I hope that in these times of economic growth for the Nation as a whole, my colleagues and the President will recognize that not everyone is experiencing the same prosperity. I hope that we can all work together on efforts to help these hard-working Americans in their time of need.

OPPOSE UNILATERAL CLOSURE OF PUBLIC LANDS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. RADANOVICH) is recognized for 5 minutes.

Mr. RADANOVICH. Mr. Speaker, yesterday President Bill Clinton announced plans to create a monument in the Sequoia National Forest. Not in Sequoia National Park, mind you, but Sequoia National Forest. It will be 400,000 acres, almost 625 square miles.

The 19th District of California is my home. It encompasses four counties, Mariposa, Madera, Fresno, and Tulare. The people of my district share their home with three national forests and two national parks. That makes my district over 85 percent federally owned, one of the highest ratios in the country.

Make no mistake, we are proud of our public lands. Yosemite and Sequoia National Parks are crown jewels. The old growth trees that are there inspire majestic awe. The people of my home love and respect the environment.

But, Mr. Speaker, this designation is not about protecting the environment and it is not about protecting giant sequoias. Nobody is logging these trees. The sequoia groves have been off limits for years. This designation is all about politics. It is a campaign looking for a press release.

It seems our President will say just about anything to prolong his rule. Today he will close down the Sequoia National Forest for some good press, and tomorrow it will be someplace else. What is next? When a government can close off public lands, on a whim, without asking for public comment, they are not really public lands any more.

Mr. Speaker, how can we allow a President to close access to public lands the size of Rhode Island without asking permission from the people who own them?

Today I am introducing a resolution. It requests that the President tell us what he plans to do with the rest of our public lands before election day. He has, so far, steadfastly refused to answer this question. It requests that the President include real public participation as he moves forward with the Sequoia Monument. He needs to talk to people who live there, not just people in Washington.

We should oppose this kind of unilateral closure of public lands, if not for the people in my district or in your district, but then for the sake of our democracy. It seems we need an administration that remembers that we do live in a democracy.

PRESCRIPTION DRUG BENEFITS AND THE MEDICARE PROGRAM

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

Mr. GREENWOOD. Mr. Speaker, this evening the gentleman from North Carolina (Mr. BURR) and I are going to talk about prescription drug benefits and the Medicare program.

In 1965, when Medicare was created of course it was created without a prescription drug benefit. It seems unimaginable now in the year 2000 that the Congress would create a program to provide for the health care of the elderly without providing a prescription drug benefit, but those were different times. In 1965, a far smaller percentage of Americans in general and American seniors used prescription drug benefits on a regular basis, and so Congress did not include prescription drug benefits in the creation of Medicare.

But today, as we stand at the millennium in the year 2000, the world is a very different place, and today's seniors, as we all do, benefit from health care innovations that were inconceivable just 35 years ago, and particularly in the area of pharmaceutical products and biological products.

Today if you do not have access to the latest miracle drugs produced by the pharmaceutical industry and you do not have access to the latest biological products that are being produced, that are creating cures for diseases that could not have been imagined 35 years ago, if you do not have access to these products, you really do not have good health care in America. Yet 35 percent, over one-third of all of the seniors in the United States, as well as the disabled, who also receive their health care through the Medicare program, do not have access to these products.

This chart to my left here, the pie chart on the right, describes which Americans do and which Americans do not have access to prescription drugs through the Medicare program and other similar programs.

About 31 percent of American seniors receive a prescription drug benefit from their former employer. They worked long enough to receive a lifetime of benefits and their employer was in a position and perhaps the union negotiated for a benefit that would be a good prescription drug benefit that would last for the rest of the life of the retiree.

About 11 percent of today's elderly population purchase a prescription drug benefit when they purchase a Medigap policy, the Medigap policies that cover those costs of health care not covered by the regular Medicare program.

Then there are about 10 percent of America's senior citizens who are of such low income that they are eligible for the Medicaid program, health care for the poor, and they have through that program a pretty good prescription drug benefit.

Then there are about 8 percent of the elderly who choose to receive their Medicare in what is called Medicare Choice Plus plans, and that is that they have a managed care package, and that managed care package provides them with the benefit.

But the yellow piece of the pie there, the largest piece of the pie, represents the 31 percent, the chart says, and the estimates are between there and 35 percent, of America's seniors who do not in fact have any Medicare prescription at all.

Let me change charts for a moment.

This is a chart that demonstrates of those that do not have, the 35 percent of Americans's elderly who are without prescription drug benefit, who they are in terms of income levels. As this chart readily indicates, the likelihood that one is covered with a prescription drug benefit is in direct proportion to one's income at retirement. So those American retirees who have incomes in excess of $50,000 per year, 95 percent of them are able to in one way or another meet their prescription drug needs.

