Please read his words in the RECORD, and tomorrow vote ''no'' on permanent trade status for China.

Supporters of Permanent Normal Trade Relations (PNTR) for China tell us the US is giving up nothing in its trade deal with the regime in Beijing, that China is making all the concessions. This claim is false.

The US is giving up something of profound importance—its ability to aid people everywhere in their struggle for human rights and democracy. The US has enormous power, due to its economic leverage. Although the US has been reluctant to use this power against Chinese tyranny, the power exists; Beijing recognizes this fully, even if the US does not.

The annual renewal of China's ''driver's license'' on trade may have become routine, but the power to grant the license remains critical. That is why Beijing is desperate to obtain PNTR, and rid itself of this power. That is why both Rep. Levin and Cox's proposals, no matter their very fine points, are ''toothless'' if this power is not retained. The hope that the World Trade Organization (WTO) and the World Bank will place limits on China will amount to little, for multinational financial institutions are woefully inadequate to take over responsibility of the US Congress. It may not follow the US lead in any event.

Framing the debate on WTO and PNTR as ''keeping the door open'' is misleading. America's door is open. The door to China is only half-open. However, the Chinese people have learned that they lack the rights other people enjoy. If this were not so, the enormous uprising in hundreds of Chinese cities known as the 1989 Tiananmen movement would never have occurred. Yet the door to China remains and will remain half-closed, because that is the way to retain power under tyranny.

Trade alone simply cannot open the rest of China's door. If the US Congress grants PNTR now, it legitimizes this half-open/half-closed status. To certify Communist China as ''normal'' in its abnormal state would deprive reformers within the government of needed pressure to push for change.

The claim that PNTR gives American access to the ''vast Chinese market'' is specious, because it does not exist. Simply put, we cannot construct the ''vast Chinese market'' without first the rule-of-law being instituted, as President Lincoln put it, ''by a government of the people, by the people, and for the people.''

In fact, the multinational business community is making an unholy alliance with Chinese tyranny. The Communist government uses brutality to subjugate Chinese workers while U.S. corporations use the threat of moving their businesses to undercut American workers' demands. Businesses in China's neighboring countries—Japan, South Korea, Thailand, Taiwan, and Hong Kong—will use ''slave labor'' to China to flood the U.S. market. PNTR is a loss-loss proposition for most workers in Asia and America, but especially for China's. The business community should not be so complacent, because Chinese tyranny will redirect Chinese people's anger against them toward the outsiders.

The majority of pro-democracy organizations are against PNTR, yet a few prominent individuals in China have announced their support. Why such contradiction? The question we must ask is how much can we credit the words of kidnaped victims when they are at the mercy of their captors? The answer is not much. We simply cannot take the current opinions of Bao Tong and Dai Qing to represent their true thoughts, nor can they represent the opinions of others, when Bao and Dai have long been in the grip of a tyrannical government.

Those who have experienced brutal oppression and insidious threats understand their quandary. We can, and must, express sympathy for their deplorable and excruciating plight. My criticism is not directed at them personally, but at the tiresome propaganda regularly doled out by the Chinese Communist Party and their supporters in the United States.

Still, the basic principle against PNTR is very simple: if PNTR is granted, the US surrenders its power to be a force for positive change in China—its power to promote human rights, to deter China's increasingly aggressive military posture, and as well, to compel the regime to live up to its economic promises. How can anyone call this nothing?

Wei Jingsheng has spent 18 years in prison for insisting on speaking the truth to power.

These comments are based on Chinese government honoring its commitment that they will do, but they don't.

COMMENTS

There are reports of ''dissidents'' in China who support PNTR. First, we'll know that without freedom of speech and press, the Chinese government controls what they want Chinese people to know. Secondly, please put yourself into their shoes—when the hostages speak kindly of their captors and ask you to believe what the captors say that they will follow their promises would you believe that?

