grateful. We are honored to have you continue in serving our great country in the United States Navy.

Mr. Speaker, Will Merchen and Josh Heupel are young men that have already accomplished much, and they have very promising futures ahead of them; and they are an example of the type of character, the type of values, the type of principled commitment to action that I believe is reflective and represented in my great State of South Dakota. For these young men's efforts in their particular fields, I am particularly grateful and proud; and I know that South Dakota is very, very proud as well.

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PRESCRIPTION DRUG COVERAGE

The SPEAKER pro tempore (Mr. THORNBERRY). Under the Speaker's announced policy of January 6, 1999, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes.

Mr. GANSKE. Mr. Speaker, I am going to talk today about the high cost of prescription drugs and a little bit about what happened on this issue this year, both here in Congress and why this issue became an important issue in the presidential election, and talk about some proposed solutions to this problem as we look forward to the 107th Congress next year, because, Mr. Speaker, I am afraid we will end up this 106th Congress without addressing at least in a major way the high cost of prescription drugs. We have done something on this which I will talk about a little bit later.

Mr. Speaker, what is the problem? Why do we have such high prescription drug costs? How are those high prescription drug costs affecting people in the country?

Mr. Speaker, this is a photo of William Newton, who is 74 years old. He is from Altoona, Iowa. He is a constituent in my district whose savings vanished when his late wife, Juanita, whose picture he is holding, needed prescription drugs that cost as much as $600 a month. Mr. Newton said, ''She had to have them. There was no choice. It's a very serious situation and it isn't getting any better because drugs keep going up and up.''

Mr. Speaker, when James Weinman of Indianola, Iowa, just south of Des Moines where I live, and his wife, Maxine, make their annual trip to Texas, the two make a side trip, as well. They cross the border to Mexico and they load up on prescription drugs, which are not covered under their MediGap plan. Their prescription drugs cost less than half as much in Mexico as they do in Iowa.

This problem is not localized to Iowa, it is everywhere. The problem that Dot Lamb, an 86-year-old woman in Portland, Maine, who has hypertension, asthma, arthritis, and osteoporosis, has paying for her prescription drugs is all too common. She takes five prescription drugs 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 a letter from a computer-savvy senior citizen who volunteers at a hospital that I worked in 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!

He goes on:

> 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 cost of $1.05 per pill, plus handling and shipping.
>
> C: I can send $15 to a Texan,

which may interest the Speaker,

> 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.

Mr. Speaker, I want to make it 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 we will 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. Thirty-three of the 50 drugs rose in price at least 1½ times inflation. Half of the drugs increased at twice inflation. Sixteen drugs increased at least three times the inflation rate, and 20 percent of the 50 top selling drugs for senior citizens rose at least four times the rate of inflation in the last year.

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

That was not a 1-year phenomenon. 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 increased at three times inflation, and six drugs at over five times inflation. Lorazepam rose 27 times inflation and furosemide 14 times inflation in the last 6 years.

Prilosec is one of the two top-selling drugs prescribed for seniors. The annual cost for that 20 milligram GI drug, unless one has some type of drug discount, is $1,455. For a widow at 150 percent of poverty, the annual cost of Prilosec alone will consume more than $1 in $9 of that senior's total budget.

Let us look at a widow living on $16,700 a year. That is 200 percent of poverty. That is a lot more than a lot of widows have. If she has diabetes, hypertension, and high cholesterol, so she is taking a glucophage, Procardin, and Lipitor, her drug costs are going to be 13.7 percent of her income. If she is just taking that drug Prilosec for acid reflex disease, we can see that one drug alone even at this income represents about 8.7 percent of her total income.

My friend from Des Moines, the Iowa Lutheran hospital volunteer senior citizen, as do the Weinmans from Indiana from their shopping trips in Mexico for prescription drugs, know 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 verified that drug prices are higher here in the United States than overseas.

