chart shows the difference in annual cost to a 65-year-old woman for a Medigap policy with or without a drug benefit. For a Medigap policy of moderate coverage, she pays $1,320 without a drug benefit and $1,917 for a policy with a drug benefit. For extensive coverage, she would pay $1,524 for insurance without drugs and $3,252 for insurance with drug coverage.

Why is there such a price gap? Because the drugs benefit is voluntary. Only those persons who expect to actually use a significant quantity of prescriptions purchase a Medigap policy with drug coverage. But, because only those with high costs choose that option, the premiums must be high to cover the costs of a high average expenditure for drugs. What is the lesson we can learn from the current program? Adverse selection tends to drive up the per capita cost of coverage—unless the Federal treasury simply subsidizes lower premiums.

The very low-income elderly and disabled Medicare beneficiaries are also eligible for payments of their deductibles and coinsurance by their state's Medicaid program. For these ''dual eligibles,'' the most important service paid for entirely by Medicaid is frequently the prescription drug plans offered by all states under their Medicaid plans.

There are several groups of Medicare beneficiaries who have more limited Medicaid protection:

Qualified Medicare Beneficiaries (QMBs) have incomes below the poverty line ($8,240 single, $11,060 couple) and assets below $4,000 single/$6,000 couple. Medicaid pays their deductible and premiums.

Specified Low-Income Medicare Beneficiaries (SLIMBs) have incomes up to 120% of the poverty line and Medicaid pays their Medicare Part B premium.

Qualifying Individuals (QI–1) have income between 120% and 135% of poverty. Medicaid pays only their Part B premium, but not deductibles.

Qualifying Individuals (QI–2) have income between 135% of 174% of poverty. Medicaid pays part of the Part B premiums.

QMBs and SLIMBs are not entitled to Medicaid's prescription drug benefit unless they are also eligible for full Medicaid coverage under their state's Medicaid program. QI–1s and QI–2s are never entitled to Medicaid drug coverage.

A 1999 HCFA report showed that, despite a variety of potential sources of coverage for prescription drug costs, beneficiaries still pay a significant proportion of drug costs out-of-pocket and about one-third of Medicare beneficiaries had no coverage at all.

It is also important to look at the distribution of Medicare enrollees by total annual prescription drug expenditure. This information will determine, based on the cost of the benefit, how many Medicare beneficiaries will consider the premium cost of a ''voluntary'' drug benefit insurance policy ''worth it.''

This chart from the Medicare Payment Advisory Commission (MedPAC) report to Congress shows that in 1999, 14% of those in Medicare had no drug expenditures and 36% had expenditures of $1 to $500. 19% had drug expenditures from $500 to $1,000, 12% from $1,000 to $1,500, 14% from $1,500 to $3,000 and 6% over $3,000.

Please note that 50% of those in Medicare had drug expenditures of less than $500 per year, and 69% had drug expenses less than $1,000 per year.

As we look at plans to change Medicare to better cover the cost of prescription drugs, we face some difficult choices for which there is currently no public consensus or, for that matter, among policy makers.

There are many questions to answer. Here are a few: First, should coverage be extended to the entire Medicare population or targeted toward the elderly widow who isn't so poor that she's in Medicaid but is having to choose between her rent, food, and drugs? Should the benefit be comprehensive or catastrophic? Should the drug benefit be defined? What is the right level of beneficiary cost-sharing? Should the subsidies be given to the beneficiaries or directly to the insurers? How much money can the Federal Treasury devote to this subsidy? Can we really predict the future cost of the benefit?

The desire to add a prescription drug benefit is not new. It was discussed at the inception of Medicare back in 1965 and many times since. The reason why adding a prescription benefit is such a ''hot'' issue is that here has been an explosion in new drugs available, huge increases in demand for these drugs, and significant increase in the cost of these drugs in just the past few years. Many of these drugs are life-preserving as with those that my own father takes.

Before I discuss the Democratic and Republican proposals, I think it is instructive to look at what happened the last time Congress tried to do something about prescription drugs in Medicare. This is because the outcome of reform in 1988 has seared itself into the minds of the policy makers who were in Congress then and are committee chairs now. The Medicare Catastrophic Coverage Act of 1988 (MCCA) would have phased in catastrophic prescription drug coverage as part of a larger package of benefit improvements.