That figure climbs for those between $25,000 and $50,000 to 16 percent. Between $15,000 of income and $25,000 of annual income those uncovered by a prescription drug benefit is 22 percent. Between $10,000 and $15,000 the number is 20 percent. For those Americans below $10,000 and yet with enough income so they do not qualify for the Medicaid program or a State-operated Medical Assistance Program, 37 percent of those elderly do not have a prescription drug benefit.

As this chart indicates, this problem is going to be exacerbated by time. In 1999, 13 percent of the American population was older than 65, and of those over the age of 65, 33 percent were taking some form of medication on a regular basis.

Thirty years from now, when the baby-boom is fully retired, about 20 percent of Americans will be of retirement age, over 65 years, and more than half, 51 percent of them are expected to require daily medications. So clearly this problem will get worse in time unless the Congress acts to solve this problem.

As this chart indicates, the problem is being exacerbated because of the increasing costs of prescription drugs, the total prescription drug costs for any given elderly person.

In 1993, this is the price increase per year, these are year-over-year percentage changes, so in 1993 the price of pharmaceuticals increased by 8.2 percent, while the consumer price index was only 2.7 percent. As the chart shows, the annual increase in the total cost of all pharmaceuticals, this is not the per item cost, but the total cost of all pharmaceuticals, has risen to the extent that just the one year change between 1998 and 1999 was a whopping 18.5 percent, while the CPI was still down at 2.7 percent.

I wanted to bring up one other graph.

This is a very important graph, because it begins to break down the components that cause this dramatic increase in the total cost of all pharmaceuticals.

□ 1530

The purple parts of each bar are the percentage increase in each of the years between 1990 and 1998 that were related to the actual percentage increase in the cost of the pharmaceutical products on the market. So in 1990, products in general went up 8.4 percent. That has been on the decline; it is at a slight increase in the last few years. But as we can see, the percentage of increase in products on the market is a relatively small percentage of the total cost increases.

The green part of the bar shows the volume from the mix of new products. What that means is that this part of the increase was driven by the fact that seniors were getting more prescriptions, taking more medications, and new products were coming on to the market, adding to the costs. So when we look to methodologies to bring down the cost of prescription drugs, we need to understand that it is not just a freeze, for instance, on all prescription drug prices, which will not solve the problem, because as long as new products come on to the market, seniors will have access to them, and that will drive up the total cost of pharmaceuticals.

Mr. Speaker, we Republicans are committed to solving this problem. My colleagues on the Committee on Commerce have been working hard at this for some time, as have our friends on the Committee on Ways and Means; and we have been meeting together. We will have a prescription drug benefit plan in legislative form probably next month, in March, and we will bring that to our committees for consideration, and to the floor.

I am convinced that the capacity is here in the House for Republicans and Democrats to work together for the Congress, and for the House and the Senate to work together, and for the Congress, the Republican Congress and President Clinton to work together so that by the end of this year 2000 we will have been able to provide a legislative solution to this that is sound, this is reasonable, that makes sense, and that solves the problem of many seniors today where they have to choose between whether to buy groceries or whether to buy a prescription drug, or whether to take their prescription from their doctor and then never have the opportunity to fill it at all.

At this time, I yield to my colleague from North Carolina (Mr. BURR), who knows as much about this issue as any of my colleagues.

Mr. BURR of North Carolina. Mr. Speaker, I thank the gentleman from Pennsylvania for making part of his time available for me to join him in this Special Order on the drug benefits that should exist under Medicare.

I sometimes wonder if in 1960 when Medicare was created, whether they knew we would be here at some point in the future. The fact was that drug benefits were not part of the insurance package for the private sector or for any entity, and if they would have been, I am sure that those individuals who were in this institution would have included a drug package in Medicare as we know it today. But the fact is, they did not. In the last 30 to 40 years, we have seen significant change since Medicare happened.

There has not only been change in the delivery system, it has been changed in the treatment methods that physicians use; there have been changes in the devices that hospitals are able to use for treatment; and there has certainly been change in the pharmaceutical world, which I call the high-tech end of medicine. As we discover new things that treat specific illnesses, that up until yesterday we might have thought were uncurable or uncontrollable, that is the era that we are in.

The debate in Washington is not over whether we extend a drug benefit to individuals who make choices between food and drug. It is a philosophical debate in Washington over who we are going to offer a drug benefit to. The gentleman and I and others believe that it has to be universal; that we have to make sure that 10 years from now, people in this institution are not here on this House floor fixing something that had design flaws, fixing something that was not inclusive of 100 percent of the population.