GENERAL LEAVE

Mr. GREENWOOD. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 4444.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

MEDICARE PRESCRIPTION DRUG BENEFIT

The SPEAKER pro tempore (Mr. SWEENEY). 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 my colleague, the gentleman from North Carolina (Mr. BURR), and I are going to do a special order on the Medicare prescription drug benefit. As most Americans know, 1965 was a critical moment in America's health care history. That was the year that the United States Congress and the President of the United States enacted Medicare.

Prior to that time, if you were elderly or if you were disabled, you could not provide for your health care. You did without health care. You had no regular doctor's care. You had no access to hospitalization and you suffered and you died early.

In 1965, America proved its humanity and proved the level of its civilization by caring for its elderly and eventually extending that Medicare benefit to the disabled.

When it did so, it did not include a prescription drug benefit. It did not, because it was an awful lot to accomplish just to get the physician coverage and the hospital coverage. At that time, prescription drugs were not nearly as utilized as they are today. But, today, the miracles of modern pharmaceutical industry, the miracles provided by the work on the human genome and biological products have brought us to a point where if you do not have access to a pharmaceutical drug benefit, you do not have access to first rate health care, you do not have access to the best health care in the world.

For years, we folks in Washington in the Congress and White House have talked about how terrific it would be if we could create and add a prescription drug benefit to Medicare, but it has been all talk for a lot of years, and now it is time for action.

The reason it was all talk and no action heretofore was because this country was not in any state financially to provide a Medicare benefit. We were adding a $250 billion to the national debt every year, we were spending money like drunken sailors in this town, and there was no way that we could continue that practice and then add to it the addition of a prescription drug benefit.

But, since 1994, the Republicans in the Congress have changed the direction of the country. We have reformed Medicare itself to make sure that it will last well into the future. We have reformed welfare, removing ultimately half of the welfare recipients from dependency to work and to independence. We have balanced the Federal budget for several years in a row now. And in the current fiscal year, we have taken Social Security off budget and made sure that never again would the Social Security surplus be spent for other causes than Social Security.

We are now finally paying down debt. By the end of the current fiscal year, we will have paid down $250 billion in debt; and we expect, at the rate we are going, to have the United States national debt paid off by about the year 2015, if not sooner.

We have done all of this, and still we have a surplus, so this millennial year is the year we can step up to the plate; and we can provide a prescription drug benefit to America's elderly and America's disabled.

While two out of three Medicare beneficiaries in this country do have access to some kind of prescription drug benefit, that coverage is often scant and shrinking. Many of our seniors on Medicare-Plus Choice have seen that their plans have had to pull back their benefit and now, for instance, are only providing for generic coverage and not providing for the brand coverage, unless there is a very expensive extra payment paid by the beneficiary.

For those without coverage, the choices are grim. There are miracle drugs available to humanity today, but if you are an elderly woman, an elderly widow, living on a small Social Security stipend, and you have Medicare

but you have no access to prescription drug coverage, there is no miracle in that miracle cure. If you are an elderly gentleman in the same position, there is no miracle in the miracle cure for you. That is the same with the disabled in this country.

□ 1930

These folks are pressing their faces up against the glass windows of the drugstores knowing that while inside a prescription that their physician could write for them exists that could relieve their suffering, that could extend their lives, that could improve the quality of their life, that is not available to them. This is the year for the United States Congress to act and to do it in a bipartisan fashion.

Mr. Speaker, I would like to now yield time to my friend, the gentleman from North Carolina (Mr. BURR), who has been working with me and other members of the Committee on Commerce as well as the Committee on Ways and Means to craft this proposal that we hope to have introduced in the very near future.

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

Mr. BURR of North Carolina. Mr. Speaker, I thank my good friend from Pennsylvania. The gentleman makes a good point, and that is that if Medicare were a program that we developed today, certainly drug benefits would be part of the coverage given the access that drug benefits have to private sector plans that every employer offers to their employees. But the fact is that in the 1960s, that was not a common part of health care coverage, because very few new pharmaceuticals hit the marketplace, and most of the antibiotics were around for years and years. We worked to reform the Food and Drug Administration, and we started in 1995 and we completed that task, I believe, in 1996 or 1997, with a signature by the President, an agency that controlled 25 cents of every dollar.