Under MCCA, catastrophic prescription drug coverage would have been available in 1991 for all outpatient drugs, subject to a $600 deductible and 50% coinsurance. The benefit was to be financed through a mandatory combination of an increase in the Part B premium and a portion of the new supplemental premium which was to be imposed on higher income enrollees. It is also important to note that CBO estimated the cost at $5.7 billion. Only six months later the cost estimates had more than doubled because both the average number of prescriptions used by enrollees and

the average price had risen more than previously estimated.

The plan passed the House by a margin of 328 to 72 and President Reagan enthusiastically signed into law this largest expansion of Medicare in history.

The only problem was that once seniors learned their premiums were going up, they hated the bill! They even started demonstrating against it. Scenes of Gray Panthers hurtling themselves onto Ways and Means Chairman Dan Rostenkowski's car were broadcast to the nation. Angry phone calls from senior citizens flooded the Capitol switchboards.

So, the very next year the House voted 360 to 66 to repeal the Medical Catastrophic Coverage Act of 1988 and President Bush then signed the largest cut in Medicare benefits in history.

This experience left scars on the political process that are evident in today's Democratic and Republican proposals. What was the lesson? Well, Dan Rostenkowski wrote an article for the Wall Street Journal on January 17 this year that should be required reading for every member of this Congress. His most important point was this:

The 1988 plan was financed by a premium increase for all Medicare beneficiaries. Rosty says in this op-ed piece, ''We adopted a principle universally accepted in the private insurance industry. People pay premiums today for benefits they may receive tomorrow.'' Apparently the voters didn't agree with those principles. By the way, the title of his op-ed piece is Seniors Won't Swallow Medicare Drug Benefits. Former Ways and Means Chairman Rostenkowski doesn't think seniors have changed since 1988.

Apparently, the drafters of the Democratic and Republican bills agree with him because the key point of the spokesman for each of these bills makes to seniors is that their respective plans are voluntary.

There are shortcomings in both plans but before I briefly describe each plan, let me acknowledge the hard work that some members have put into these bills. The House Republican plan is estimated to cost seniors $35 to $40 a month in 2003 with possible projected rises of 15% a year. Premiums could vary among plans. There would be no defined benefit plan and insurers could offer alternatives of ''equivalent value.'' There would be a $250 deductible and the plan would then pay half of the next $2,100 in drug costs. After that expense, patients are on their own until out-of-pocket expenses reach $6,000 a year, when the government pays the rest.

The GOP plan would pay subsidies to insurance companies for people with high drug costs. If subscribers didn't have a choice of at least two private drug plans then a ''government'' plan would be available. A new bureaucracy called the Medical Benefits Administration would oversee these private drug insurance plans.

Under the Republican plan, the government would pay for all the premium and nearly all the beneficiary's share of covered drug costs for people with incomes under 135%. For people with incomes from 135% to 150% of the poverty level, premium support would be phased out. It is assumed that drug insurers would use generic drugs to control costs.

The cost of the GOP plan is estimated to be $37.5 billion over five years and about $150 billion over ten years, though the Congressional Budget Office is having a hard time predicting costs because there is no standard benefit definition.

The premiums under the Clinton Plan were estimated to cost those seniors who sign up, remember this is a voluntary plan like the GOP plan, $24 a month in 2003, rising to $51 a month in 2010. However, the Clinton Administration now talks about adding $35 billion in expenses for a catastrophic component like the GOP plan, which would make premiums higher.

Under the Clinton Plan, Medicare would pay half of the cost of each prescription and there would be no deductible. Maximum federal payment would be $1,000 (for $2,000 worth of drugs) in 2003, rising to $2,500 (for $5,000 worth of drugs) in 2009.

The government would assume the financial risk for prescription drug insurance, but it would hire private companies to administer benefits and negotiate discounts from drug manufacturers. It would aid the poor similarly to the GOP House bill and would try to control costs by the use of pharmaceutical benefit managers (PBMs). (As pharmaceutical companies buy up these PBMs one wonders about conflicts of interest and whether any discounts will really occur.)