There is a difference between where the subsidy is, the Federal Government subsidy, and making available the option for seniors to buy in. It could be that our plan, employers might buy their retirees into this drug plan. It means that seniors' high income would pay for their premiums and those below a certain level of income on an annual basis might have that Federal safety net to pay their premium and their deductible. But there are certainly plans all around this town, as we have seen.

The gentleman and I both shared an experience which was the modernization of the Food and Drug Administration, a 2½-year process that I remember well. When we started, people looked at us and said, it can never be done; it is too big. Granted, things happen slow in Washington that are big, but 2½ years later, I think even the agency would say that their ability to bring new pharmaceutical products, their ability to bring new devices to the marketplace to treat real people is better today than it has ever been in the history of that agency, while maintaining the gold standard of the FDA, and that is the safety and the effectiveness of their treatments.

I remember through that process that the gentleman and I met hours and hours with individuals young and old who came in with chronic and terminal illnesses who did not have a tremendous amount of choices. One of the results of the Food and Drug Administration modernization was that we have had new applications, a greater number for pharmaceuticals than we have ever seen, because companies invested millions and billions of dollars in research and development. The human genome project is beginning to identify disease that exists in our senior population, and we are just right around the corner from those same pharmaceuticals finding a chemical that can stop that chronic illness that they have had for year after year after year.

We have to make sure that drug benefits are affordable and accessible for the entire population, and we can only do that if we accept the challenge of presenting a universal plan, not a targeted plan like some have suggested. Clearly, it has to be universal and it has to include the entire senior population. As a matter of fact, the General Accounting Office testified in front of us today, the Senate last week; and they said to Congress, do not do anything that does not change Medicare in its entirety. Reform the whole process when you do the drug benefit. That is probably a goal that we cannot do this year. The question is, how long can seniors wait.

However, we can get that portion of it that deals with drug benefits right: universal in scope, affordable in price, and accessible from the standpoint of coverage.

Mr. GREENWOOD. Mr. Speaker, the gentleman made reference to the miracles of some of these more modern pharmaceutical products; and he also, in his remarks, has been talking about the cost and how do we devise a plan that, given the finite resources, will provide this wonderful benefit to all of our seniors. We have to remember that it is not a zero sum game, that when we add a pharmaceutical benefit, it does not simply and only add to the costs of Medicare. Because in many ways, using a pharmaceutical product, using a medicine, is the least expensive way to treat an illness as compared to surgery.

I have a chart here on my left that demonstrates an instance of that. This is the cost of treating stroke patients. If we use a treatment that consists of a pharmaceutical approach, which uses a clot-busting drug, it costs about $1,700 to treat that patient on an annual basis. Yet, by doing that, we are keeping that patient from having to go through the pain and the expense of rehab and often nursing care.

So the difference here is that we save $6,100 that otherwise Medicare would have been paying for.

Mr. BURR of North Carolina. Mr. Speaker, another important thing: we save money, and there is no figure in there on the quality of life improvement that we have made for the individuals. No hospital stay, no transportation for relatives, the type of thing

that for seniors today is a problem; just the dislocation from their home is a problem.

We have been joined by the gentleman from Michigan (Mr. UPTON), who also participated in quite a few things with us, and one of them was the expansion of Medicare in 1995, if I remember, when we made the sell that there were certain things under Medicare that we ought to cover, such as the PSA exam for senior males that checked for a certain cancer; mammograms for senior females so that we could detect at an earlier stage; not too dissimilar to the argument that the gentleman just made and that is if we find a way to detect things sooner, the faster we do it, the faster we treat, the less hospital stay that we have, the less cost that we have, a better quality of life that we have. Everything that we would chart as a goal in a health care plan we were able to achieve, and it should be incorporated into this drug benefit.

Mr. GREENWOOD. Mr. Speaker, the gentleman from Michigan (Mr. UPTON) has joined us, and with my colleague Mr. Burr and myself, along with the gentleman from Virginia (Mr. BLILEY) and the gentleman from Florida (Mr. BILIRAKIS), and others, we have been working for all of this year and beyond that, earlier than that, to devise a prescription drug plan that makes sense.

I would like to now yield to the gentleman from Michigan (Mr. UPTON).

Mr. UPTON. Mr. Speaker, I thank the gentleman from Pennsylvania for taking this Special Order. I certainly welcome the opportunity to work with my colleagues on developing a plan that makes sense.

As we go back home, particularly this next week and a half with Congress out of session, as we look at our mail that comes in virtually every day, there is a real human cry for us to do something about pharmaceutical drugs and to try and work together to allow this to happen for today's seniors.

