teachers, and that is even better. Because they are great people; they deserve our admiration and all of our praise.

I visited one school, and I will not forget it, I went in. They had so many trailers on the campus they called it the trailer park. Now, teachers can teach in that, but the problem is we do not have the space, we do not have the opportunity to move around and interact with students like we would like to. The real problem is, when it rains, guess what happens? They get wet and go into the main building. They go to the bathroom. They go to the cafeteria. They go to the media center. They present a part of the linkage of that school, and we can do better and we have some wonderful teachers in this country with hearts of gold doing the Lord's work in all kinds of conditions.

I think at a time when we have the opportunity in this body to form that partnership, we ought to do it. We have a bill pending now, as the gentleman well knows, with 228 congressional sponsors from those on both sides of the aisle. I think it is incumbent upon the Republican leadership who runs this House to bring that bill up and allow us to vote on it.

It would pass. The President would sign it, and we could send that money out to help local schools. It is in no way meddling, because they would have total control over it; all we would do is pay the interest. Those are the kind of partnerships that the business community would applaud. They are the things that the parents want to happen.

The years that I served, 8 of them as State superintendent of the schools in North Carolina, and my colleagues have heard me say this on the floor before, I have never had a child, I never had a student ask me where the money came from. They do not really care. They just know they do not have as much in some communities as others. We have a great country. We have one of the wealthiest countries ever in the world, and there is no excuse at a time of prosperity when we cannot do the things we need to do for children to prepare for the 21st century and give every child that opportunity.

Because I truly believe education is the one thing that levels the playing field, and that is what you fought for all of your life. I would not be here today if it were not for public education, and most Members of this body, if they would be honest with us, would not be here either.

And I think we have an obligation to the next generation to reach out and help when we can. There have been times when we could not do that in the past. We did not have the resources. We now have it. We can join with the President in making sure we put out that 100,000 teachers; we can do the staff development we need, start planning for the future and also provide the resources to build schools.

Mr. ROEMER. I thank the gentleman from North Carolina for his remarks and for engaging in the colloquy with me, as I have engaged with my friends from California, Florida, and Wisconsin here over the last 50 minutes or so; and I want to conclude where I started, and that is as education goes, so goes America.

As we are able in a bipartisan way in this body to work together in a civil manner, Democrat and Republican alike, to try to work to give our local public schools more arrows in their quiver to try to solve some of the problems that they are engaged in right now, whether it is parental involvement, which we quite frankly do quite a lot about; but if it is the quality of teachers, we have some ideas that they might want to try, class size reduction.

There are some ideas out there, many of them have started at some of the local levels that we have shared with other communities: professional development opportunities, such as the Eisenhower program, character education, discipline, safe schools, safe schools from drugs and drug dealers.

These are some of the things that the Democrats and Republicans should be able to work together on as we did work together in a few instances on charter schools and public choice; on the education flexibility bill that my good friend, the gentleman from Delaware (Mr. CASTLE), and I worked on and we worked on some of the ESEA together before the agreement fell apart.

So for the benefit of these children, for the benefit of an economy that needs better-educated children, for the benefit of our civil society and the way that this body and this Chamber should work in working together and sometimes we will politely or adamantly disagree, let us try to get Democrats and Republicans to work together on the single most important issue to most citizens today, and that is improving our public education.

PRESCRIPTION DRUG COVERAGE

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, several of my colleagues and I want to talk about prescription drug coverage. I want to talk about one of the most important issues that this Congress is deliberating upon and one that we believe there is a solution to and particularly a bipartisan solution.

I want to begin by reading from a letter that I received from a constituent of mine, a 70-year-old widow. She actually has some prescription drug coverage, but it is a $500-per-year limit, and this is what she writes: ''I am in pain daily, and I cannot correct the problems because of financial difficulty. I have stopped taking Prilosec, which cost $285 per month, Zoloft, which costs $100 per month, Lossomax, which also costs $100 per month, Zanaz, which costs $100 a month and Zocor, which costs over $100 a month. I need these drugs filled monthly and simply cannot afford them.

I am also in need of a pain pill, Viox, approximately $89, and I have not been able to purchase it. I have cried myself to sleep over this dilemma.''

Mr. Speaker, those words touched my heart when I read that letter, and that is why I have read it today, and I read it in many places across this country. My constituent does not care whether Republicans solve her problem or whether Democrats solve her problem or whether the Congress solves her problem or whether the President solves her problem. What she cares about is whether the pain goes away. What she cares about is whether the glaucoma that is making her eyesight weak is cured. What she cares about is whether she's depressed.

We have an opportunity now, right now, still this year, to put people before politics and solve the problem of my constituent, and solve the problem of elderly women and elderly men and disabled men, women and children all over this country if we can provide a prescription drug benefit.

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This House has passed a benefit. I just want to talk about how we got here. In 1965 the Medicare program was created and it was a milestone in American history. Prior to that time, if you became elderly and you lost your health care, you lost your job, you retired. Unless you were among the fortunate, you really were without and devastating illnesses shortened life and certainly lessened the quality of life for many of our elderly.

So the Congress, in 1965, did exactly the right thing, created the Medicare program, a wonderful thing, a wonderful part of Americana. But in those days, I do not think they even really gave serious consideration to creating a prescription drug benefit. Why? Because prescription drugs were not used nearly as frequently as they are today, and also because they had just bitten off a pretty big piece, in terms of the cost and the complexity of the program, to assure hospitalization care, to assure doctors' visits were going to be paid for. It was a huge accomplishment.