The reason that we modernized the Food and Drug Administration was we understood the great task that was before them. The FDA is an industry that this year will put $21 billion, and that is with a ''b'', into research and development. We understood that if we could unleash this industry as the human gene was mapped, that through these pharmaceutical companies, we could find cures to terminal and chronic illnesses that currently in our system today we treat and, at best, maintain through a very expensive delivery system. But we owed it in a quality-of-care way to make sure that if we could reach cures for cancer, for AIDS, for diabetes, that we put every incentive in the system to make sure that the private sector invested their money, their time, to hopefully find these breakthroughs.

Now, we are on the verge of breakthroughs. This year alone, the FDA will approve over 30 new drug applications. Not every one of them will be a big contributor to savings or quality of care, but we are clearly on the road to new therapies that we have not had in the past.

Mr. Speaker, let me say to my colleague that I think it is important that, when we talk about adding a drug benefit to Medicare, most people think of seniors. But we have a large group of disabled Americans who qualify for Medicare benefits. We cannot do a program that leaves them behind. Everybody that is eligible for Medicare has to be included under the umbrella of coverage for pharmaceuticals. It has been very challenging for us as we have designed a program also to make sure that it dovetails with the 14 States that currently offer it.

Pennsylvania is a great example. It probably has one of the most generous plans in the Nation.

Mr. GREENWOOD. Mr. Speaker, we have 300,000 participants in our program.

Mr. BURR of North Carolina. And I think it goes up to 225 percent of poverty.

Mr. GREENWOOD. All supported by our lottery.

Mr. BURR of North Carolina. All supported by the lottery. If every State had a plan, we probably would not be here tonight. We would probably have seniors with coverage that needed it. But there is still a greater need, and that is to produce a value for those individuals who do not have the option of insurance. They may have more money, but the plans just are not available. And what we are trying to do is we are trying to create new options through the private sector, which I believe is the single most important thing.

We have some disagreements between Republicans and Democrats. They are becoming smaller and fewer. One of the major ones that will continue, though, is currently the Health Care Financing Administration administers the Medicare benefit. I am not sure of very many seniors or health care professionals or hospitals, even my mother understands the problems that exist at the Health Care Financing Administration, because she has been in the hospital lately. The reality is does Congress really want to turn a new benefit that is so vitally important, over 38 million Americans, over to an agency that cannot even figure out what to do with the technological change of intravenous drugs that can now be delivered at home with a self-injection method?

Mr. GREENWOOD. Mr. Speaker, that is one of the problems. They say, where there is a will, there is a way. There is a will to get this done. Republicans want to do it. We happen to be Republicans; we have been working hard with our Republican colleagues. Democrats on the other side of the aisle sincerely want to do it. House Members want to do it, the Senate wants to do it, the President wants to do it, the elderly want us to do it, the disabled want us to do it, their families want us to do it, the pharmaceutical industry wants us to do it. Everyone is for this. What there is is a legitimate set of differences of opinion. The gentleman is talking about one right now.

The question is, do we want to give this program, this new benefit, to the same bureaucracy that has been administering the current one? I do not think there is a beneficiary on Medicare who can tell us or anyone else, they certainly do not tell me at the senior centers, that they understand the paperwork that they get related to their Medicare and they would like to have more paperwork related to their Medicare and they would like the decisions made about their health care to take as long as ones do today.

The fact of the matter is that what is available at the drugstore is changing at the speed of light. Every day, practically, we can find new products out there in the drugstore. What we are concerned about, the gentleman and I are, is that we do not want it to be the case that the Food and Drug Administration approves a new cure for arthritis or a new treatment for colon cancer or a new medicine that will relieve suffering. The doctor says to the Medicare recipient, boy, this is a great drug for you, I wish I could give it to you, but the bureaucrats in Washington, it is going to take them a long time, as it would a bureaucracy, to get around to figuring out how much to reimburse for this product and so forth. So we are looking at a different system, a system that would create a separate board that could make those decisions quickly so that these beneficiaries do not have to wait and suffer in hospitals, or maybe die, while they are waiting for a Federal bureaucracy to get around to making sure that this product is available for them.