I am sorry that I was a little bit late when this Special Order started. We all have a number of hearings that have been going on, so I missed the beginning. I saw some of the charts just briefly before I left my office to come over. But we are part of a group that is working on a comprehensive plan that tries to do a number of things. Obviously, we have been the leader in terms of the pharmaceutical industry looking for drugs that are going to save lives and in effect save big time in costs. We heard today, the three of us, in our committee a woman from Pennsylvania with osteoporosis, or from Florida, or maybe California. Anyway, she was a wonderful lady.

Mr. BURR of North Carolina. Mr. Speaker, she could have been from anywhere.

Mr. UPTON. Yes, she could have been from anywhere. But these drugs, particularly for osteoporosis, have saved her life. We are looking at some of these advances that are just around the corner with diseases before that have been so crippling, and again, we are almost there in lots of cases. That medical research money is so necessary, not only that we provide to the National Institutes of Health, but also the research and development money that pharmaceutical companies use as well, to try and develop drugs in major ways.

Mr. BURR of North Carolina. Mr. Speaker, in her particular case, it was not limited to osteoporosis, which is the case with a lot of seniors today who have multiple health problems or multiple health conditions. She herself said that she took 11 prescriptions a day.

Now, one of the reasons that she came to see us is she is one of the fortunate seniors that is insured. She has an add-on policy that provides some costs for drugs; and she said, whatever you do, let everybody else have the opportunity who is a senior to buy, but do not limit me; let me stay with the plan I am comfortable with. That is a challenge to us, to make sure that whatever we design is equally as good, if not better, than what she has.

Mr. GREENWOOD. Mr. Speaker, clearly what we want to do is we want to provide choice. One of the first charts I held up demonstrated that a significant portion of America's elderly, two out of three already have prescription drug coverage and about half of those, or about a third of the senior population, receives those benefits from their employer.

Now, what we do not want to do is do anything that is going to cause either those retirees who have a nice prescription drug benefit to suddenly have to pay for something they already have, nor do we want to do anything that would create a disincentive for the employers to provide that. So we have to be careful that we fix what is broken and we do not fix what is not broken in the world of prescription drug benefits.

Mr. BURR of North Carolina. Mr. Speaker, the challenge for us, as everybody will agree, is that there are 30-plus million Americans who fall under this umbrella of Medicare, and it grows every day. We certainly know what the demographic shift is in America. We have heard the numbers as they relate to Social Security. We talk about it enough related to Medicare, but the fact is the senior that goes on Social Security is also the senior that will go on Medicare. The population will double in the next 15 to 20 years in America, and I think there is a responsibility that we have to make sure that the system is sound enough that it will go on.

Mr. Speaker, I think it is important to talk about some of the numbers that we hear on a daily basis as we discuss drugs. Individuals might see on the nightly news when they talk about the individual who is making a choice between food and drugs or drugs and something else in their monthly budget.

□ 1545

The President's new proposal has a full subsidy at 135 percent of poverty. That income level on an annual basis is $11,727 a year; excuse me, the 150 percent is $11,727.

What happens to that person that is at 135 to 150? Clearly they have the same choices that they have to make, maybe not as great as the person at 100 percent. But I think one of the things we have to do is we have to identify where is that safety net needed the most, whether there is a transitional safety net for people in the middle, because today we can look at 200 percent of poverty for seniors and realize that there is no State, Federal, or community safety net that fills their need, and how expansive we can be is only limited to how creative we can be at producing a new model.

Mr. UPTON. Mr. Speaker, I would just note, if the gentleman will yield, that a number of States, Michigan being one, have just embarked on a program that in fact will help how many HMO seniors, those as high as 150 percent of poverty. But again, it is not a very high dollar figure, as the gentleman suggested.

But what do we do with those States that already have something in place? We have to be very careful not to undo what they have done, and yet try to encourage other States to follow the same lead that States like Michigan have already taken.

Mr. BURR of North Carolina. The gentleman is exactly right. The challenge for us as well is to make sure that the plan that we produce has a value. I think sometimes we leave value out of it because we are talking about this captured audience, and I guess that is how people can look at the current health care system and say, it is the best in the world.

When we talk to seniors, they will point out every problem that exists in Medicare today from the standpoint of the limited scope of coverage to the cost and the out-of-pocket cost, $760 when one really gets sick and has to go in the hospital.

That is an area we should look at, but we are doing drugs now. We have to make sure that it fits in that modernized Medicare system of the future. If not, our work would only be changed by somebody else's mistake later on.

Mr. GREENWOOD. Mr. Speaker, I yield to the gentlewoman from New Mexico (Mrs. WILSON). She is a member of the Committee on Commerce, as we all are here doing this special order, and she will be playing a critical role in determining what kind of prescription drug benefit we can provide to our elderly and to our disabled.

Mrs. WILSON. Mr. Speaker, I thank the gentleman for yielding to me.