Now, in the 35 years that ensued between the creation of Medicare in 1965 and today, our constituents have told us, with increasing frequency, with increasing poignancy, that they are making horrible decisions between choosing to pay for the prescriptions that their doctors tell them they must have and putting food on the table; between taking the three or four pills that they are prescribed per day or maybe only taking one because they are trying to stretch out their medicines, which really is not in the interest of their health.

The Congress has not done anything. Congress has not done anything for 35

years. Why not? Well, the fundamental reason is because Congress, in most of those years, was spending money like mad and plunging this Nation into what seemed like an irreversible dive into debt, adding hundreds of billions of dollars to the national debt every year to the point where the public debt was approaching $6 trillion. There was just no way for Congress to seriously consider adding a new entitlement to the Medicare program, no matter how important it was, when we did not have any idea how we were going to pay for what we were already spending here in Washington.

Well, that has changed now; and since 1995 there has been a big change in this country. In 1997, we balanced the budget. In 1994, the Congressional Budget Office predicted that this year, I think that the deficit, the annual deficit that we would add to the national debt, was going to be something in excess of I think $240 billion or something like that. That was the projection. Today, because of the steps that we took in 1995, in 1996, in 1997, we balanced the budget and, in fact, this year, in 2000, we do not have a quarter of a trillion dollar deficit; we have a quarter of a trillion dollar surplus.

Now, we took the next step, this fiscal year, we said and we will not spend another penny of the Social Security revenues for anything else, as Congress had done for years and years, except Social Security. We locked it away, and we still have this surplus. We are paying down the debt. We have surplus. We have given some tax relief where it was needed and now we are in position to provide this benefit, and we can do it.

I have something in my wallet. It is a prescription drug card. I take a prescription for my cholesterol level, and when I go to the drugstore to fill out my prescription I take this little card out of my wallet and I give it to the pharmacist and the pharmacist gives me a prescription, and I give the pharmacist a few dollars in copay for that prescription. When my wife needs her prescriptions filled or my children are sick, we do the same thing. I am a fortunate man. My family is fortunate.

But every American in this country needs to have one of these. Every American, particularly the elderly, I mean I have one prescription, but my 70-year-old widowed constituent has numerous prescriptions, obviously, and she does not have one of these, except that it is good for $500 for the whole year. Mine is good all year around. The bill, the legislation we passed in this House earlier this year, would make sure every American senior and every disabled Social Security beneficiary has a card just like this to take to the drugstore to provide for their drugs. That is what we are going to talk about this evening.

Mr. Speaker, I am going to next yield the gentleman from Pennsylvania (Mr. SHERWOOD), my distinguished colleague.

Mr. SHERWOOD. Mr. Speaker, I am very grateful to my colleague, the gentleman from Pennsylvania (Mr. GREENWOOD), for arranging this opportunity to discuss the importance of making prescription drug coverage available to all older Americans. I see it as really vital to the health and well-being of seniors throughout the Commonwealth of Pennsylvania and all across the country, and that is why I voted for the Medicare Prescription 2000 Act, H.R. 4680 when it passed the House in June of this year.

In Pennsylvania, we are very fortunate to have the PACE program and the PACE Net program, which is available for low-income seniors. I am a strong supporter of the PACE program, which was enacted in 1984 by the Pennsylvania legislature and is administered by the Department of Aging. I know just how vital the PACE program is to those Pennsylvania seniors who qualify, but I also recognize that there are many individuals who have exorbitant prescription drug bills and limited incomes and are not covered by PACE.

For that reason, I supported H.R. 4680, which helps States with pharmacy assistance programs and allows them to expand coverage to more seniors.

For instance, PACE today, the State pays $205 million for people of low income. Then the State has $131 million annually for low- to moderate-income people. Now, PACE tomorrow, with the addition of the money for our prescription bill, would mean that the Federal Government would pay that $205 million that PACE was picking up for Pennsylvania's poor and low income.

So the State then would have $336 to spend for low- and moderate-income. So what would happen, the Federal Government would take over the prescriptions for the very limited-income Pennsylvanians, and the Pennsylvania program then could be a great help to the middle class.

New Federal subsidies would allow governors to expand popular State pharmacy assistance programs to the middle class. The Republican Congress can really take credit for creating these subsidies. The bill we passed in the House allows States flexibility to take advantage of these new Federal subsidies.

Speaker HASTERT wrote to Governor Ridge to advise him that there would be a seamless transition to all seniors and the disabled to this new pharmaceutical assistance program. Our delegation is working closely with the leadership to assure that all Pennsylvania seniors have access to affordable, voluntary prescription drug benefit.

All the costs incurred by the PACE program, for those under 135 percent of poverty, would be picked up by the Federal Government under our new plan. Any costs incurred after $6,000 are picked up by the Federal Government. States are completely off the hook for the big expense and the low-income people. For beneficiaries of 135 percent to 150 percent of poverty, there is a partial subsidy and it allows States like Pennsylvania, New Jersey and Connecticut to greatly expand their coverage to the middle class.

This new Federal benefit goes into effect in 2003, giving our governors the time necessary to make any changes to their State programs. The bipartisan bill transfers financial liability for the millions of dually eligible beneficiaries from medicaid to Medicare, giving the governors $22.8 billion, that is billion with a ''B'' in additional funds to expand drug coverage.

The substitute bill sought to keep prescription drug coverage as a financial responsibility of the Medicaid program for which States must fund half the cost. Nothing in our bill 4680 prevents the States from funding senior access to any pharmacy. This is a cost already incurred by State pharmacy assistance programs.