Mr. BURR of North Carolina. Mr. Speaker, if the gentleman would yield, I am not sure that there are very many seniors, if any, in the country that would tell us the creation of a new agency whose sole function it is to make sure that the Medicare drug benefit is run effectively and efficiently is a bad thing. But clearly, that is a difference that we have in Washington. It is a difference that will probably exist until this bill becomes law. My hope is that it is this year; that, in fact, that long list of individuals that you talked about, Republicans, Democrats, the President, the bureaucracy, when they say that they are interested in a drug benefit, I hope that they are talking about today, this year, the 106th Congress, not the 107th, because clearly, we know individuals who do not have the capabilities to pay for their prescriptions today, who go without that prescription.

As the gentleman and I both know, because we deal in Medicare from a standpoint of the big picture of Medicare, when those individuals make a decision not to take their antibiotics or not to take some drug that has been prescribed, the likelihood is that the

result is that they end up in the hospital. When they end up in the hospital, we have a greater cost to our Medicare system than the $100 prescription that they should have taken for 2 weeks.

Mr. Speaker, for the first time, I believe that the Congressional Budget Office recognizes there is a savings to making sure that everybody has a benefit. The gentleman and I went through the expansion of Medicare coverage several years ago when we included mammograms, PSAs for prostate cancer, and diabetes daily monitoring, and we now cover those under the normal Medicare coverage. But it took us a long time to convince people that it was actually less expensive to supply a daily monitoring strip for diabetics than it was to pay for amputation or blindness. Put the quality of life aside for a second; the sheer dollars were more beneficial. Bring the quality of life in; and clearly, this is something that we should have done much sooner than 2 years ago. But we are finally there.

Now, we are talking about the expansion of an area of Medicare which will give us a new treatment method for the majority of the problems that seniors and the disabled run into, where hopefully, we can eliminate the hospital stay. Hopefully, this is a method of treatment where an individual can take it at home, and we do not have the transportation needs that are a problem with many seniors. Clearly, this is a benefit that we have a responsibility to find a way to get it into law.

Mr. GREENWOOD. Mr. Speaker, there is no reason why we cannot do that. It is oh so easy in politics to point fingers and bash the other guy for political gain, but the fact of the matter is that the gentleman and I have both discovered that all of the intelligence does not lie in one party or another here in Washington. It is not all in the House or all in the Senate. It is not all in the Congress or all in the White House. But in fact, there are good, decent thinking people in all of those places that really want to get this job done.

To the extent that we can recognize that we have some different ideas, some people want to go strictly to a price control mechanism, some people want to attack the issue of what happens when one goes across a border to Canada or Mexico, some people, as the gentleman and I do, want to create an insurance model where we think for a very reasonable amount we can create a system where every American, regardless of income, will be able to afford this benefit, and for the lowest income, the Federal Government would pay for all of it.

Mr. BURR of North Carolina. Mr. Speaker, let me make this point here. A voluntary plan, a plan where we create the benefit and say to the 38 million seniors and eligible disabled, it is your choice. If you currently have coverage that was extended by an employer in your retirement, you do not have to, you do not have to buy into the Federal plan. It is an option. It is a vast difference in approach from the catastrophic debate of 1993 or 1994 when we, or it may have been earlier than that, when we asked seniors to pay more for something they were already getting for nothing.

Mr. GREENWOOD. They were not very happy about that. We all remember Chairman Rostenkowski's car being rocked by a group of seniors because essentially what the Congress was saying is that if you already have this benefit, we are going to make you pay for it anyway. As we said earlier, two out of three beneficiaries already have some kind of coverage.