Here is a crucial point. In order to cushion the costs of the sicker with premiums from the healthier, both plans calculate premiums premised on about 80% participation of all those in Medicare.

The partisan attacks on the Clinton plan and on the GOP plan are already starting. Democrats say, ''Republicans are putting seniors in HMOs. HMOs provide terrible care and this isn't fair to seniors.'' Republicans say, ''The Democratic plan is a one-size-fits all plan that is too restrictive and puts politicians and Washington bureaucrats in control.''

I could criticize each in depth, but don't have that much time tonight. Suffice it is to say that the details of each of these plans is very important as to how they would work, for that matter, if they would actually work. The GOP bill's legislative language just became available Thursday and so I have been reading this 150-page document over the past few days.

I believe that if you let plans design all sorts of benefit packages, as does the GOP plan, it becomes very difficult for seniors to be able to compare apples to apples, to compare equivalency of plans in terms of value. I also think that plans can tailor benefits to cherry-pick healthier, less expensive seniors and game the system. Representatives of the insurance industry seemed to share that opinion in a hearing before my committee. In my opinion, a defined benefit package would be better.

I have concerns about the financial incentives that the House Republican bill would offer insurers to enter markets in which no drug plans were available. Would these incentives encourage insurers to hold out for more money?

I have doubts that the private insurance industry will ever offer drug-only plans. In testimony before my committee, Chip Kahn, President of the Health Insurance Association of America, testified that drug-only plans will not work.

In testimony before the Commerce Committee on June 13, 2000, Mr. Kahn said, ''Private drug-only coverage would have to clear insurmountable financial regulatory, and administrative hurdles simply to get to market. Assuming that it did, the pressures of ever-increasing drug costs, the predictability of drug expenses, and the likelihood that the people most likely to purchase this coverage will be the people anticipating the highest drug claims would make drug-only coverage virtually impossible for insurers to offer a plan to seniors at an affordable premium.''

Mr. Kahn predicted that few, if any, insurers would offer this type of product.

I could similarly criticize several particulars of the Democratic bill but, in the spirit of bipartisanship, I want to expand on what I think is the fundamental flaw of both plans and that is what is called ''adverse risk selection.''

If the Clinton Plan has comparable costs for a stop-loss provision of catastrophic expenses, the premium costs will be comparable to the GOP plan. Under these bills, a person who signs up for drug insurance will pay about $40 per month, or roughly $500 per year. After first $250 out-of-pocket drug costs (deductible), the enrollee would need to have twice $500 in drug costs ($1,000) in order to be getting a benefit that is worth more than the cost of the premiums for the year. Put another way, the enrollee must have $250 plus $1,000, or $1,250, in annual drug costs in order to get half of the rest of his drug expenses, up to a maximum of $2,100, paid for by the plan.

Who will then sign up for these plans? Those seniors with over $1,250 in annual drug expenses. Those with less would end up paying more in premiums than they are currently paying. Remember the MedPAC data from last year that I showed you earlier in this speech? 69% of seniors spend less than $1,250 per year on drug costs.

Remember also that the premiums are premised on an 80% participation rate. I think it highly doubtful that anywhere near 80% of seniors will sign up for either of these plans. And if only those with high drug costs sign up for these plans, then we know what will happen by looking at the current Medigap policies. Only three plans have any prescription drug coverage, and they are expensive because of unfavorable selection. Only 7.4% of beneficiaries enrolled in standard Medigap plans were in these drug coverage plans (plans H, I, and J).

One way to avoid adverse risk selection in a voluntary benefit system would be to offer the drug benefit for one time only when a beneficiary enrolls in Medicare. Even with this restriction, there would still be some adverse selection in that some seniors already have high drug costs at age 65 and would be more likely to join such a program. This provision is not in either plan.

The authors of the GOP bill recognize the adverse risk selection problem. They try to address it by saying that if a beneficiary doesn't sign up for the drug insurance program on initial registration for Medicare, then, thereafter when he or she wants to sign up for the drug insurance program, the premium would be ''experienced based'' and potentially more costly. The theory is that the threat of higher premiums would act as an inducement for seniors with no or low drug costs to sign up initially.