My colleagues and I are totally committed to enacting a Medicare prescription drug benefit program which will allow seniors to take full advantage of a subsidized plan to hold down drug prices. The folks in this country that pay the most for a prescription are the ones that go in and buy it on their own without having the benefit of being in any plan. So that card that my colleague, the gentleman from Pennsylvania (Mr. GREENWOOD), held up a few minutes ago, if we all had access to that, that means that all prescription drugs to seniors would most probably be reduced in price from 25 to 40 percent. That, in addition to these subsidized benefits is real progress for our seniors.

Prescription drugs for seniors is far too an important issue to be playing partisan politics with. We owe it to our seniors to have a plan which is voluntary, affordable and available.

My colleagues and I are totally committed, before we go home this year, to having such a plan enacted.

Mr. GREENWOOD. Mr. Speaker, the gentleman from Pennsylvania (Mr. SHERWOOD) has made a really important point here on the floor of the House with regard to our State of Pennsylvania. If we take the legislation that we passed and match it to our current program, our PACE program, which by the way is the best program in the whole country, there are, I think, 300,000 low-income seniors in Pennsylvania who receive almost virtually cost free drugs under the PACE program financed by our lottery, the PACE Net program elevates the standard, so with some copay even more middle-class Americans, Pennsylvanians, I should say, get the benefit.

And the legislature, because the State of Pennsylvania also has a surplus, has just proposed even raising the levels higher to reach into the middle class. So by the time we take this Federal legislation that we have passed here and relieve the State of Pennsylvania, our State, of the burden of the lowest income and then you add all of those new State dollars and the existing lottery dollars to that, we will have

virtually cost free or certainly no premiums, no copays, no deductibles for a very significant portion, well up into the middle class, in Pennsylvania, and so it makes these benefits completely affordable to every one of our constituents.

I know that the gentleman from Pennsylvania (Mr. SHERWOOD) shares that.

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Mr. Speaker, I yield to the gentleman from Pennsylvania (Mr. SHERWOOD).

Mr. SHERWOOD. Mr. Speaker, I think what is so important about H.R. 4680 is that it is a flexible plan so that it fits with what we have in Pennsylvania. Because as the gentleman said, we have this wonderful PACE program, when the Federal Government picks up the part of the program that PACE has handled, then Pennsylvania, as I described before, has all of this extra money to make PACE a wraparound program so that it comes up into the middle class.

I have so many constituents that have worked hard all their lives and they have done everything right, and they own their home, and they have saved just a little money, and they have their Social Security benefit. If nothing catastrophic comes along, they can get through their golden years pretty well. But they all live in fear of a catastrophic illness or catastrophic prescription drug cost, which would drain down their resources and lose their nest egg or force them to sell their home to pay these bills.

This is a program that removes that fear for senior citizens. By supplementing the PACE program, it takes care of a great deal more of their prescription costs, and it also puts an absolute cap on the top, so that no senior should have to worry about losing their home because of the very high cost of prescription drugs.

The other thing it does is akin to a group purchasing power. As I said before, people who pay the most are the people who walk up and buy their pharmaceuticals cold turkey and pay with their own money. Anybody that is a member of a buying plan buys them at a reduced rate.

We have heard in the discussion that pharmaceuticals sometimes cost less in other countries than they cost here. That is a very involved discussion, but we need to pull the costs down here. One way that H.R. 4680 will do that is by the group purchasing power. If we take all pharmaceutical costs and reduce them by 25 to 40 percent before the government has to step in and pick up their share, then the government's money, your money, goes a lot further.

So this plan has some very good points to it. It is voluntary. If one has a plan through one's former employer or through one's union that is superior, one does not have to leave it. One can stay with that and not be charged anything because they voluntarily did not get in the plan. If this is a better plan than someone has, one can join it. If one is low-income, it will take care of all of their prescription costs. If one is middle-income, it will take care of a great many more of them than they have ever had the opportunity to do before, and it will have a level above which they have no responsibility.

Mr. Speaker, I think that the merging of our plan and PACE and PACENET in Pennsylvania would take very good care of our citizens. I am very proud to be associated with it.

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman. The fact is that two out of three of our elderly, as the gentleman mentioned, already have some kind of coverage. Some, as we have mentioned, have coverage through the PACE program. Others who are so low-income that they qualify for Medicaid get their drugs through the Medicaid program. Some have a fee-for-service Medicare program, and then they buy a Medigap insurance that in many cases provides prescription drugs; and others have a Medicare HMO, we call it Medicare+Choice, and they get their Medicare benefits through an HMO and many of those HMOs have been providing a prescription drug benefit.

The problem, as the gentleman well knows, because he has had me to his district to visit his district and to discuss this problem and its solution, the problem is that the Medicare+Choice programs have been ratcheting back their benefits. They have been providing, they used to provide relatively generous prescription drug benefits, but they are pulling back. They are pulling back because they feel that the Congress, frankly, and the administration has not been providing sufficient funds to pay for the full health care benefits of today's seniors in managed care Medicare.

So then the gentleman and I understood that both in my district and in his district and throughout Pennsylvania and throughout the country, many of these plans announced, just in July, that they were going to leave areas.

Mr. SHERWOOD. Mr. Speaker, there is a very serious problem in my district in northeastern Pennsylvania. It is inequitable. The formula was set years ago, and then it has grown over the years; and it is now that the HMO Plus Choice plans in my most rural counties are reimbursed at the rural national rate, and that is approximately $400 a month, and in the larger cities, the rate is over $700 a month.