For example, that drug Prilosec for acid reflux is 2 to 2½ times as expensive in the United States. Prozac was 2 to 2½ times as expensive. Lipitor was 50 percent to 92 percent more expensive. Prevacid was as much as four times more expensive. Only one drug, Epogen, was cheaper in the United States than in the 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 United States and Canada, prices for 98 of the drugs were higher in the United States. Comparing 77 drugs sold in the United States and the United Kingdom, 86 percent of the drugs were higher in the United States, and three out of five were more than twice as high.

Look at this chart that shows some of the high drug prices in the United States, that is the first row, compared to the European price: Prozac, $36.12 in the United States; the European price, $18.50. Claritin, one of the most popular antihistamines: in the United States, $44; in Europe, $8.75. We can go right down this list. Here is one, Premarin. In the United States, it is $14.98; in Europe, $4.25.

Mr. Speaker, the drug companies claim that drug prices are so high here because of research and development costs. I do want to say that there is a great need for research. For example, around the world, we are seeing an explosion of antibiotic-resistent bacteria, like tuberculosis, and we are going to need research and development for new drugs.

A new report by the World Health Organization outlines that concern on infectious diseases. However, data from PhRMA, the pharmaceutical trade organization, that I saw presented in Chicago several months ago showed little

increase in research and development, especially in comparison with significant increases in advertising and marketing by the pharmaceutical companies.

Since 1997, the FDA reform bill, advertising by drug companies has gotten so frequent that Healthline recently reported that consumers watch, on the average, nine prescription drug commercials on TV every day.

Look at the 1998 figures for the big drug companies. In every case, marketing, advertising, sales, and administrative costs exceeded 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 did on research and development. Only one of the top ten drugs companies spent more on research and development than on marketing, advertising, and administration. Administration costs have not increased that much, so we know that the real increase in drug company spending 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 profit rates of 18 percent compared to approximately 5 percent for other Fortune 500 companies.

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

Mr. Speaker, as I said at the start of this special order speech, 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 they get prescription drug discounts from their HMOs. 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 a 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, like 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 of co-insurance on those 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 you buy in a pharmacy with a prescription from your doctor, as compared to those drugs that you would get if you are a patient in the hospital.

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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; but some areas like Iowa have had such low payment rates that no HMOs with drug coverage are available. That is typically a rural problem, but also a problem in some metropolitan areas that have inequitably low reimbursements.

I must say that I have led the fight to try to ''even up'' that. This is one of the things I think we ought to look at when we are talking about solutions.

Employers can offer their retirees health benefits that include prescription drugs, but fewer employers are doing that. From 1993 through 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 10 standard plans offer drug coverage.

All three plans have 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 those plans are significantly higher than the other seven MediGap plans because of the costs of that drug benefit.

This chart shows the difference in annual costs to a 65-year-old woman for a MediGap policy with or without a drug benefit. For a MediGap policy of moderate coverage, she would pay $1,320 for a plan without prescription drug coverage; but if she wants prescription drug coverage, she is going to pay $1,917. If she wants extensive coverage without drugs, her premium is $1,524 a year, with drugs her premium would be $3,252 to insurance.

Why is there such a price gap? Well, 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 have to be high to cover the costs of a higher average expenditure of drugs.

So what is the lesson that we learn from the current Medicare program? The lesson is adverse selection tends to drive up the per capita costs 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. These beneficiaries are called dual eligibles, and 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 called Q–M–Bs or QMBs have incomes below the poverty line, so it is less than $8,240 for a single person or $11,060 for a couple. And they have assets below $4,000 for a single person or $6,000 for a couple. Medicaid pays their deductibles and premiums. Specified low-income Medicare beneficiaries, S–L–I–M–Bs, or SLIMBs, have incomes up to 120 percent of poverty, and Medicaid pays their Medicare part B premium.