Mr. BURR of North Carolina. One thing that we learned is that not every employer planned for their retirees' coverage. It may cover a very narrow set of generics or certain areas of the drug industry. We have designed this Medicare benefit to say to employers, if you made a promise to retirees, why do you not look at this new plan which might be better coverage and less money and buy your employees, pay the premium for them to be a part of this, supply the deductible for them. Let them be part of a larger plan where we really leverage the volume of individuals in the Medicare plan by pooling them all into these private sector entities, companies that are willing to create different options because of the size of the pool they are interested in participating, interested in designing a benefit package that might fit the different health care needs.

Mr. GREENWOOD. Mr. Speaker, our staff, and we with our staffs, have been working very hard at this for a long time. The goal is clear, but the way to get there is complex and it is difficult and it requires some very complex calculations about if we raise the eligibility level, for which the Federal Government will pay for anything, what does that do to the cost, and where can we put the stop loss benefit for the insurance industry so that it is willing to sell the product at a price that everyone can afford. That is complicated stuff. But we can get there, and we can get there working across the aisle; we can get there working with the White House.

I would hope that anybody watching C-SPAN this evening would take from listening to us this evening that number one, it is time to do this; number two, the country is financially in a position to do it; number three, there is universal desire and commitment to do it in Washington.

□ 1945

Number four, it is complex.

Number five, anyone who demagogues this issue is really doing a disservice to his country.

I have heard so many speakers, unfortunately on this floor, pointing fingers at one party or the other saying their plan is better than ours or our plan is no good or nothing is being done, or I distrust the motives; I think this special interest is being served or that special interest.

I would hope that as this debate moves on and as we hopefully get to the point where we can put a product on the President's desk and that hopefully he will sign it, that those who are frequent callers to C–SPAN, for those who are frequent correspondents to their Members of Congress or phone their Members of Congress, that they call to task any Member of Congress or the President, if they see those Members or those politicians try to take political advantage on this issue. This is not the time to do this. This is the time for bipartisanship. This is the time for putting our heads together and getting something good done for the benefit of the country, and I think we can do that.

Mr. BURR of North Carolina. I have to think that if an administration that is Democrat and a Congress that is Republican can get together and be on the same side of a trade bill with the People's Republic of China, that surely a Democrat President and a Republican Congress could get together in a bipartisan way to design a drug benefit for the seniors and eligible disabled in America. Clearly, the trade deal has to be more difficult to put together. We know, because we are here, that it is not partisan. There are Democrats on one side along with Republicans, and there are Republicans and Democrats on the other side, and at one time the administration was split. To some degree, it is regional across the country.

Health care is not regional. Health care is something that we ought to make sure is the best for every person who is eligible.

One of the additional tasks that we were given, though, is not only did we have $40 billion to work with over the next 5 years, we were also given that task that says make sure that the long-term solvency of Medicare is protected. Make sure whatever is done does not bust the bank down the road.

We know, as seniors know probably more than we do, that health care costs, specifically pharmaceutical costs, are rising. If they have 30 new drugs next year and 11 of them are targeted toward illnesses that seniors are prone to have, we know that our pharmaceutical cost in this country is going to continue to rise; and hopefully, we have taken that into account. That is one of the reasons that we have chosen the private sector to produce the plans because clearly they have a better history of the efficiencies in health care than does the Health Care Financing Administration or any Federal agency, and I would include Congress in that as well.

Mr. GREENWOOD. If I can refer to this chart here, the gentleman referred to the difference between us and the seniors, and despite the color of my hair I am hoping to continue to be able to see that difference between myself

and my parents. And yet if we look at this chart, we will see that in 1999, and this is probably very much the case now, medication is used by about 33 percent of seniors today. So about 1 out of every 3 beneficiaries needs a drug product on a regular basis.