So what it boils down to is that my rural constituents are going to be denied a benefit under Medicare that people that live in more urban areas have the benefit of. So this is a basic unfairness in the system. I have written HCFA, and I have written the President to try and solve this problem, and my colleague and I have a bill together to try and solve it, and there are some other bills coming out; but that is very important that we make sure that problem is solved before we go home by election time. Because it is basically unfair that a senior that lives in Bradford County, Pennsylvania, should not be able to get the same benefit under Medicare that a senior who lives in Philadelphia County in Pennsylvania, or in Washington, D.C., or Houston, Texas, or Miami, Florida.

So I have a great many people in my district that receive these notices. I think there are approximately 30,000 people in my congressional district that were informed in July that their Medicare+Choice provider would cease to do business under the plan on the first of January.

Now, we have asked those Medicare+Choice providers to reconsider, to wait until we can do something, and I have written to the administrator of HCFA to ask that that date be moved out so that it can be solved. But we have to get enough funding to the rural areas that people who live in rural areas have the same benefits under Medicare as people who live in urban areas.

Mr. Speaker, it goes back to something that was said earlier. Seniors do not care whether the Congress solves it or the President solves it, and they do not care whether it is prescription drug prices or HMO Plus Choice. It is all health care; it is all health care costs. We need to continue to work to make health care more available and more affordable for seniors.

This plan, H.R. 4680, goes a long way towards that. But we will have to complement that with some legislation like the gentleman's which will solve or help to solve the flight of the Medicare+Choice providers.

Mr. GREENWOOD. Mr. Speaker, if I may, the legislation is ours. I serve on the Subcommittee on Health of the Committee on Commerce, and it was the gentleman who came to me and said this is a real problem in my area; this is a real serious matter, and we put our heads together and we wrote that legislation.

The fact of the matter is, and I do not think the gentleman is even aware of this, but it is my expectation that on Tuesday of next week, yours and mine, will be taken up by the Committee on Commerce, by the full committee, will be part of a comprehensive bill to try to restore a variety of payments, probably $21 billion into the Medicare program to help our hospitals, to help our nursing care facilities, to provide better benefits for home health care, as well as to expand the likelihood that these HMOs will be able to stay in place and continue to offer that benefit.

So I am cautiously optimistic. I am actually very optimistic that, as the gentleman says, we will do that. We recognize the problem in your area and in mine and throughout the country, and we will hopefully report that legislation from committee on Tuesday. It will pass this House of Representatives, it will be signed by the President, and we will have made a real difference.

Mr. Speaker, it is my fervent hope that those health insurance plans, those HMOs that provide the Medicare+Choice benefit all over the country, once that is done, will be able to reverse the decision that they made, that they announced in July, because they have to do it in July, according to law, we require them to make that announcement; but they will be able to reverse this judgment and continue to provide service, good quality health care for our seniors in the gentleman's district and mine.

Mr. SHERWOOD. Mr. Speaker, that is very good news, and I thank the gentleman for continuing to work that bill with the Committee on Commerce, because I have made the pledge to my seniors that I will do everything in my power to get the HMO plus choice providers to stay in our area.

That is one of the big problems. Health care in rural areas is short of money, short of resources; and I have worked with local hospitals to fund the blend and to do all of the things that they need to do to remain viable, that is, to keep our medical institutions strong. This bill would help keep a service to our older Americans that live in rural areas that they deserve. I think we will have to be flexible in that, and we will have to make sure that there are enough resources there that the program works.

Mr. Speaker, I think there has been nothing since I came to Congress that has been as hard for me to get my arms around as health care has been. Being a businessperson all of my life, I always thought that I could understand any program and put it together very quickly. Well, our health care system is very, very complicated. The rules that administer it under HCFA have grown over a period of time, and some of them need changing. This is one that certainly needs changing, and I thank the gentleman for his efforts; and we will be glad to push that bill through.

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman from Pennsylvania for participating in this special order this afternoon and for all of his hard work on behalf of his seniors in his district. He must be known for that one thing in his district, because he sure talks about it here in the whole of the House.

We are joined tonight by another of our colleagues who wants to participate, fortunately, in our special order, the gentleman from Tennessee (Mr. BRYANT). And I yield to him at this time.

Mr. BRYANT. Mr. Speaker, I thank the gentleman from Pennsylvania who certainly has taken the lead in this very important legislation in the House and has been there from day one to get it started and to participate and lead us down the road, and as we pass this bipartisan bill out of the House, has been a consistent proponent of it, a spokesman, a worthy advocate of this bill. Certainly the background and the experience he brings to this House on this issue and coming from a State like Pennsylvania, which has an outstanding program, certainly cannot be lessened in any degree and must certainly be valued.

Several months ago, the gentleman from Illinois (Mr. HASTERT), the Speaker of the House, appointed a task force of House Republicans to study this issue of prescription drugs and Medicare. Along with the gentleman from Pennsylvania (Mr. GREENWOOD), I was privileged to serve on that task force; and we worked very diligently over a long period of time with the Committee on Ways and Means and the Committee on Commerce, the two primary committees that have jurisdiction over this issue, and brought forth under the Speaker's very direct, hands-on leadership, a bill that ended up being a bipartisan bill in the sense that it had both Democrat and Republican support. It had more Republicans than Democrats, quite honestly; but there was support from both sides of the aisle, although now, that party, the Democrat Party, has their own separate bill that is very different, that is the President's, the administration's bill that is very different than ours; and I will talk about that more in a minute.