I appreciate the gentleman from Pennsylvania (Mr. GREENWOOD) having this discussion today, Mr. Speaker, because I think Congress is just really beginning the hard work of developing the legislation to address this problem.

All of us agree that we have a problem that we have to deal with. It is a problem brought about by marvelous advances in medical care that did not exist at the time that Medicare was established. We look at what the pharmaceutical industry has brought to the quality of life in America. We have a much longer lifespan and a much higher quality of life because there are miracle drugs that are available today that were not available 10 or 15 years ago, but the cost is often very high.

I heard about this a lot when I was at home over our recent break. There was a little lady who came in to see me at one of our town hall meetings. Her name is Jean Welch. She did not say anything during the meeting itself, but she came up to me afterward. She has trouble walking now.

She gave me a little envelope, and just whispered into my ear, don't look at this now, but when you go home, I want you to know that this is half of what I spend on prescription drugs every month. I just want to you to know.

So I went home and I pulled out of this little envelope a receipt from Wal-Mart for over $360. If someone is on social security and they have that high a price for paying for their prescription drugs, it is a real burden, and it is something that we have to address.

I think maybe I would like to just take a minute here, if I might, to talk about how we are grappling with this issue and what the choices are that face us as a Nation and as a Congress, and how we are beginning to sort through those choices.

There are issues really in three areas. One is the scope of coverage. We know that about half of American seniors now have some kind of prescription drug coverage. They have some kind of insurance, but we also know that about one-third of our seniors have no coverage at all. The rest have had some kind of coverage, but it is very, very limited.

So how do we craft a program that allows continuing choice for those who have insurance that they want now, and does not overly burden the Federal government and take away choices from seniors who have exercised their right to choose? So the scope of coverage is one of the issues that we have to deal with.

How do we administer this program? There are a number of options that have been proposed in a lot of different pieces of legislation here, but I think they kind of fall into three groups.

We could have a government-managed benefit, as we do with a lot of other Federal Government programs, with regional entities to purchase and administer our drug program.

We could have private insurers that take care of this, and we would give seniors some kind of a voucher or a credit in order to buy prescription drug insurance. That would not have some of the burdens that go along with being a government-run program.

Or, a third proposal that has been floated is to allow the States to manage this and administer the program. So there is not one prescription drug proposal, there are a lot of different ways that we could do this, and those are ways that we are grappling with here in the Congress starting this week.

There is also the problem of who we cover. All of us know that we need to cover low-income Americans and low-income seniors. But there is also the problem of those that may not be low-income, but they have huge, high drug costs.

That was one of my concerns with the initial proposal that came out that said, yes, we are going to give everyone coverage, it is going to cost us somewhere between $300 and $600 a year to buy it, and by the way, there is no coverage beyond the first $2,500 worth of costs.

Well, my husband handles the insurance in my house, but even I can figure out that I do not need the insurance for the things I can afford, I need it for the things I cannot afford. So if we have caps at $2,500, that does not help Jean Welch after May or June. We need to think about those who have high costs, as well as those who have low income.

There are a lot of models for reform that the Congress is beginning to grapple with and grapple with seriously. I am very pleased that the Speaker has asked the chairman of the Committee on Ways and Means and the chairman of the Committee on Commerce, who have all of the expertise on these programs, to get together, to have the public hearings, to begin to craft a proposal that solves a very real problem that real Americans face every day.

Mr. GREENWOOD. Mr. Speaker, the gentlewoman from New Mexico has well illustrated that there are a variety of plans that are on the table taking different approaches. This is a hard job. This will not be easily done. We are talking about being able to find billions of dollars, many billions of dollars, scores of billions of dollars on an annual basis for the foreseeable future to be able to do this.

We have finite resources. We have many, many competing demands on our budget. We have to do it in a way that makes sense to all of the stakeholders.

There is an old saying, which is that it is amazing how much you can accomplish if you do not care who gets the credit. A lot of the political observers who watch what happens here in the Nation's Capitol will say, do not bet on there being a prescription drug benefit. It is an important election year, it is a presidential election year. The Democrats want to take the Congress back and the Republicans want to keep the Congress, and both parties are vying for the presidency, and it will be too easy for the Republicans and Democrats to get into a fight over who gets credit and who gets blame for getting something done or not getting it done.

Republicans can fight Democrats, Congress can fight the President, but this is too important for that. As the gentlewoman from New Mexico said, her constituent has a real life problem. This is about, literally, life and death. Our ability to solve this problem in a timely fashion really has everything to do with whether some of our elderly loved ones live or die, whether they live in pain and suffering, or whether they can enjoy their golden years and their grandchildren because they have access to the miracles of these industries.