By the time this gentleman is about 80 years of age, and I expect to be alive and kicking at that time, 51 percent of the seniors, of our generation, will be medication dependent. So this is not an issue of importance only for those who are above 65 years of age today or who are retired. It is an issue for us because they are our parents today. We love them, and we care about them. But it is also an issue because in the relatively near future it will be, the gentlemen and I, in our retirement, very much not only in need of these prescription drugs but having available to us prescriptions that certainly are not available to our parents today.

Mr. BURR of North Carolina. One thing we have both seen is that anything that we do in the Medicare model is usually replicated at some point not too far down the road in the private sector plans that employers provide for their employees.

I know that the gentleman is familiar with a frustration that we have had over the years in Medicare, which is their policy as it relates to organ transplants for seniors. Under any organ transplant in the world, the recommendation is that the recipient takes an immunosuppressant drug for the rest of their lives to make sure that the rejection of the organ does not take place, but our current policy in Medicare is that we will pay for the immunosuppressant drug for a 3-year period after the transplant.

It is an amazing thing that when seniors go off of the drug, because the cost is high, that maybe in the 4th year or 5th year or 6th year they begin to reject the organ. But what is our health care policy in Medicare? We will actually pay for another transplant, but we will not pay for the immunosuppressant drug any longer than 3 years.

So it really does make a lot of sense why we are here today talking about a drug plan that even some of the entities that oversee Medicare are not enthusiastically out front leading the parade saying we have to have this benefit and it needs to look like this. Because clearly they cannot make the decisions today to extend drug coverage even in the cases where we know it makes a difference in the quality of life but where we know also the option is another very expensive transplant that makes the solvency of the Medicare Trust Fund even shorter than where it is today.

Mr. GREENWOOD. These prescription drugs, as miraculous as they are and as beneficial as they are, are increasingly expensive. Not only are they expensive, it is not simply that the price of a particular medicine goes up and up and up; but as this chart here shows, the total pharmaceutical spending between 1993 and 1999, the annual increase in those costs, continues to go up.

So it is not just, if we look at these pink indications here, the CPI, the Consumer Price Index per year, has been pretty low; but because of the addition of new products on to the market, the increases in some of those products once they get on the market, what is being spent, the costs for all pharmaceuticals paid by individuals and hospitals and insurers continues to skyrocket. It is a situation that demands our response.

Mr. BURR of North Carolina. Not only are we faced with a situation where pharmaceutical costs continue to increase at double digit rates, we also look at a growth in the senior population. We know from looking at the demographics that really do not lie, as seniors grow older, as one reaches that magical age of 65 long before I do, then in fact the population eligible for Medicare over the next 15 years will grow from somewhere in the neighborhood of 38 million today to somewhere in the neighborhood of 75 million.

So if this were a company we were at and we were trying to do long-term planning as it related to our costs, we would look at some of the things down the road that we knew were going to happen and we would try to address those as early as we could so, in fact, the impact was more predictable, our options were greater and the cost was less. That simply is what we are talking about doing with the drug benefit in Medicare.

We know that the senior population will double over the next 15 years. We know that pharmaceutical costs are going to continue to rise, in part, because we have the gold standard in the world in the FDA of drug approvals. We know when drugs come through that they have passed the safe and efficacy standards. That does not mean that we do not have some after-market approval problems, but hopefully we have an FDA that is on top of that and monitoring it and getting a lot better.

The reality is that as we see the population increasing, as we see the cost of drugs increasing, is not the smart thing for Congress and the administration to do this year to pass a drug benefit to watch that benefit to make sure that in fact it is the type of benefit that seniors need; that it has the cost controls that we know we have to have for the long-term; that we begin to accumulate some information about whether we have chosen the right option up front before the senior population doubles, in case we guessed wrong, and we could go back and change the way the benefit is offered or how the benefit is paid for while the size of that senior population is 38 million versus when it becomes 70 million and our options are so few?

Mr. GREENWOOD. That is an issue for our children. How they are going to be able to pay for the costs of our retirement. This issue gets complicated, and I know some of the viewers across the country watching this tonight are maybe trying to decipher all of this language and sometimes we in Washington use language that is a little difficult to decipher.