But the Speaker's task force was charged with developing a fair and responsible plan to help seniors and disabled Americans with their drug expenses. We started with a set of principles that the Speaker gave us. He wanted a plan that was a voluntary plan, a universal plan that was available to everyone and affordable, and affordable, to all of the beneficiaries. He wanted to give seniors meaningful protection, some real protection and bargaining power, the ability to use the numbers, the bulk in purchasing, to achieve lower prescription drug prices, and he wanted to make sure that we preserved and protected all Medicare benefits that seniors currently have.

Finally, the Speaker wanted an insurance-based, public-private partnership that set us on a path toward a stronger, a more modern Medicare, and which would extend the life of the program for my baby boomer generation, and beyond that even.

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Coming up with a good plan that fits all of these guidelines and principles that the Speaker laid out was a very tall order. The bipartisan Medicare Prescription RX 2000 legislation, in my view, does follow these guidelines, and I believe it is the right approach.

First, our plan provides prescription drug coverage that is affordable. Seniors in my district and across the State of Tennessee that I represent have been writing and calling me asking for help with their high drug costs. We will help more people get prescription drug coverage at lower cost by creating, through this plan, the power of group purchasing, group buying, without price fixing and without government control, something we really, really do not want in this process.

For the first time, Medicare beneficiaries will no longer have to pay the highest prices for prescription drugs if we effectively use this bulk purchasing power. Under this proposal, seniors will have access to the same discounts that the rest of the insured population presently enjoys.

An analyst for the Lewin Group concluded after studying this private market-based insurance policy, they concluded that it could reduce consumer prescription drug costs by as much as 39 percent, 39 percent. That is 39 cents on every dollar.

Also, our proposed bipartisan plan strengthens Medicare so that we can protect seniors against out-of-pocket costs that are very high, that threaten the beneficiaries' health and their financial security. In other words, sometimes people have such high drug costs that they literally, seniors do, literally have to sell their home, they have to exhaust their lifelong savings to pay these drug costs. This should not be.

Our plan sets forth a monetary ceiling beyond which Medicare would come back in and pay 100 percent of the drug cost of these high cost expenses over that ceiling.

Second, our plan is available to all Medicare beneficiaries. Our public-private partnership ensures that drug coverage is available to everybody who needs it, by managing risk and lowering premiums. The plan calls for the government to share in insuring the sickest seniors, those that have those extraordinarily high drug costs, thereby making the risk more manageable for the insurers and lowering the premiums for every other beneficiary, which is something that will be very attractive to our senior citizens.

We protect the most vulnerable citizens by providing the 100 percent Federal assistance for the low-income beneficiaries. In other words, those seniors that cannot afford to pay these premiums at the lower end get their premium subsidized 100 percent by the government under our plan.

Thirdly, our plan is voluntary and provides seniors the right to choose the coverage that best suits their needs. Beneficiaries would be able to choose from several competing drug plans. Also, because the drug benefit is 100 percent voluntary, it preserves the beneficiaries' right to keep the coverage they already have.

I cannot tell my colleagues how many times I go home and I start talking about this, this plan, and somebody stands up and says, listen, I do not want the government taking away the present drug benefit I have. I am retired. I like the plan I have got. I do not want this one-shoe-fits-all type government response that you are talking about.

I tell them, well, that is not what we are talking about here. Our plan is voluntary. If one likes what one has, then one can keep that. But if one is among

those 35 percent of American seniors who do not have any drug coverage, this is certainly a good solution for one.

I could go on and talk about this. I think I have adequately covered what I wanted to cover about this plan. I could talk about the President's plan and how it is a good start and it moves us along the right direction, but it lacks so many of the good parts of our plan, that our plan is superior. But we believe that if the White House has a sincere interest in providing a prescription drug benefit to senior citizens, that they will be willing to begin to work with us and we, as a Congress, work with them, a commitment that we made a long time ago, and we can come up with a plan that I think that will be beneficial to our senior citizens.

But right now I do not think we sense that willingness, or I am not sure how I would put that, but maybe it is an election year. I do not know.

Mr. GREENWOOD. Mr. Speaker, it certainly is an election year. I think the thing some of us find so discouraging is we have a tendency sometimes to take our eye off the ball and remember that these are real people out there.

I read a letter from a real constituent who, in her letter, said she cries herself to sleep because she cannot afford the medicines. That story is repeated all over this country. The wealthiest country in the world, the most powerful Nation in history, and we have our grandmothers who are making these painful decisions, and they are suffering from arthritis. They are suffering from all kinds of health problems because they do not have access to these prescriptions.

Now, we did pass a bill. It happens to be the gentleman from Tennessee (Mr. BRYANt) and I are Republicans, but the bill is a bipartisan bill. It had both bipartisan sponsors as well as both Republicans and Democrats that voted for it. It is, I believe, the only comprehensive prescription drug add-on for Medicare that the Congress has ever passed. It is our bill, and we passed it, and that is terrific.

Now, we happen to like our plan better than some of the other bills, and that is what one would expect in a democracy where one has the lively debate of issues and different points of views and philosophies.

But what troubles me, frankly, is that what tends to happen, because it is an election year, is people say, well, let us take a look at their bill and see how many holes we can punch in. Let us take a look at their bill and see how many holes we can punch in that. Then we can use it in the campaign and see who gets elected to President over this issue and see who gets elected the majority in Congress over this issue and see how many Republicans and Democrats we can knock out of office over this issue. That is pretty cynical, and it does not do the issue justice.