There are also temptations that are nonpartisan. There is a temptation to pick on the various industries that are involved. There is a temptation to say, let us all pound on the pharmaceutical industry. They are a good target. We can beat them up.

The fact of the matter is we do not want the pharmaceutical industry to be price-gouging or making excessive profits, but we do want them to be able to continue to provide these miracles, and there is no country that compares with the United States when it comes to our ability with our pharmaceutical industry to make these products.

They do not do this in Canada, they do not do this in Mexico, or in many countries in Asia, or more than a handful in Europe. These products are for the most part innovated in the United States of America. We have to make sure that we do not kill the goose that is laying these golden eggs.

We think we can bring the price of prescription drugs down dramatically because when we get all of these elderly people and disabled people who do not have the benefit now, get them into the marketplace, subsidized by the Federal government, we will get the price of those prescription drugs down.

Mr. BURR of North Carolina. If the gentleman will continue to yield, the gentleman raises a great question. That is, a movement of 30-plus million people into a plan of coverage has a devastating effect on the cost of the items that are purchased under that plan.

Mr. GREENWOOD. Supply and demand.

Mr. LATHAM. This is a supply and demand situation, where if they buy them individually, the cost is so much higher. I think that is one of the reasons we have to look at some of the plans that are out there, and look at the hard and real facts of what does it cover.

In 1995, the average cost for a senior in America for drug coverage was about $500. That was the extent of all the drugs that they purchased. But more importantly, we are faced with a situation of trying to integrate what we are here trying to put together in with every State who takes care of the poorest seniors.

Somewhere between 58 and 100 percent of those in poverty are currently under Medicaid plans. Those Medicaid plans will be affected by what we do.

We have to make sure this is integrated into it.

The President made a proposal earlier this year. In the President's proposal, the same 135 percent of poverty are covered, just like we talked about the need to cover them. After that, individuals are asked to pay 50 percent of every dollar that they spend after they buy a premium, an insurance policy. The co-pay is 50 percent. There is no insurance product in the marketplace today like that, nor is there one that anybody would buy.

Let me give one figure. On $1,100 worth of drugs under the President's plan, in the year 2002 the benefit, the benefit for the senior would be $197.60. Eight hundred and two dollars of the $1,100 worth of drugs would be out-of-pocket costs by that senior. What an incredible challenge for anybody to buy into.

Mr. GREENWOOD. Mr. Speaker, I yield to the gentlewoman from New Mexico (Mrs. WILSON).

Mrs. WILSON. If I could follow onto something the gentleman mentioned about how easy it is to attack the pharmaceutical industry, these big companies, and why are the prices so high, but these are the companies that brought us the miracles in the first place.

I just want to reinforce something the gentleman said about the worst thing we could do here is to salt the earth or poison the well that will bring us the next generation of miracles, the medicine that will cure Alzheimer's or Parkinson's or diabetes. We want this great medical miracle that we have seen in the 20th century to continue in the 21st century, and the worst thing we can do is to pass legislation which would cause the pharmaceutical industry to shrivel in America and stop creating the next generation of miracle drugs, because I want them to be there for my kids and when I am old and gray.

Mr. GREENWOOD. It takes about something on the order of 9 years and half a billion dollars to bring a product to market, to bring a new pharmaceutical product to market. That is a very expensive proposition. We need to make sure that there are industries in America, companies in America that want to continue to make that kind of investment and take that kind of risk.

At the end of the day, an elderly woman who goes to her doctor because she has some kind of ailment and gets a prescription and takes that prescription to her corner drugstore, all she cares about is, can I afford to get this medicine that is going to make me better? She is not out to kill the pharmaceutical industry. She is not out to kill the biological industry or her corner pharmacist, for that matter, or the insurance industry. What she wants to know is, can I afford at a reasonable cost to get this drug so that I can take it home and get better and feel better and enjoy the rest of my days?

What we have to figure out here as policymakers is how to bring all of these stakeholders, the medical community, the doctors, nurses, hospitals, the insurance industry, the pharmaceutical industry, Republicans, Democrats, Congress and the President, and above all, listen to the seniors, listen to the seniors and to the disabled who are in need of this benefit so that we can share their wisdom, and get beyond the political credit-taking and partisanship and solve this problem.

I would certainly say that any Member of Congress or any president, for that matter, who serves in the year 2000 who can end this year at a bill-signing ceremony seeing that this gets done, and knowing that from that day forward no little old lady, no little old man, walks into any drugstore in America, hands trembling because he or she is not sure they can afford this drug, that will be enough for this Member to retire on, feeling that the time we spent here was worthwhile.

I yield to the gentleman from North Carolina (Mr. BURR).