Qualifying individuals 1 have income between 120 percent and 135 percent of poverty. Medicaid pays part of their part B premium, but not deductibles. Qualifying individuals 2 have income between 135 percent and 175 percent of poverty, and Medicaid pays part of the part B premiums.

Now, the QMBs and the SLIMBs are not entitled to Medicaid's prescription drug benefit unless they are also eligible for full Medicaid coverage under their State Medicaid plan. Q1s and 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 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.

Mr. Speaker it is also important to look at the distribution of Medicare enrollees by total annual prescription drug costs, because it will make a difference in terms of what kind of plan we devise and how successful it is and how much we will need to subsidize such a plan.

This chart from the Medicare Payment Advisory Commission, MPAC, Report to Congress shows that in 1999, 14 percent of those in Medicare had no drug expenditures, 36 percent had less than $500, 19 percent had less than $1,000, 12 percent less than 1,500 and down the line.

Please note that if you add up those who have no drug expenditures at 14 percent and those who have drug expenditures of $500 to $1 at 36 percent, 50 percent then, 14 percent plus 36 percent, had drug expenditures of less than $500 per year. Then if you add in the next group, 69 percent had drug expenditures of less than $1,000 a year. The problem is with those who have much higher drug costs.

Now, as we look at plans to change Medicare to better cover the costs of prescription drugs, we are going to have to face some difficult choices. Mr. Speaker, there is currently no public consensus or, for that matter, policy consensus among the policymakers on how we do that. There are a lot of questions we have to answer.

Here are a few: First, should coverage be extended to the entire Medicare population or targeted towards the elderly widow who is not so important that she is in Medicaid, but is having to choose between her rent, her food, and her drugs? Should the benefit be comprehensive or catastrophic? Should the drug benefit be defined? What is the right level of beneficiary costs-sharing? Should the subsidies be given to the beneficiaries or to the insurers? How much money can the Federal Treasury devote to this problem? Can we really predict the future costs of this new benefit?

These are all really important questions, Mr. Speaker. Maybe we can learn something from what has happened in the past.

I want to talk a little bit about what happened in 1988 and then what happened earlier this year on prescription drug benefits. The prescription drug benefit has been discussed since the start of Medicare in 1965. The reason why adding a prescription drug benefit is now such a hot issue is that there has been an explosion in new drugs available, huge increases in demands for those drugs, largely fueled by all of the advertising dollars by the pharmaceutical companies and a significant increase in the costs of those drugs in the last few years.

I will tell you what, it is great that we have a lot of these new drugs. My parents are on some of those drugs. My dad is very well alive today because he is on some of those drugs. Well, let us look at what happened when Congress tried to do something about prescription drugs in 1988 and again this year.

That is because the outcome of reform in 1988 made a big difference with what happened here in Congress in the year 2000. 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, catastrophic prescription drug coverage would have been available in 1991 for all outpatient drugs subject to a $600 deductible and 50 percent 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 the Congressional Budget Office estimated the costs at that time as $5.7 billion. Well, only 6 months after the cost estimates, 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. That plan passed this House by a margin of 328–72.

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 hurling themselves on to the chairman of the Ways and Means Committee, Mr. Rostenkowski, were broadcast to the Nation; angry phone calls from senior citizens flooded the Capitol switch boards.

The very next year, the House voted 360–66 to repeal the Medical Catastrophic Coverage Act of 1988, and President Bush then signed the largest cut in Medicare benefits in history. Well, that experience left a lot of scars on the political process that became evident earlier this year when the Democrats and the Republicans made their proposals on prescription drugs.

What was the lesson? Well, Dan Rostenkowski wrote an article for the Wall Street Journal on January 20, early this year, that I think a lot of Members from Congress read. His most important point was this: the 1988 plan was financed by a premium increase for all Medicare beneficiaries. Rosti said in his piece: ''We adopted a principle universally accepted by the private insurance industry. People pay premiums today for benefits they may receive tomorrow.''