Let me try to give some perspective as to how different folks around the country might see this. First off, if one is retired now or soon to retire, and they have a good prescription drug benefit because they work for an employer, a government employer or a large Fortune 500 employer that provides coverage, and they are in pretty good shape, they do not need to worry about this because they are not going to be forced to buy anything they do not need. They are in good shape.

If that changes at any time, we think we are going to create some products in the market that they want to avail themselves of but no one is going to force anything on them. If they are retired or disabled today and they are one of that one out of three who does not have access to a prescription drug benefit, what we are saying to them is we are going to make one available to them and one that they can afford. And we think we can do it very soon.

If one is low income, if they are at that 135 to 150 percent of poverty level and they do not already qualify for Medicaid or a State-run lottery program, the Federal Government will pay all of their premium. So this is really a great benefit for them. It is at no cost and it is real coverage and they do not have to wait until they get to some catastrophic level. It is there.

If, on the other hand, they do not have the coverage or they expect that by the time they retire they will not have the coverage and they are middle- or upper-income, they just want access to it, they just want to find something they can afford, we think that somewhere at a cost of about $50 a month, as a Medicare beneficiary they will be able to buy this coverage just like they do now, through their part B premium, pay for the extra coverage to go to the physician and the outpatient care and so forth.

So from many of those perspectives, it is a good deal.

Let me make one other comment before I yield back to the gentleman. If one is a taxpayer out there and they are looking at this saying, yes, it is great for Congress to provide this coverage; but we do not want to see the budget broken again, it has been broken before. This is not free drugs for all, this is a prudent, affordable plan that tries to make it affordable at the low-income level and make it affordable at the middle- and upper-income level with those folks contributing something out of their pocket so that they understand this is a shared responsibility between the Federal Government and the Medicare beneficiary.

Mr. BURR of North Carolina. The gentleman is exactly right, and I think for the average American who watches the nightly news or reads the morning

paper, they would probably go away from that news show or from that article in the paper thinking, my gosh, Republicans are over here and Democrats are over here as to who they are trying to help, and the reality is that we are both right here.

We are targeting the same people who do not have an annual income that is big enough to afford housing and food and health care costs, where we are going to supply a government subsidy. We are looking at a group right above that where we are trying to figure out how can we do some type of phase-in subsidy to help them?

Then we are looking at the group above that saying they are not all high income, but they have the capabilities to buy into a plan to have coverage.

The discrepancies between the plans that are being floated in Washington are not about who is being covered. We are using the same $40 billion pot of money. It may be configured slightly differently. The President gives a subsidy to everybody on the front end. He lowers the price of everybody's premium so it is more attractive. We choose to have a market value on the premium, and we go to what we refer to as the stop loss, a certain dollar amount on an annual basis where we say to a senior if they reach this, if they really get sick and they reach this point, they do not have any additional cost past that. Their plan picks up 100 percent of it. There is no co-insurance. There is no copayment, once they reach that point.

The President's plan does not do that. He subsidizes the premium costs. We subsidize the high risk so that, in fact, we can say to seniors and disabled who are eligible for Medicare they will never lose everything that they have because in any given year they have a significant illness.

I think that is the role of the Federal Government. That is the definition of a safety net when things get tough, they are there. What we have tried to do is design a plan that says let us put value, let us be honest on what the cost is, let us give people confidence in who they deal with, which is usually not the Federal Government, that is why we chose the private sector, and let us say at what point their exposure stops, at what point do they reach where they do not have any additional costs.

□ 2000

To some degree, it is criminal for us to ever present a plan that would suggest to individuals when they really get sick and they exceed a certain amount that the burden falls 100 percent on them, when they have reached that point where they might have 100 prescriptions filled in a year. That is when they need us to kick in.

We are trying to design a plan that gives them coverage underneath and security underneath, but more importantly, security for what is unexpected. We know in health care that happens many times.