I still believe that if President Clinton wants to, that we can sit down and we can find the common ground and we can split our differences and we can take the best issues, the best ideas from each side and at least solve a good portion of this problem in this year and, if we do not solve it all to everyone's liking this year, to continue that next year. But we ought not to lose this rare opportunity.

We are finally one Chamber, the House of Representatives has passed the first bill to provide this prescription drug benefit.

Mr. BRYANT. Mr. Speaker, will the gentleman yield?

Mr. GREENWOOD. I yield to the gentleman from Tennessee.

Mr. BRYANT. Mr. Speaker, let me echo what the gentleman from Pennsylvania is saying. I was a late baby. My mother is actually 93 years old and will be 94 her next birthday. The medical technology is great. A couple of years ago, she had a pacemaker put in, I think, about age 91 or 92, and she is rolling strong again. She has to take medication as a result of that, and, fortunately, for her, it is not too expensive, and she can pay for that.

But I think about all those other folks out there who are not as fortunate as we are as a family that have these kinds of prescription drug benefits that they really need or even higher costs that they have to incur and literally in some cases have to pick between paying other bills and having their medication filled.

As the gentleman from Pennsylvania (Mr. GREENWOOD) pointed out, this is the first Congress that has passed this type of bill. Here we are literally within reach of getting a bill that can help so many people and yet, unfortunately, it seems like the politics are out there involved in it. It is going to happen at some point, but it needs to happen now, this year, and not be politicked to death.

I see the gentleman from North Carolina (Mr. BURR) is here to talk a little bit about that. He is another expert on that subject. I am going to quit talking now and yield back to the gentleman from Pennsylvania (Mr. GREENWOOD) and thank him for what he is doing today and thank both of these gentleman for the work they have done on this very worthwhile project.

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman from Tennessee (Mr. BRYANt) for his contribution and his very great work in the committee.

We are joined now by the gentleman from North Carolina (Mr. BURR), another colleague of mine from the Subcommittee on Health and Environment of the Committee on Commerce, who really does work very hard day and night on this issue.

Mr. Speaker, it is a pleasure to yield to the gentleman from North Carolina (Mr. BURR).

Mr. BURR of North Carolina. Mr. Speaker, I thank the gentleman from Pennsylvania (Mr. GREENWOOD) for yielding to me.

The gentleman and I have done this numerous times. We did it when it was not popular to get out and talk about the expansion of a benefit. But because both of us worked 2½ years on reforming the Food and Drug Administration, we understood from that process just how many people in America were relying on the research and development that not only public entities but private companies were doing.

We understood the great advances we had made in the last 30 years in this country in treatment of disease, prevention of disease, through the use of pharmaceuticals that did not exist in the 1960s when we created Medicare.

It is not hard for me to believe that, when Medicare was created, Republicans and Democrats, neither one perceived that prescription drug coverage was a benefit that should be encompassed in it. But we have also seen through the evolution of Medicare that today the Health Care Financing Administration is, in fact, the wrong agency for us to look to to administer a new drug benefit.

I think that is why many of us took on the great challenge of, one, being the first to talk about expansion of a drug benefit for seniors, but to, two, do it in a way that addressed what we saw the problems in the delivery system, that we needed a new entity whose sole job it was to administer this benefit to the 37 million Americans, those seniors, the disabled who qualified for Medicare benefits.

It is a shame that it is an election year. If this was not a Presidential election year, we would have a drug benefit, not only passed in the House of Representatives, it would be passed in the Senate, it would be signed today by any President in the White House. But the sheer realities of the year 2000 is it is a Presidential election year. The gentleman and I have been faced with that before. But because it is a Presidential election year, it means that politics do come into health care.

At a time where we know in America that the senior population over the next 10 to 15 years will double, will move from 37 million to 72 million seniors in this country, all with the same challenges about how do I pay for prescription drugs, at a time that the mapping of the Human Genome project will be finished, we will be able to treat diseases that were chronic or terminal up to that point, we never had a cure for, and that in many cases those pharmaceuticals will now give us the ability to treat and in some cases hopefully cure, but it does no good if people cannot pay for it.

This is the first real opportunity that we have had to present a plan that is market based, that subsidizes those most at risk, that is designed in a way that the majority of seniors would want to participate out of their pocket to be part of, and for those that cannot, that they receive a government subsidy; and that it provides them the choice that they look for in any health care plan that they might look for when we created Medicare+Choice as

an option for seniors who had an insurance-based option, many of which are in Pennsylvania with the gentleman from Pennsylvania (Mr. GREENWOOD). We did not limit it to one company. We did not say it could only be offered by the Federal Government.

The American people have been very specific. One size fits all does not work in health care. Drug benefits should be no different. We should supply seniors affordability, choice, access. The sooner we can do that, the better they can plan for those later years. But, more importantly, long term, the gentleman from Pennsylvania and I both know the less expensive health care is going to be to us, because what we have been treating or what we have been operating on today might just be a prescription drug in the future.

Heart disease because of high blood pressure is controllable with pharmaceuticals today. Bypass surgery could be a thing of the past with a noninvasive procedure or with pharmaceutical treatment in the future. We will never experience this unless this body, this institution, the government moves forward with a prescription drug benefit plan that allows seniors access, choice, and affordability.

Mr. Speaker, I would appreciate the observations of the gentleman from Pennsylvania (Mr. GREENWOOD) on that.