If everyone had already acted with such prudence, we wouldn't be dealing with this bill. Unfortunately, the low participation in the current voluntary Medigap programs indicates

that unless seniors must sign up initially, a large number won't. They'll wait until they need drugs, and then complain vociferously to Congress about their high premiums and we'll be back where we started. Since other seniors will have a prescription drug benefit, there will be enormous pressure on legislators to further subsidize the seniors who are tardy in signing up for a drug program. This, of course, will significantly increase the cost of the program.

Another way to control adverse risk selection is to try to devise a risk-adjustment system. These adjustment systems are very hard to design and implement. It remains to be seen whether risk-adjustment systems already on the books for other parts of Medicare are really going to work.

A similar benefit package helps control adverse risk selection. Consumers are able to select plans based on price and quality, rather than benefits. If plans are allowed wide variation in benefits, some plans may be more likely to attract low-cost beneficiaries. The GOP plan has some weak community rating and guaranteed issue provisions in acknowledgment of this problem, but these provisions depend on oversight by the new Medical Benefits Administration and the Inspector General already tells us how hard it is to oversee adverse risk selection in Medicare HMOs.

One sure way to avoid adverse risk selection would be to mandate enrollment. This of course was the approach of the Medicare Catastrophic Coverage Act of 1988 and we saw what happened to that law. To say that mandatory enrollment has little appeal to policy makers in an election year is an understatement.

Finally, we could avoid adverse selection for a ''voluntary'' benefit like prescription drug coverage if we subsidize the benefit so much that seniors simply share very little of the cost. The benefit then becomes cost-effective for the vast majority to participate, regardless of health, because it is such a good deal.

But a $400 or $500 billion subsidy reminds me again of the article by Mr. Rostenkowski. As Rosty says in his op-ed piece. ''The problem was, and still is, a lack of money.'' Yes, we have a projected surplus, but the ten-year costs of more highly subsidized drug coverage could, in my opinion, easily double or even triple the projected costs of both proposals.

There are several reasons why, even in this time of plenty, this is very difficult to do. First, we have made a bipartisan commitment not to use Social Security surplus funds. Second, there are people who have no health insurance at all, much less prescription drug coverage. Should we expand coverage for some while the totally unprotected group grows? Third, Medicare is closer to insolvency than it was back in 1988. Shouldn't our first priority be to protect the current Medicare program?

Given these constraints, what can we do to help seniors and others with high drug costs? Here's a 10-step modest proposal for helping seniors and others with their drug costs:

1. Allow Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLIMBs) and Qualifying Individual (QI–1&2) with an additional phase-out group to 175% of poverty to qualify for state Medicaid drug programs. States could continue to use their current administrative structures and implementation could be done quickly. About a third of Medicare beneficiaries would be eligible, especially those most in need, and the drug benefit would encourage those who qualify to sign up. A key feature of this program would be that the State programs are entitled to the best price that the manufacturer offers to any purchaser in the United States. Judging from estimates of the Bipartisan Medicare Commission, this expansion of benefits would probably cost about $60–80 billion over ten years.

2. Congress should fix the funding formula (the Annual Adjusted Per Capita Cost—AAPCC) that puts rural states and certain low-reimbursement urban areas at such a disadvantage in attracting Medicare-Plus plans that offer drug coverage. The GOP plan increases the floor to $450, but this increase is grossly inadequate. Testimony from the executive director of the American Association of Health Plans indicates that Medicare HMOs are leaving markets where the payment is already $550. We should raise the floor to a minimum of $600 per month per beneficiary, and not do an across-the-board increase in payment which would disproportionately increase reimbursement to areas with AAPCCs already over $780.

3. In response to my constituents who want to purchase their drugs in Canada, Mexico, or Europe, we should stop the Food and Drug Administration from intimidating seniors and others with threats of confiscation of their purchases. The FDA has sent notices to people that importing drugs is against the law. The FDA should not send a warning notice regarding the importation of a drug without providing to the person involved a statement of the underlying reasons for the notice. Mr. GUTKNECHT, my colleague from Minnesota, has introduced legislation called the ''Drug Import Fairness Act of 1999'', H.R. 3240, and Congress should pass this common sense provision.