Mr. GREENWOOD. Mr. Speaker, security is what all seniors want. It is what we will want when we are seniors, and that is the security, the peace of mind to know that I do not have to worry about whether I can afford the drugs that my doctor says I need. It is as simple as that. I do not have to worry about whether I can afford the drugs, the medicines that my doctor says I need. That is what we ought to be about providing for Americans.

I have what I call my Medicare prescription drug advisory group at home. I have seniors, I have disabled folks, I have the local pharmacists. We sit around and meet regularly and talk about this issue and talk about where the hardships are and talk about the people. Particularly, the druggist is an interesting participant because he talks about the people who come into his little store, his corner store, and try to buy a prescription drug, and he has to turn them away if they do not have a plan or they are shocked by the cost of this. For those people, there is no peace of mind; there is no security that the American dream afforded by these miracle products is for them.

But the bottom line is that we can do it. We can do it as Republicans. We can do it as Democrats. We can get the job done, and we can get the job done this year.

Mr. BURR of North Carolina. Mr. Speaker, the gentleman from Pennsylvania is exactly right. Let me take this opportunity in closing my part of this out to say, for the first 5 months, there has been a tremendous amount of work, not only work by Republicans, but by Democrats, a tremendous amount of work by the administration and by Congress to try to figure out what the right plan is, to try to figure out exactly what the benefit should look like and what value we can extend to seniors under a drug benefit.

Will it be perfect? No. But there is no substitute for the commitment of this institution to say we need it and not do it today. This is not a time where we can delay another year, another generation, another Congress, another administration. We do not get a better opportunity than this where we have shown fiscal restraint, we have accumulated some additional money over and above Social Security surplus, over and above every other trust fund that we have got. These are real dollars.

As I said to my constituents, when we get to real dollars, when we know that we are paying down debt in a responsible way, and we have got real dollars, we will look at real problems that we think we can solve. This is a real problem today. This is a real problem today that we can solve.

All it takes is the will of Republicans, Democrats, the administration and Congress. It takes every American out there that is listening to us tonight that can benefit from these, calling their Members and saying, do it now. Do not wait.

Mr. GREENWOOD. Mr. Speaker, the gentleman from North Carolina and I happen to be Republicans; and we can say, because we work more closely and more frequently with our Republican Members on our side of the aisle, from the Speaker of the House to the majority leader to the Whip to all of the officers and leaders in our party down to every Member, freshman on up, there is a complete commitment and a desire to get this job done. I think that is true on the Democratic side of the aisle, and I think it is true in the White House.

But we know we cannot get it done by ourselves. We can bring a Republican bill out here, a purely Republican bill, and if the Democrats in the House and the Senate tell the President it is a bad bill, he will veto it. That has not helped a single senior.

So we have to try to get a bill through the Congress that Republicans and Democrats like. We have to be able to do what most Americans want us to do, compromise, find the middle, accept each other's positive suggestions, get that job done, put the bill on the President's desk. I believe that this President, as he leaves town, can say that is one thing I got done; and I think this Congress can say, come the election, come what may, we got that job done.

Because the odds are, even if we did not get this done this election, this year, wait till the next election, we will be back in the same position. There will still be Republicans and Democrats in town. The Congress may be divided. The difference between the White House and the Congress will still be there.

So there is no point in waiting. The time to do it, as the gentleman from North Carolina (Mr. BURR) said, is now. The will is here. The financial situation is here to do it and certainly the need to do it is.

Mr. Speaker, I thank the gentleman from North Carolina for his participation in the Special Order this evening.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SHIMKUS). The Chair reminds all Members that debate should be addressed to the Chair and not to the viewing audience.

STOP RISING PRESCRIPTION MEDICATION COSTS FOR SENIORS

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

Mr. BAIRD. Mr. Speaker, I came before this body about a month ago to address the problem of prescription medications, which my colleagues were addressing. I pledged at that time to go back to my district and carry the voices of the people of my district back to this body.

What we did was we visited senior citizen centers; and we asked the people there, please share with us your