He goes on to say apparently the voters did not agree with those principles. By the way, the title of his Op-Ed piece was ''Seniors Will Not Swallow Medicare Drug Benefits.'' Former chairman of the Committee on Ways and Means Rostenkowski did not think seniors had changed much since 1988. And apparently the drafters of this year's Democratic and Republican bills agreed with him, because the key point that the spokesman for each of those bills made to Congress and to senior citizens was that their bill would be voluntary.

There were shortcomings in both plans this year, but before I briefly describe each plan, let me acknowledge the hard work that a lot of Members on both sides of the aisle made in working on those bills. The House Republican plan this year was estimated to cost seniors $35 to $40 a month by the year 2003, with possible projected rises in 15 percent a year. Premiums could vary among plans.

There would be no defined benefit plan and insurers could cover 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 were on their own until their out-of-pocket expenses hit $6,000 a year. At that time a catastrophic provision would kick in and the Government would pay the rest.

The GOP plan would have paid subsidies to insurance companies for people with high drug costs. If subscribers did not have a choice of at least two private plans, then a ''government plan'' would have been available.

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A new bureaucracy called the Medicare Benefits Administration would have overseen those private drug insurance plans.

Under the Republican plan, the Government would have paid for all the premiums and nearly all the beneficiary's share of covered drug costs for people with incomes under 135 percent. For people with incomes 135 to 150 percent of poverty level, premium support would have been phased out.

It was assumed that drug insurers would use generic drugs to control costs. The cost of the GOP plan was estimated to be $37.5 billion over 5 years and about $150 billion over 10 years. But the CBO, the Congressional Budget Office, had a very hard time predicting costs because there was no standard benefit in the plan.

Now, the premiums under the Clinton-Gore plan were estimated to cost those seniors who signed up, remember it was a voluntary plan like the GOP plan, $24 a month in 2003, rising to $51 a month in 2010. But then the Clinton administration talked about adding $35 billion in expenses for a catastrophic component like the GOP plan, which would have made the premiums higher and similar, in my opinion, to what the Republicans were proposing.

Under the Clinton plan, Medicare would have paid half of the cost of each prescription, and there would have been no deductible. The maximum Federal payment would have been $1,000 for $2,000 worth of drugs in 2003, rising to $2,500 for $5,000 worth of drugs by 2009.

The Government would have assumed the financial risk for prescription drug insurance, but it would have hired private companies to administer the benefits and negotiate discounts from drug manufacturers. That was pretty similar in both the Clinton-Gore and the Republican plans.

But, and here is the crucial point, in order to cushion the costs of the sicker with premiums from the healthier, both the Clinton-Gore plan and the GOP plan calculated premiums, and this is the most important point, they calculated those premiums based on the premise that 80 percent of all of the people in Medicare would sign up for the plan. In other words, one has got to have a lot of people who are healthy in the plan paying their premiums to keep the premiums lower for those who have higher drug costs.

Well, right away the partisan attacks started on both plans. The Democrats said Republicans are putting seniors into HMOs. HMOs provide terrible care. This is not fair to seniors. The Republicans said the Democratic plan is a one-size-fits-all plan, it is too restrictive, it puts politicians and Washington bureaucrats in control. Now, tell me, anyone who has watched TV and saw all the political ads in this last campaign knows that is exactly what each side was saying about the other.

I could criticize each plan in depth, but I do not have that much time. Suffice it to say that the details of each of those plans was very important to how they would work.

I believe that if one lets plans design all sorts of benefit packages, as did 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 the plans can tailor benefits to cherry-pick healthier, less expensive seniors, and to gain the system. Representatives of the insurance industry shared that opinion in a hearing before my committee. In my opinion, a defined benefit package would have been better.

I had concerns about the financial incentives that the House Republican bill would offer insurers to enter markets in which no drug plans were available. Would those incentives encourage insurers to hold out for a better deal?