□ 1600

Mr. BURR of North Carolina. I know the gentleman remembers well the visits that we had from young and old when we were in the hopes that we could modernize the Food and Drug Administration. I think to many Americans they might have looked at it and said, all that is being accomplished is to have a new version of an old drug on the marketplace and this is a process that will allow that to happen. In fact, it was not.

In many cases, the drugs that come through that pipeline today, as we refer to it, are drugs that we have not had anything available to treat that chronic or that terminal illness.

Today, as the gentleman and I know, we have a rampant increase in infection, in seniors predominately, but in all Americans; and it does not have anything to do with sterilization. It just has to do with the change in bacteria that goes on as we have treated one strain so long. The need exists in this country for new antibiotics but, more importantly, the need for patients to take all of the drugs that are prescribed for them so that the illness is eliminated totally.

We know what happens to a senior when they get halfway through the prescription. They have another month to go. That means going to the drugstore. It means the out-of-pocket cost of another $50 or $60 or $70, and they have had a cold month and the heating oil is higher than they thought, they may say I feel great now, the signs that I went in with are gone, and they do not get that second month of prescription. Pretty soon, that problem is back; it is worse. It means hospitalizations. It means doctors' bills. We pay for that side of it, under Medicare, and it is time that we lift the shells that we have got the pea under and make sure that everybody sees them and realizes that regardless of where it happens in the system, somebody has to be responsible and somebody is paying.

We have to make sure that we can say to the taxpayers in this country that they are getting the best value that they could purchase. We have to say to the patients, the recipients, the beneficiaries, they have the most quality delivery system with the greatest scope of coverage out there that we could possibly design. We are not there yet, and clearly we have seen a tremendous amount of options; but too many times we want to focus on the most at-risk and stop before we realize that an important part of this process is to make sure that we design a product that is as attractive to people in the upper income scale of seniors as it is needed in the lower income scale. Because by their participation, that pool of seniors grows and the purchasing power of that group, regardless of whose plan they are under, is that much better for their pharmaceutical coverage.

We have seen it happen in the private sector in health care. We can see it in what is the public sector today, which is Medicare.

Mr. GREENWOOD. Mr. Speaker, when I began my remarks, I mentioned that 1965 is when Medicare was begun, and as we look back 35 years, it is hard to imagine now a time when seniors did not have Medicare, when they did not have a guarantee of health care, just as it was impossible for them to imagine looking forward into time what health care could provide now.

We are at a particularly wonderful moment in our history. Over just the past 5 years or so, we took a Nation that was plunging into debt, $250 billion a year adding to the Nation's debt, and by 1997 making a lot of difficult decisions, including many that affected the Medicare program and trying to squeeze out some of the waste and fraud in Medicare, and we balanced the budget.

Last year, in fact just late last year, we made another huge decision here in Washington. We said we are not going to spend any more of the Social Security trust fund on anything else but Social Security, and that is another milestone that was brought about because of the fiscal discipline that we have demonstrated over the last several years.

Now we are taking down debt. We are to the point where by the end of this fiscal year, by next October, we will have paid down over a quarter trillion dollars in debt.

So this is a golden moment in American history. The economy is strong. Revenues are coming in. The budget is balanced, and we have an opportunity now to take another leap forward; and that leap forward, I think, involves creating this prescription drug benefit. It is a quality of life item. We have the opportunity to do it, and again there is not any question in my mind that there is enough talent in this town, some of it actually in the Congress, certainly in this staff and elsewhere, enough talent in this administration,

talent in both the Republican and Democratic parties and a willingness across this Nation to do this, that we can do this.

This is a solvable problem, and if we decide not to care who gets credit for it and work together across party lines, it can and it will be done. I just hope that all of the Members of the House and Senate who can hear the sound of my voice take that to heart and decide that this will be the year that we will do this in a bipartisan fashion, get the job done.

Mr. BURR of North Carolina. Mr. Speaker, the gentleman raises an important point that we need to remind everybody of. The House of Representatives does not have the ability to do it on their own. The United States Senate does not have the ability to do it on its own. Our Founding Fathers designed a very difficult system, but a system that works. It has its checks and balances, but it requires the legislative branch and the executive branch to agree.

It means that we not only have to pass the test of our 434 colleagues and our 100 colleagues in the Senate, and the executive branch's power over whether something moves, but we have the American people to deal with, too. We have to pass the test of: Is this a good product to them? That is not just limited to the 30-plus million seniors, because certainly the payment in the subsidy, the safety net is created by the American taxpayer.

We have not done a good job of explaining in the past what Congress did and why they did it. I think the reason that they did not was that we are finding they did not do some things just exactly right.