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Mr. GREENWOOD. The point that I was thinking about making right now is that this conversation almost always turns towards the senior beneficiary of Medicare, and the gentleman has frequently in his remarks cojoined the fact that there are seniors and there is the disabled population that in fact are eligible for Social Security. And what is important to remember, when we think about that disabled community, that disabled community includes those who have very serious physical disabilities, frequently because of complicated and debilitating illnesses; and these are people who are under the age of 65.

We forget about the fact they do not have prescription drug benefits either. And they are less likely to have prescription drug benefits coming from a an employer, because they are less likely because of their disability, obviously, to have worked for an employer long enough to have had a prescription drug benefit that carries into the years when they cannot work and they are on disability. So this is another group of people who certainly need this benefit and they need it soon.

And some of those, a good number of those, their disability is the result of a mental health issue, and of course the treatment of mental illness is more and more pharmaceutical. There are more drugs coming on to the market all of the time that can help with these serious debilitating mental illnesses and in fact help those folks get back into the workforce. So our ability to provide a prescription drug benefit that also provides the benefit to the disabled population as well as the senior population is an important component of what we did pass in this House, and I commend the gentleman for remembering to remember that Medicare applies to the disabled as well as to the elderly.

Mr. BURR of North Carolina. I know the gentleman from Pennsylvania remembers that it would have been easier with a limited pot of money to say let us take care of seniors. Those other ones who might be ancillary groups, they do not fall into the same category. There was that strong argument from Members, but also that sense of responsibility that we had that we cannot leave anybody behind.

This was the most inclusive piece of legislation on prescription drugs to be debated in this institution ever. The only regret that I have is that it did not yet move past the House of Representatives; that we have not had the engagement of our friends at the other end of Pennsylvania Avenue, who talk about prescription drugs; but we have done something on prescription drugs.

We have done something that works. It expands the coverage and it provides the benefit. It means that those seniors who have had to make crucial decisions between rent and drugs, food and drugs, will not have to do it because of limited incomes. It means that we have looked at that disabled population. We have not excluded them. In many cases seniors have more employment opportunities than those who are in that disabled category, but we did not leave them behind. We included them because we knew the importance of medication but, more importantly, the importance of taking medication on a regular basis; not just when you can afford it, but on a regular basis. Because we know that those individuals, more than most, need that regular routine and that they cannot go with interruption based upon their cash flow, their lack of work that week, their lack of income that month. That safety net was provided for them, as it was for seniors.

I cannot imagine another issue that this institution could take up where we so clearly had enough vision to look down the road and see the demographic change that was happening, where we knew that the senior population will, in fact, double; where the institution did not use that vision to prepare for that future. If we miss this opportunity, how in the world will we design a benefit program that is right for my mother and that is affordable for my children when we are talking about twice as many people and having to learn how to find the right program then?

The smart thing for us to do, even though the gentleman and I know that we will not do it this calendar year, is to come back in January, to reintroduce this bill, and to make a commitment to whoever is on the other end of Pennsylvania Avenue that we are going to pass it and that we want to work with them.

Unlike a lot of talk about prescription drugs in this town, for those of us that have worked on it now since January, we have always said our door is open; we want to talk. It is just nobody has ever knocked. And when we have left it open, no one has ever shown up.

Mr. GREENWOOD. If I can reclaim time for a moment, the thing that is ironic is that, as we have said, in the history of the Congress, certainly in the last 35-year history of Medicare, it is only the one bill the gentleman and I helped to author that has passed in the House.

Now, there has been plenty of talk for 35 years from politicians on the stump running for this House and the Senate and the presidency. They have all talked about this issue. But when it came to sitting down, as we did, and saying how would we actually write this; what would the words be that we would choose to put in the bill; what would the provisions look like; how would we pay for it; how would it be flexible; how would we be able to make it affordable to the lower-income and still be affordable to the taxpayers; how does it reach into the middle class; how would we take care of the catastrophic end of things; how do we make sure it is appropriate for the disabled population as well; how do we make sure that by offering this we do not create a disincentive for employers to continue to provide the benefit; how would we do that, we grappled with all of those questions, as the gentleman knows, and we had to make decisions.

We put those decisions into a document and we said, now, can we get 218 votes out of 435 Members of the House to pass it. That meant we had to talk to various constituencies within the House to make sure that it worked in the Northeast, and that it worked in the Southwest, and it worked in the Southeast and the Northwest, and across the country. We had to do that. But when we did that, we had a document and, of course, no good deed going unpunished, we become subject to criticism. Because now people had an actual document instead of just words, and they could take that document, and they could look at it, and they could criticize this aspect or that aspect.

I think that that is what has happened, to a large extent; and I think that is unfortunate, that having put something together for the first time in history and getting it to pass the House, that we have become subject to some criticism about all of that. The hard part for us is that right now the President does not have a proposal. We do not have a bill from the President that says on paper, a document that thick, this is how I would answer all those questions about making sure that it is affordable and making sure that it meets all of these needs. We do

not have that. So we have a real document against just rhetoric, and it is making for an unbalanced debate.

I think if we can get the Members at the other end of this building, as well as the gentleman at the other end of Pennsylvania Avenue in the White House, to in fact give us some documents, we would have the basis about which we could sit in a room and combine them and merge them and work out the differences, as we do regularly and is our job.

I yield to the gentleman from North Carolina.