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

In testimony before the Committee on Commerce on June 13, this year, Mr. Kahn said, ''Private drug-only coverage would have to clear insurmountable financial, regulatory, and administrative hurdles simply to get to the market. Assuming that it did, the pressures of ever-increasing drug costs, the predictability of drug expenses, and the likelihood that people most likely to purchase this coverage would be the people anticipating the highest drug claims,'' that adverse selection problem, ''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 that type of product.

I could similarly criticize several particulars of the Clinton-Gore bill in the spirit of bipartisanship; but I think we should look at the fundamental flaw of both plans, and that is that ''adverse risk selection'' problem.

If the Clinton plan had comparable costs for a stop-loss provision on catastrophic expenses, the premiums would have been comparable to the GOP plan. Under those bills, a plan who signed up for drug insurance would have paid about $40 per month or roughly $500 per year.

After the first $250 out-of-pocket drug cost, the enrollee would have needed to have twice $500 in drug costs, or $1,000, in order to be getting a benefit that was worth more than the cost of the premiums for the year. Put another way, the enrollee must have had $250 for that deductible plus $1,000 in drug expenses 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.

Now, look at this chart again. Look at this: 69 percent of the people in Medicare in 1999 had less than a thousand dollars. If the cost of the plan, signing up for the plan was going to be more than $1,000, would they sign up for something that was going to cost them more than what they were already paying? I do not think so. In fact, I know they would not.

How do I know they would not? Because we already have those options in the current Medicare plan. We have those three options that I talked about earlier where one can voluntarily sign up for a drug benefit. But most people do not because the premiums are higher than what their drug costs are. They would have to be fools to be paying more for an insurance premium than what the premium is going to give them if it is voluntary. This is just the mindset that people have.

I think Regis could have asked, Who would have signed up for those plans? The final answer would have been those seniors with over $1,250 in annual drug expenses. Well, remember also that the premiums were premised on that 80 percent participation rate. I think it is highly doubtful that anywhere near 80 percent of seniors would have signed up for either of those plans. If only those with high drug costs signed up for the plans, then we know what would have happened. The premiums would have had to go up significantly, or we would have had to transfer significantly more sums from the Federal Treasury to subsidize that benefit.

Well, one way to avoid that adverse risk selection in a voluntary system would be to offer the drug benefit one time only, when a beneficiary enrolls in Medicare. The problem with that is that one is still going to get adverse risk selection because, at the age of 55, there are a number of people who do have high drug costs, and of course they are going to sign up; whereas, a lot of people have no drug costs, and they may simply decide I do not want to sign up right now, I will wait until later.

The authors of the GOP bill recognized that problem. So what they tried to do was say, well, if you do not sign up initially, then later on when you sign up, you may have to pay a higher premium.

But I tell my colleagues this, if seniors were going to do that, they would do that right now. All the seniors would voluntarily sign up for one of those three options. It would bring down the cost of premiums. But they do not do that.

Another way to control adverse risk is to try to devise a risk adjustment system. We tried to do that in some other areas in Medicare. I will tell my colleagues what. It is really tougher to do risk adjustment. A uniform benefit package would help control adverse risk selection. Consumers would be able to select plans based on price and quality rather than benefits. If plans are allowed a slight variation of benefits, some plans may be likely to attract low-cost beneficiaries.

The GOP plan had some weak community rating and guaranteed issue provisions, but it is hard to see how the adverse risk selection would have been solved by their solutions.

Now, one sure way to avoid adverse risk selection would be to say we have a uniform benefit, prescription drug benefit, and everyone, when they sign up for Medicare, is going to be in that prescription drug plan.

That was the approach of the Medicare Catastrophic Coverage Act in 1988. We saw what happened to that law. That lesson was not lost on people in this Chamber this year. To say that mandatory enrollment had little appeal to policy makers in this election year was an understatement.