We have an opportunity, as the gentleman said, as we head to a period where as we pay down debt, we could alleviate off of our annual expenditures $260 billion worth of interest payments every year, interest payments that we get zero for. We do not educate children. We do not provide health care for seniors. We get zero in services. That is the one area that infuriates me as a taxpayer, that we cannot get that interest off and we cannot do it until we pay the debt.

As the gentleman knows, in North Carolina I have a mix of every type of health care in this country. I have some of the finest medical universities at Wake Forest and Chapel Hill and Duke and East Carolina. I also have some secondary hospitals that I think are models in the county, in Alamance County and Surry County, North Carolina.

I also have rural health clinics and community health centers. They treat this population as well, and their livelihood has been Medicare.

It was so important that we went back the end of last year and we beefed up some of the reimbursement changes we made in the Balanced Budget Act of 1997, because we saw that we were falling short of supplying the best health care to the seniors in the community health centers and rural health clinics. We went back and in a bipartisan way, very quickly, without a lot of public debate, we found those areas and we strengthened them. Today, those seniors in North Carolina that go to the rural health clinic and in every State now have quality delivery, a delivery system that they are not going to worry whether it is going to be there next year.

That is the opportunity we have with drugs. We can put aside the partisanship of it. We can commit with the President to do a plan, let it pass the test of seniors, let it pass the test of the American people, the American taxpayer. Those are the two most important. The least important is the personal agendas of individuals up here, whether it be at this end of Pennsylvania Avenue or the other.

I am willing to work with the gentleman from Pennsylvania (Mr. GREENWOOD) and with our other colleagues on both sides of the aisle and let seniors, the associations that represent them, the American taxpayer, judge our product at the end on the value of it to them and of the scope of coverage and of the quality of life that it provides for all of them.

Mr. GREENWOOD. Mr. Speaker, the whole concept of aging is changing dramatically in this country. It was not very long ago that people in their sixties and their seventies, because of the state of the health care, they became feeble a lot faster and were not as vital as seniors are today. That trend can only continue.

My mother and father are 78 years of age, and I admit this with a certain amount of hesitancy, but it was just about a year and a half ago that my mother and father and I, on a dare from my father, jumped out of an airplane at 13,000 feet and went skydiving together. That is pretty good for a couple of septuagenarians. I think the baby boom generation expects to extend its years of vitality even farther, and we expect to be still physically able and fit and enjoying life well into our seventies and our eighties and our nineties, and of course the fastest growing segment of the population is those above 100 years of age.

Nothing more than the advancement of these miracle medicines, these miracle pharmaceutical products, these coming biological products that will result from the human genome study will continue to enhance the vitality of our elderly.

That is why, again, we have this golden opportunity here to make the golden ages more golden for generations yet to come, and I look forward to working with my colleague and, hopefully, we will get it done this year.

Mr. BURR of North Carolina. Mr. Speaker, I look forward to working with the gentleman from Pennsylvania as well.

We are at a time where this week alone we saw the President for the first time say to Congress, I will sign a bill that eliminates the earning limits that we created on seniors, an opportunity for those that want to continue to work, that choose to work voluntarily, possibly stay in a private sector health plan; but the key thing is that they realize that the longer they work, the healthier they are. Those that make that choice will not be penalized now under the Tax Code.

If there is an area that we penalize them, it is suggesting that when they get to a certain age the only thing we provide is a limited health coverage for them, and I think we have a responsibility and an obligation to make sure that we do develop a model that is universal, that it is accessible and it is affordable for everybody, regardless of who is paying the bill, a subsidy or an individual. I think that is a test that we will ultimately be under, and I look forward to working with the gentleman on it.

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman from North Carolina (Mr. BURR) for joining me on this Special Order this evening, as well as our colleague from Michigan (Mr. UPTON) and our colleague from New Mexico (Mrs. WILSON).

CELEBRATING BLACK HISTORY MONTH

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

Mr. DAVIS of Illinois. Mr. Speaker, I want to compliment my colleagues on a very interesting discussion that just took place, especially as it relates to health care and the role of community health centers and rural health centers in providing for the health of this Nation.

As we continue to celebrate African American History Month, a time that is set aside largely due to the efforts of Dr. Carter G. Woodson, where we pause, take a look at the contributions as well as the needs, hopes and aspirations of African Americans in this country, I am pleased to be joined by my colleague, the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), who is a physician, has been a practicing physician, and who has been a director of clinics and community health centers, who currently serves as chair of the Congressional Black Caucus' Health Brain Trust, but is indeed a dynamic Member of this body.

Mr. Speaker, we come to talk a bit about not only the contributions of pioneer African Americans in the area of health, but also as we look at continually the health problems and disparities that exist in our Nation, especially as they relate to the needs of African Americans. So I say to my colleague, it is a pleasure to be here with her this afternoon.