4. Congress should at least fully debate Congressman TOM ALLEN's bill, the Prescription Drug Fairness for Seniors Act, H.R. 664. The idea is simple. It would allow pharmacists to buy drugs for Medicare beneficiaries at the best prices available to the federal government, typically the Veterans Administration price or the Medicaid price. It creates no new bureaucracy. There is no significant cost to the government. It gives Medicare beneficiaries negotiated lower prices, just as customers of Aetna, Cigna and other private plans receive the benefit of negotiated lower prices.

5. Congress should enact full tax deductibility retroactive to January 1, 2000, for the self-insured. It isn't just seniors that have medical expenses. 40 million Americans have no insurance at all, much less prescription drug coverage. We should devote at least $40 billion over ten years to this problem.

6. There are 11 million children without any health insurance and, of course, no prescription drug coverage. Roughly 7 million of these kids already qualify for Medicaid or the State Child Health Insurance Program which do provide prescription drug services. These children should be enrolled. This requires a commitment on the part of the federal government to find these individuals and get them signed up. We need to streamline the system to help these states.

7. Many pharmaceutical companies do have programs where they provide drugs to low income individuals free of charge. These company programs are to be commended but most people who meet the company requirements don't know about these programs. Both physicians and patients need to be better educated to take advantage of free or discontinued drugs.

8. Currently 16 states have pharmaceutical assistance programs targeted to Medicare beneficiaries. Some of these programs could serve as models for state grant program options Congressmen MIKE BILIRAKIS and COLLIN PETERSON have introduced H.R. 2925, the Medicare Beneficiary Prescription Drug Assistance and Stop-loss Protection Act of 1999 which encourages states to expand their drug assistance programs with federal matching funds and assistance to beneficiaries up to 200% of poverty. I think QMB, SLMB solution would work quicker and more certainly, but this option deserves a more complete debate than it has received.

9. I believe that Congress should revise the FDA Reform Act of 1997 and restrict direct marketing to consumers by the pharmaceutical companies. There is no question that seniors are being bombarded with ads on the latest, greatest new drug with very little data on contraindications, alternatives, and potential complications, much less cost. At a minimum, drug companies should be required to fully discuss their major potential complications of these drugs in their radio and T.V. advertising.

10. Finally, I think Congress could actually get signed into law a combination of the above in a bipartisan fashion. Yes, this approach is more limited than either the Clinton plan or the House GOP plan. However, a more comprehensive drug plan should, in my opinion, be a part of over-all Medicare reform where all the pieces fit together so as to do no harm to one part while benefiting another. It won't do Iowa seniors much good to have an unlimited drug benefit if they don't have a local hospital to go to.

This prescription drug issue is complicated. As I said at the beginning of this speech, there is little consensus yet on some of the most important provisions. Furthermore, a reform like this truly should be a bipartisan effort, with more than just a few members of the other party signed on to a bill.

For a long time, in its wisdom, Congress has gone through ''regular order'' in legislating. This means a bill with all its details dropped in the bin and made public. Hearings on the bill's particulars, comparisons of language and the implications of legislative language. Subcommittee mark-ups with amendments and debate. Full committee mark-ups with amendments and debate. All committees of jurisdiction weighing in and marking up the bill. Rules that allow full debate on the floor.

''Regular order'' isn't just for the members of the committees of jurisdiction, it is really for the other members so that they can watch and learn and make sure that an issue is fully vetted before they vote on it.

I am sorry to say that on this very important issue, ''regular order'' is not being followed

and for political reasons a bill is being rushed to the floor. I would advise my colleagues to be very careful. I am sure that television archives preserve the image of unhappy Chicago senior citizens surrounding Dan Rostenkowski's car when he visited a decade ago to explain why he thought the Medicare reform bill then was a good deal. That tape is a warning to any politician who deviates from ''regular order'' and doesn't pay attention to the lessons of the past.

As for me, I will find it very difficult to vote for a bill of this magnitude that doesn't go through regular order. That means a chance to improve it in the Commerce Committee. Regardless of what happens in the next week, I remain committed to seeing a bill signed into law. Let's just make sure that it is a good one.