Finally, we could avoid adverse selection for a voluntary benefit like prescription drug coverage if we simply subsidized the benefit to such an extent that is such a good deal that everyone will do that. But we are really talking about large sums of Federal dollars when we do that. We cannot even predict what the costs are going to be. There are new drugs coming on board that could cost thousands of dollars per treatment where treatments have to be repeated and repeated and repeated. We could easily be talking about a trillion dollar drug benefit.

That cost reminds me again of that article by Mr. Rostenkowski. As Congressman Rostenkowski said, ''The problem was and still is a lack of money. Yes, we have a projected surplus, but the 10-year cost of more highly subsidized drug coverage would, in my opinion, easily double or even triple the projected cost of both proposals.''

Now, there are several reasons why even in this time of a surplus I think we need to think hard about this. First, we have made a bipartisan commitment not to use Social Security surplus funds. Second, there are people in this country who have no health insurance, 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. Should not our first priority be to protect the current Medicare program?

Given those constraints, what can we do to help seniors and others with high drug costs? Here are some modest proposals for helping seniors and others with their drug costs. First, let us allow those senior citizens, those qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, qualifying individuals who are not so poor that they are in Medicaid in addition to Medicare, but are just above that, many of whom are having to make difficult decisions because they are living solely on their Social Security and they have very high prescription drug costs, why do not we allow these individuals, say, up to 175 percent of poverty, to get into or access the State Medicaid prescription drug plans? We could pay for it from the Federal side. We would not have to require any match from the States.

The plans are already in existence. The bureaucracy is already there. The

States have already negotiated discounts with the pharmaceutical companies. We know who these individuals are because they are already getting discounts on their premiums and copayments and deductibility.

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We could simply give them a card that would enable them to access the State formulary for their State Medicaid drug programs free for those individuals, at no cost for them. We could pay for it through the Federal side. Estimates are that that would probably cost about $60 to $80 billion over 10 years. It might be more than that, but that is a lot less than what we are talking about with the other plans. We can afford that. It would be an important first step.

We ought to also fix the funding formula in which some States, particularly rural States, have such low reimbursement rates that Medicare HMOs are never there. We ought to raise that floor, reduce the gap between some States and other States, so that we have an equitable benefit through the Medicare plan. And that would require a floor of at least $600. We already have Medicare HMOs that are leaving areas where they are getting paid $550 per month per beneficiary. Raising it to $480 or $450 is never going to induce those Medicare+Choice plans to go into the rural areas.

And in response to my constituents who want to purchase their drugs from Canada or Mexico or Europe, we started to address that problem in Congress this year, and it has been signed into law, and that is on the reimportation of drugs that are made in this country, packaged here, shipped overseas, whether or not they can legally come back into the country. However, we need to go back to that issue, because there were some loopholes in that legislation that passed the House and the Senate that we need to fix. We need to strengthen that law. That would help a lot. That would increase the competition. In my opinion it would automatically result in lower drug prices, not just for senior citizens but for everyone.

I think we should enact full tax deductibility for the self-insured. I think that we should look at those 11 million children that do not have any health insurance and, consequently, do not have any prescription drug coverage. Roughly 7 million of those kids already qualify for Medicaid in the State Child Health Insurance Programs. Those children should be enrolled. We should do things to help those States get those kids enrolled.

Many pharmaceutical companies do have programs to help low-income people afford prescription drugs. Both physicians and patients need to be better educated to take advantage of those discounted drugs. Currently, 16 States have pharmaceutical assistance programs targeted to Medicare beneficiaries different from the Medicaid solution.

My colleagues, the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Minnesota (Mr. PETERSON), have a bill, the Medicare Beneficiary Prescription Drug Assistance and Stop Loss Protection Act, which would allow beneficiaries up to 200 percent to get into programs like that. But that would require, in many States, the creation of whole new bureaucracies. I think there is a simpler solution. The solution is to utilize the State Medicaid drug programs.