Mr. BURR of North Carolina. As the gentleman from Pennsylvania knows, it is one thing to talk about catastrophic coverage, which is the ability to look at the senior population and say the one thing that we can do is put the Federal Government where it should have been in health care, the safety net, and assure our seniors that if they ever spend out of pocket a certain amount of money in a given year that they will never be exposed for any more than a fixed amount, catastrophic coverage, a limit. It is one thing to talk about it; it is another thing to put it on paper and to pass the test of the Congressional Budget Office or the Office of Management and Budget and have that number scored. But we did it. We did it and we lived within the framework of the available money, and we provided a stop loss for seniors of $6,000.

The President had a bunch of pieces of a plan, and he said he would like to incorporate stop loss or catastrophic loss, but the fact is that he could never do it in a way that he could put it on paper and have that paper scored because of the way he proposed designing the original plan, which was no choice, which got very little discount from the current price of pharmaceuticals in the marketplace.

The Congressional Budget Office looked at our approach and said that because we had competition, because we had provided seniors and the disabled choice in the plans that they could choose from, we will achieve at least a 25 percent discount across the board for things that are insurance-based purchased and for things that are purchased out of pocket, a 25 percent savings just by creating choice that the administration does not get with their proposal.

Mr. GREENWOOD. And if I may, that is before we even apply the Federal contribution to the actual price of the item. So that 75 is cut in half. And, of course, we pay 100 percent of the remainder for the low-income and for middle-class folks, a half. So now we are talking about going from paying 100 percent of retail price to paying 37½ percent of retail price. It is almost a two-thirds reduction in the cost of the pharmaceutical product to the average American.

Mr. BURR of North Carolina. If there existed truth in advertising on this we would have stars all across this plan because it provides at every level what seniors want.

Before the gentleman mentioned employers, I had written the word employers on a piece of paper up here because that was one of the biggest challenges that our whole task force had. There is a segment of America, a large percentage of America that are seniors today that are currently provided prescription drugs as a benefit of their retirement. As we see prices go up 11 or 12 percent a year, the question we have to look out and ask is how long will they continue to offer that benefit. Because they are not obligated to, it is just a commitment that they made when individuals retired.

We found a way to incorporate into our plan that those employers that provide that benefit, once those individuals reached that stop-loss amount, they would be covered under the Federal stop loss, a great incentive for employers to continue to provide that first dollar coverage for the millions of seniors that are currently under their health plans. We found the approach to keep the employer engaged.

We found a way to incorporate the catastrophic or the stop loss into their plan without dislocating them, which made our plan totally voluntary to every eligible person regardless of where they currently had their coverage, if they did. They could stick with that and still utilize that stop-loss protection of the national plan.

Clearly, we spent a lot of time on that, making sure that we got it right. But the fact that it was voluntary, the fact that for those that chose to participate there was choice, the fact that everybody, whether they were in their employer plan or chose one of the accredited plans by that new entity that ran the prescription drug benefit, all of them benefited from an annual stop-loss amount that protected every senior and made sure that they could not lose everything that they had accumulated because they had run into a health care problem that required unusual pharmaceutical costs.

Mr. GREENWOOD. I believe our time has just about elapsed. I want to thank the gentleman from North Carolina for his participation, as well as my other colleagues from around the country.

This clearly is, if not the number one issue in America, certainly ought to be. There is still time to resolve this issue. All we need to do is to work with the House and the Senate and the President together and, in fact, we can all be proud of meeting a need that just cries out to be met; and we think we have made a good start.

ANNOUNCEMENT OF INTENTION TO OFFER MOTION TO INSTRUCT CONFEREES ON H.R. 4205, FLOYD D. SPENCE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2001

Mr. SCARBOROUGH (during the Special Order of Mr. GREENWOOD). Mr. Speaker, pursuant to clause 7 (c) of rule XXII, I hereby announce my intention to offer a motion to instruct conferees on H.R. 4205 tomorrow. The form of the motion is as follows:

> I move that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the bill (H.R. 4205) be instructed to recede to the Senate language contained in section 701 of the Senate amendment to H.R. 4205.

The SPEAKER pro tempore (Mr. PEASE). The notice of the gentleman from Florida will appear at the appropriate place in the RECORD.

HEALTH CARE ISSUES

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

Mr. GANSKE. Mr. Speaker, I am going to speak on several issues related to health care this afternoon. As my colleagues know, before I came to Congress I was a physician practicing in Des Moines, Iowa. I do have some insight into some of these health care issues that we are trying to tie up before the end of this session, whenever that will happen.

Let me first speak about the prescription drug problem. I just finished a series of town hall meetings around my district.

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I will tell my colleagues that the high cost of prescription drugs is a real one, not just for senior citizens but for everyone, and it is a major component to the increased premiums that we are seeing for working families in terms of their health insurance premiums. Prescription drug costs for those health plans are going up 18 to 20 percent per year, and then those costs are being transferred on to the businesses that pay for health insurance and then on to increased premiums for the family. So it is not senior citizens. But from my town hall meetings, I had a senior citizen in Council Bluffs come up to me and tell me that between his wife's drug costs and his drug costs, they were spending almost $13,000 a year on prescription drugs. They were by no means a wealthy family. I had another gentleman in Atlantic, Iowa come up to me and he had a whole packet of his prescription drug costs. They amounted to almost $7,000 a year.

Now, it is true there is a certain percentage of senior citizens who are fortunate, who are healthy, who do not have any drug costs. That is about 14 percent of the Medicare population. And about 36 percent have less than $500 out of pocket. But there is a group of senior citizens that have very high drug costs. We need to address that problem.

As a Republican, I just have to offer a polite voice of dissent, because the plan that passed this House is simply not going to work. It relies heavily on