I think that we should revise the FDA Reform Act of 1997, and we should restrict direct marketing to consumers in a way that does not limit their free speech but at least requires that they provide equal time to discussing the possible complications of those new drugs as they do to the benefits.

Finally, I think the new Congress could actually get signed into law a combination of the above in a bipartisan fashion. Yes, it is more limited than what the Clinton-Gore administration has proposed; it is more limited than what passed this House, but it has many advantages in that it is a step-by-step progression and it is something that I think is common sense and responsible until we are able to look at a more comprehensive prescription drug benefit in the context of making sure that Medicare stays solvent when the baby boomers retire.

This is a complicated subject. At the beginning of the speech, I said there was not yet a consensus on how we go on this. But I know this: On something this important, the only things that get done in Washington are done in a bipartisan way. There will be some on both sides that say it does not go far enough; there will be some that say my proposal goes too far, that we do not want to expand Medicare beneficiaries into State Medicaid drug plans. But I think I am hitting a down-the-middle approach to this, and I am going to be reintroducing my bill in the beginning of this next Congress. I sure hope that a lot of Members will take some time, listen to this special order speech, look at the bill and the information that we will be providing to them, and think about this as a solution that we can do for now.

Finally, I want to say this: For a long time, in its wisdom, Congress has gone through what is known as ''regular order'' with legislation. That means a bill, and all of its details, is dropped in that bin over there. It is made public. We have hearings on those bills. We compare language to other bills. We look at the implications of the legislative language. We have subcommittee markups with amendments and debate. And then we have a full committee markup with amendments and debate. Then we have it go to the Committee on Rules to be brought to the floor. The Senate does the same thing. It is an orderly process. That was not done this year. That was not done. And I think the legislation was not as strong as it should have been because we did not go in regular order.

So I very much hope that when we look at this issue again this coming year, 2001, that instead of just rushing something to the floor, that we have full debate and discussion; that people know what the provisions mean when the bill reaches the floor; that it does not become just a ''Republican bill'' or a ''Democratic bill,'' but in our wisdom we debate the various provisions in a free way, debating amendments to improve the bill, voting them up or down, and doing things in a regular order.

Mr. Speaker, we did not get it done this year, at least I certainly do not think we are in these last few days of the 106th session, but I think we have a good chance to do something on this next year. So I urge my colleagues to look over my proposal, and we will be getting information to my colleagues.

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TURKISH GOVERNMENT MUST RECOGNIZE BASIC HUMAN RIGHTS OF KURDISH PEOPLE

The SPEAKER pro tempore (Mr. HULSHOF). Under a previous order of the House, the gentleman from New Jersey (Mr. PALLONE) is recognized for 5 minutes.

Mr. PALLONE. Mr. Speaker, today I want to speak about the need for the Turkish government to recognize the basic human rights of the Kurdish people, and I rise this afternoon to condemn recent, though ongoing, violations of these rights in Turkey.

I have always said the Kurds must be respected as a people, the world must finally listen to and respect their aspirations, and that they should enjoy the same right of choosing their representatives as other people do all over the world. The Turkish government has not accepted the validity of the Kurdish struggle or even of the Kurdish people. They have jailed leaders, but the message of these leaders continues to ring loud and clear.

Mr. Speaker, in the past few weeks, the Turkish government has extended a 13-year-old state of emergency in four mainly Kurdish provinces for an additional 4 months, and who knows what will happen at the end of those 4 months in terms of another extension. Further, the extension of emergency rule occurred despite the European commission's formal expression that the lifting of emergency rule is an objective for Turkey to achieve.

On December 4, The Washington Post reported that the director of a Kurdish linguistics institute in Istanbul is facing a trial on charges that the institute is an illegal business. The charges come despite the fact that Turkish security courts have hired interpreters from this very institute for the past 8 years. This incident illustrates the type of human rights violations infringements that continue to occur but that must be halted immediately against the Kurdish people.

I call upon my colleagues to join me, Mr. Speaker, in urging the Turkish